

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235238	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/12/2026
NAME OF PROVIDER OR SUPPLIER Evangelical Home - Saline		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to treat each resident with dignity and respect for one resident (R1) of three residents reviewed. Findings include: Review of the clinical record revealed R1 was admitted into the facility on 2/16/26 with diagnoses that included: lymphedema, morbid obesity, chronic pain, and age-related osteoporosis without current pathological fracture. According to the Minimum Data Set (MDS) assessment dated [DATE], R1 scored 15/15 on the Brief Interview for Mental Status exam (which indicated intact cognition). On 6/10/26 at approximately 12:45 PM, during an interview with R1, when asked about therapy services, it was reported that is a sore spot with me and described an interaction with Physical Therapist (PT) J where he told her that she didn't want to stand, he became upset with her and told her she just wanted someone to blame for not being able to stand. R1 reported that this upset her and that she had notified the facilities administrator via email but never heard back from her. R1 reported that her family friend (FF) K and family member (FM) L also expressed concerns to facility leadership about how she had been treated by PT J. In review of potential verbal abuse, when R1 was asked if she felt her interactions with PT J were expressed as verbal abuse, R1 stated I saw it that way. On 6/11/26 at 12:15 PM, during an interview with FF K it was reported that the concerns related to how R1 had been treated by PT J were relayed to the facility as concerns of verbal abuse. FF K stated, it was callous and insulting to (name of R1). A review of the Grievance Form provided by the facility revealed an attached, typed letter from FM L which stated On 2/20, (R1) called me. She was extremely upset. The physical therapist (PT J) had (R1) sit on the edge of the bed and do leg kicks then told resident to stand without assistance or equipment which she was unable to do. This had gone on for several days. The grievance form continued: (Name of R1) asked (PTJ) what she could do to improve. Told by (PT J) that she just didn't want to, that she was looking for someone to blame. (R1) described her contact with this physical therapist as verbally demoralizing and rude. R1 requested a different physical therapist. On 2/23 I called (facility name redacted). I requested to speak with case manager, social worker and head of PT. I received a call back from the nurse caring for (R1) that day. I explained my concerns. I stated I still wanted to speak with social worker, case manager and head of PT. I did not receive any call backs. On 6/12/26 at 11:45 AM, during an interview with PT J it was reported that R1 had been transitioned to a different therapist per her request but PT J was not sure why. PT J reported that nobody from leadership spoke with him regarding concerns that R1 had and he was surprised that he had been removed from her care. On 6/11/26 at 1:20 PM, during an interview with Therapy Director F, it was reported that he was aware of a concern expressed by R1 when she initially came in but he was unsure exactly what it was, I think it was a personality conflict. On 6/11/26 at 1:55 PM, during an interview with Unit Manager (UM) G, it was reported that R1 had said something to her about the therapy staff not being patient with her and felt like they were telling her that she wasn't trying. On 6/11/26 at 3:01 PM, during an interview with DON B, it was reported that the expectation would be that if it had been reported that a staff member had been verbally demoralizing and rude that it would be that they should move forward with getting more information, (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
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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	ask the resident how did it make you feel, it would prompt an investigation so that they feel safe and are in a safe environment. On 6/11/26 at 3:26 PM, DONB stated that both NHA A and UM G had copies of the grievance letter from FM I, but they reported not reading it word for word. There was no documentation that requests to speak to social worker, case manager and head of PT was honored on behalf of the resident regarding the filed grievance.		

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to notify resident representative of a change of condition, in a timely manner for one resident (R3) of three reviewed. Findings include: This citation pertains to intake 3022365. Review of the clinical record revealed R3 was admitted into the facility on [DATE] with diagnoses that included: olecranon bursitis-right elbow (inflammation of the fluid-filled sac at the tip of the elbow), encounter for surgical aftercare and need for assistance with personal care. According to the Minimum Data Set (MDS) assessment dated [DATE], R3 scored 13/15 on the Brief Interview for Mental Status exam (which indicated intact cognition). On [DATE] 2:26 PM, during a telephone interview with Family Member (FM) I, it was reported that her father had passed on 5/20, after experiencing a change of condition (low blood pressure) around 11pm on 5/19. FM ?I reported not being called when R3 began to decline and was not notified of his passing until after the body had already been sent out of the facility. FM I reported that the spouse of R3 was notified of his death by the police knocking on her door, which she described as traumatic since the spouse was alone and they were not expecting him to pass. FM I reported that she spoke with the director of nursing (DON) about her concerns related to how the family was notified of R3's passing, about not being able to view the body before it was removed from the facility, not being able to properly say good bye, and not being notified when his condition changed prior to his passing. FM I reported that the DON told her that she wasn't notified of the change of condition because she wasn't the resident's durable power of attorney. FM I added that the facility had called her in the middle of the night on a separate occasion to inform her R3 had fallen, since she was listed as the first emergency contact person which contradicted what the DON had told her. A review of R3's progress notes revealed LPN N documented on [DATE] at 9:19 AM, Resident noted a decline in condition throughout shift. Writer observed resident with labored breathing and breathing with mouth open at approximately 0315. Lung sounds assessed and noted to have abnormal breath sounds/crackles. Resident continued to have shallow respirations throughout shift and was monitored closely. Writer paged Dr. and was preparing a transfer to hospital and contact (name of ambulance service redacted). At approximately 0540, resident found unresponsive in bed. No response to verbal or sternum rubs. Charge nurse notified immediately and code blue initiated at approximately 0541. CPR/compressions initiated per facility protocol and 911 called. Oxygen provided by ambu bag during CPR efforts. Resident remained unresponsive despite emergency interventions. Time of death pronounced at 0623 by EMS. Physician, DON, police, and appropriate parties notified. Family/emergency contact notified per policy. Writer received verbal order from Dr. at 0803 to release body to funeral home. Body released per physician order and facility protocol. Several attempts were made to contact LPN N during the week of survey however; no contact was made prior to survey exit. On [DATE] at 11:34 AM, during an interview with DON, it was reported that she did not know what time the family was notified of the change of condition or death. When asked why the family was not allowed to view the body prior to it being sent out, DON reported it was because the medical examiner had already called for the resident's body to be removed and that when the police contacted the spouse, the family did not indicate which funeral home they preferred. DON confirmed that FM I was upset that R3's spouse was alone when she was told of his passing and that she was not informed by the facility. DON reported that she could not answer why the family was not notified of the change in condition that occurred at approximately 3am (as indicated in LPN Ns progress note) and that the expectation would be that the family would be called. A review of the facilities policy titled Notification of Changes Policy, documented in part The purpose of this policy is to ensure the facility promptly informs the resident, consults the resident's physician; and notified, consistent with his or her authority, resident's representative when there is a change requiring notification. The facility must inform the (continued on next page)		

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident, consult with the resident's physician and/or notify the resident's family member or legal representative when there is a change requiring such notification. The change in condition, as well as all before mentioned notifications, must be documented in the resident's medical record by assigned nurse unless otherwise designated. Circumstances requiring notification include: Significant change in the resident's physical, mental or psychosocial condition such as deterioration in health, mental or psychosocial status. This may include: a. Life-threatening conditions, or b. Clinical complications. Competent individuals: a. The facility must still contact the resident's physician and notify resident's representative, if known. A family that wishes to be informed would designate a member to receive calls. c. When a resident is mentally competent, such a designated family member should be notified of significant changes in the resident's health status because the resident may not be able to notify them personally, especially in the case of sudden illness or accident.		