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	01/29/2026

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

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, interviews, and record reviews, the facility failed to effectively clean and maintain food service equipment affecting 108 residents who consume food, resulting in the increased likelihood for cross-contamination and bacterial harborage.Findings include:On 01/27/2026 at 10:25 A.M., An initial tour of the food service was conducted with Director of Dining Services S. The following items were noted:Two 16-inch fry pans were observed (etched, scored, particulate). One of two 16-inch fry pans were also observed out-of-round.Four 8-inch non-stick fry pans were observed (etched, scored, particulate). An interview was conducted with Director of Dining Services S regarding employment longevity. Director of Dining Services S stated: I have only been here since November 17th.The 2022 FDA Model Food Code section 4-501.11 states: (A) EQUIPMENT shall be maintained in a state of repair and condition that meets the requirements specified under Parts 4-1 and 4-2. (B) EQUIPMENT components such as doors, seals, hinges, fasteners, and kick plates shall be kept intact, tight, and adjusted in accordance with manufacturer's specifications. (C) Cutting or piercing parts of can openers shall be kept sharp to minimize the creation of metal fragments that can contaminate FOOD when the container is opened.The clear plastic handled scoop was observed stored internally resting directly upon dry food product (Panko-Breadcrumbs), within the dry food storage bin. An interview was conducted with Director of Dining Services S regarding proper food scoop storage. Director of Dining Services S stated: The general practice is to store the scoop on the inside hanger.The 2022 FDA Model Food Code section 3-304.12 states: During pauses in FOOD preparation or dispensing, FOOD preparation and dispensing UTENSILS shall be stored: (A) Except as specified under (B) of this section, in the food with their handles above the top of the food and the container; (B) In food that is not time/temperature control for safety food with their handles above the top of the food within containers or equipment that can be closed, such as bins of sugar, flour, or cinnamon; (C) On a clean portion of the food preparation table or cooking equipment only if the in-use utensil and the food-contact surface of the food preparation table or cooking equipment are cleaned and sanitized at a frequency specified under SS 4-602.11 and 4-702.11.Numerous soup cups and saucers were observed stored within a black plastic storage tub, resting on the top surface of a transportation cart non-inverted.The 2022 FDA Model Food Code section 4-903.11 states: (A) Except as specified in (D) of this section, cleaned EQUIPMENT and UTENSILS, laundered LINENS, and SINGLE-SERVICE and SINGLE-USE ARTICLES shall be stored: (1) In a clean, dry location; (2) Where they are not exposed to splash, dust, or other contamination; and (3) At least 15 cm (6 inches) above the floor. (B) Clean EQUIPMENT and UTENSILS shall be stored as specified under (A) of this section and shall be stored: (1) In a self-draining position that allows air drying; and (2) Covered or inverted.On 01/29/26 at 08:45 A.M., Record review of the Policy/Procedure entitled: Storage of Pots, Dishes, Flatware, Utensils dated 5/95 revised 1/26 revealed under Policies: Pots, dishes, and flatware are stored in such a way as to prevent contamination by splash, dust, pests, or other means.On 01/29/26 at 09:00 A.M., Record review of the Policy/Procedure entitled: Food and Supply Storage dated 5/95 revised 1/26 revealed under Policies: All food, non-food items and supplies used in food preparation shall be stored in such a manner as to prevent contamination to maintain the (continued on next page)

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

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	safety and wholesomeness of the food for human consumption. Record review of the Policy/Procedure entitled: Food and Supply Storage dated 5/95 revised 1/26 further revealed under Procedures: Dry Storage: (4) Store foods in their original packages. Foods that must be opened must be stored in NSF approved containers that have tight-fitting lids. Label both the bin and the lid. Hang scoop. Scoops may be stored in bins on a scoop holder. The food level must be no closer than one inch below the handle of the scoop.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to effectively clean and maintain the physical plant affecting 108 residents, resulting in the increased likelihood for cross-contamination and bacterial harborage.Findings include:On 01/27/2026 at 3:50 P.M., An environmental tour of the facility Laundry Service was conducted with Environmental Service Manager V. The following items were noted:Clean Laundry Room: The flooring surface was observed (etched, scored, particulate). The flooring surface measured approximately 22-feet-wide by 24-feet-long. Environmental Services Manager V stated: I will enter a maintenance request into WorxHub.Soiled Laundry Room: The flooring surface was observed with black electrical tape adhered to the surface. The black electrical tape measured approximately 4-inches-wide by 60-inches-long. The flooring surface wall/floor junctures and entrance door frames were further observed soiled with accumulated and encrusted dust/dirt deposits.On 01/28/2026 at 10:40 A.M., An environmental tour was conducted with Environmental Services Manager V. The following items were noted:B-Hall/C-Hall Cut-ThroughClean Linen Room: 1 of 2 overhead light assemblies were observed non-functional.D-HallClean Linen Room: The [NAME] Silex microwave oven interior door face plate was observed (etched, scored, bubbled, chipped, corroded), exposing the inner metal surface. The damaged area measured approximately 0.5 inches wide by 3-inches-long. Environmental Services Manager V indicated she would have staff remove and replace the microwave oven as soon as possible.Redies SouthClean Linen Room: 2 of 4 overhead light assemblies were observed non-functional.Chapel: One 24-inch-wide by 24-inch-long acoustic ceiling tile was observed stained from a previous moisture leak.OT/PT: The laminate wood grain board was observed loose-to-mount on the mobile table. The wood grain board measured approximately 24-inches-wide by 60-inches-long.Entrance Foyer: One overhead light plastic lens cover was observed soiled with accumulated and encrusted dust/dirt deposits. Numerous dead insect carcasses were additionally observed within the plastic lens cover. Environmental Services Manager V indicated she would have maintenance remove and thoroughly clean the plastic lens cover as soon as possible.On 01/27/2026 at 2:50 P.M., The environmental concerns (leaking roof) were reviewed, within resident room D-1-2. Three acoustic ceiling tiles were observed missing. Plastic Vis queen sheeting was also observed protruding from the false ceiling cavity, capturing the leaking roof water into a large plastic gray receptacle. Bath towels were additionally placed strategically to absorb moisture. One taupe colored plastic waste bin was further observed with water approximately two-thirds full. On 01/27/2026 at 3:02 P.M., An interview was conducted with Maintenance Technician P regarding the roof leak, within resident room D-1-2. Maintenance Technician P stated: Maintenance was notified around 2:00 A.M. this morning. Maintenance Technician P also stated: Maintenance Technician Q was notified and came to the facility to funnel the water leak. Maintenance Technician P also stated: We moved the resident from D-1-2 to B-8-1.On 01/27/2026 at 3:08 P.M., An interview was conducted with Maintenance Team Lead N regarding the roof leak, within resident room D-1-2. Maintenance Team Lead N stated: (Contractual Vendor Name) from [NAME], OH has been called and will be onsite at approximately 4:30 P.M. today.On 01/27/2026 at 4:53 P.M., An interview was conducted with Facilities Director R regarding the status of the roof leak, within resident room D-1-2. Facilities Director R stated: (Contractual Vendor Name) is onsite and determined a defective seam was creating ice damming and roofing material buckling. Facilities Director R also stated: (Contractual Vendor Name) placed a temporary patch on the defective area, until warmer temperatures are reached for permanent repair.On 01/27/2026 at 5:05 P.M., An interview was conducted with Facilities Director R regarding the maintenance work order system. Facilities Director R stated: We have the Worx Hub software system.On 01/28/2026 at 1:50 P.M., A common area environmental tour was conducted with Facilities Director R. The following items were noted:Redies (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	North Shower Room: The commode seat was observed loose-to-mount. The commode seat could be moved from side to side approximately 4-6 inches. B-Wing Dining Room Restroom: The overhead light assembly was observed non-functional.Beauty Shop: Two 24-inch-wide by 48-inch-long acoustic ceiling tiles were observed stained from a previous moisture exposure. Facilities Director R stated: I will have staff replace the stained ceiling tiles as soon as possible.On 01/29/26 at 10:00 A.M., Record review of the Policy/Procedure entitled: Environmental Services Inspection dated 5/27/2021 revealed under Policy Statement/Purpose: It is the policy of this facility to regularly monitor environmental services to ensure the facility is maintained in a safe and sanitary manner and assessed on a regular basis.On 01/29/26 at 10:15 A.M., Record review of the Policy/Procedure entitled: Routine Cleaning and Disinfection dated 5/27/2021 revealed under Policy Statement/Purpose: It is the policy of this facility to ensure the provision of routine cleaning and disinfection in order to provide a safe, sanitary environment and to prevent the development and transmission of infections to the extent possible.On 01/29/26 at 10:30 A.M., Record review of the WorxHub Maintenance Work Orders for the last 60 days revealed no specific entries related to the aforementioned maintenance concerns.

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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 observation, interview, and record review, the facility failed to revise care plans and maintain accurate care plans for six (R2, R5, R32, R56, R91, and R101) of 22 reviewed. Findings include:Findings Include Resident #56 (R56) Review of the medical record reflected that R56 was admitted to the facility on [DATE]. Diagnoses of Hemiplegia and Hemiparesis following Cerebral Infarction affecting the right dominate side, Dysarthria following Cerebral Infarction, Expressive language disorder, major depression, Hearing loss bilateral and chronic instability of right knee. The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) revealed R56 had a Brief Interview of Mental Status (BIMS) of 14 (Cognitively intact) out of 15. Under section G0100, Activities of Daily Living (ADL) Assistance reveals R56 was 1 to 2 people for personal care. During observation and interview on 01/27/2026 at 3:58 PM, R56 was sitting in her wheelchair staring at her TV. R56 had her over the bed table beside her and she did not have anything meaningful to do to help add value to her day. No observation of an activity calendar present, no observation of activities that she could do independently. R56 stated she just has TV, not aware of anything else going on. During observation and interview on 01/28/2026 at 12:00 PM, R56 had finished her lunch and was sitting in her wheelchair parked in front of the TV. No visible activities or items to work on for entertainment. R56 stated she didn't have anything to do but watch TV. Record review revealed R56 had received three short one on one visits during the last 30 days. R56 had received four short activity rounds in the last 30 days. The last life enrichment progress note was dated 10/15/2024. No other progress notes were available to reflect visits, participation, or time spent with R56. AD E stated she was the one responsible for updating the care plans. Record review revealed R56 did not have a one-on-one visit documented for the month of January 2026. Record review revealed R56's care plan has not been updated, revised or new interventions added since 2020, six years ago. Encourage to participate in unit activities. Date Initiated: 12/17/2016 Revision on: 04/15/2020 Observe for decline in mental function and assess for physical cause report to MD Date Initiated: 09/17/2016, Revision on: 03/15/2018 COMMUNICATION: Use R56 preferred name. Identify yourself at each (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	interaction. Face the R56 when speaking and make eye contact. Reduce any distractions- turn off TV, radio, close door etc. R56 understands consistent, simple, directive sentences. Provide R56 with necessary cues- stop and return if agitated. Date Initiated: 09/05/2024 Revision on: 01/03/2025 Provide R56 with a homelike environment, Date Initiated: 09/17/2016, Revision on: 02/09/2021 R56 needs supervision and assistance with all decision making. Date Initiated: 09/17/2016, Revision on: 02/09/2020 Keep R56 informed about changes in their care, life at the facility, etc. Date Initiated: 12/10/2019, Revision on: 12/10/2019 Encourage R56 to be as independent as possible and encourage them to be involved in their own care, Date Initiated: 12/10/2019, Revision on: 12/10/2019 Encourage relationships with family and friends, Date Initiated: 12/10/2019 Record review revealed R56's care plan had not been updated to reflect changes in several years and is not getting updated or new interventions added during quarterly assessments or care conferences. Resident #101 (R101) Review of the medical record reflected that R101 was admitted to the facility on [DATE]. Diagnoses of Chronic Respiratory Failure, Diabetes Mellitus, Chronic Obstructive Pulmonary Disease, Chronic Kidney Disease, Depression, Anxiety and Chronic Pain. The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) revealed R101 had a Brief Interview of Mental Status (BIMS) of 14 (Cognitively intact) out of 15. Under section G0100, Activities of Daily Living (ADL) Assistance reveals R101 was dependent of all personal care. During an observation and interview on 01/28/2026 at 9:18 AM, R101 stated he usually watches TV, there was no activity calendar visible, no activity items that would have been brought into his room for him to do at his leisure, R101 stated that nobody had brought anything in for him to do. During an observation and interview on 01/28/2026 at 11:45 AM, R101 sat up in his bed eating lunch, with the TV on. Record review revealed R101 had not had a one-on-one visit in the last 30 days. R101 had three activity rounds in the last 30 days. Care Plan revealed R101 had no interest to attend OOR group activities. Date Initiated: 02/05/2024 Revision on: 02/05/2024 (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R101 will continue to enjoy independent activities of choice through review date. Date Initiated: 02/05/2024 Revision on: 04/21/2025 Target Date: 03/22/2026 Compile and provide R101 with materials for independent in-room activity participation. Date Initiated: 02/05/2024 Revision on: 02/05/2024 Encourage and guide R101 to OOR group activities of interest. Date Initiated: 02/05/2024 Revision on: 02/05/2024 Provide and document 1:1 visits, per request. Date Initiated: 02/05/2024. R101's care plan had not been updated for two years to see what this resident may or may not enjoy. Provide and document 1:1 visits - enjoys conversation, dogs, her family, etc. Date Initiated: 04/15/2020 Provide pet visits when available – R56 really loves dogs. Date Initiated: 04/09/2019 Revision on: 04/12/2021 Provide weekly schedules and in-room activity handouts. Date Initiated: 05/30/2020 MOBILITY: staff participation required for mobility. Date Initiated: 01/26/2024, Revision on: 09/16/2024 AP mattress Date Initiated: 09/17/2024 Pressure relieving mattress to bed and pad in wheelchair or RPD, non skid pad below cushion. Date Initiated: 01/26/2024, Revision on: 09/16/2024 Bathe biweekly or PRN, Assess skin at bath and PRN Date Initiated: 01/26/2024 Revision on: 09/16/2024 Assist Dean in developing /Provide Dean with a program of activities that is meaningful and of interest. Encourage and provide opportunities for exercise, physical activity. Date Initiated: 05/08/2024, Revision on: 05/08/2024 If/when Dean needs time to talk, encourage Dean to express his feelings. Date Initiated: 01/29/2024, Revision on: 05/08/2024 Record review revealed R101 is not getting his care plan revised or new interventions added during quarterly assessments or care conferences to reflect any changes Resident #32 (R32) Review of the clinical record, including the Minimum Data Set (MDS) with an Assessment Reference (ARD) date of 11/15/25 revealed Resident #32 (R32) was a [AGE] year-old female admitted to the facility on [DATE] with a diagnoses epilepsy and delayed psychological development. R32 scored 5 out of 15 (severe cognitive impairment) on the Brief Interview for Mental Status (BIMS). On 01/27/2026 11:05 AM R32 observed in her room sitting up in bed wearing a gown. The room was (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	dark, no television was on, no radio, no books, puzzles or any type of leisure activity observed in room/bedside. Upon approach R32 was engaged in conversation easily and was very, friendly. On 01/28/2026 at 12:15 PM, R32 was observed sitting up in bed, no television, no radio on, no books or other type of leisure activity observed at bedside. At 1:32 PM R32 was observed sitting in the B unit hallway in her wheelchair. Review of R32's activity assessment dated [DATE] revealed R32 like to watch television, coloring, spend time with friends and family and music by Bon Jovi. Review of R32's activity care plan dated 11/17/25 revealed R32 liked to spend her free time in her room with self directed activities of choice. The care plan was not individualized, it did not include what that activity of choice was, what approaches/interventions should be taken to assist R32, and it did not match the activity assessment. On 1/29/2026 at 9:51 am during an interview with Life Enrichment Director (LED) E reported R32 liked to attend anything and everything if nursing got her up and dressed. LED E further reported R32 was very social and had friends in activities that she regularly would socialize with. R32 needed to be transported by staff to and from the activity room and needed regular reminders of planned activities. LED E offered no explanation why the care plan was not person center and individualized. Resident #5 (R5): Review of the medical record reflected R5 admitted to the facility on [DATE] and readmitted [DATE], with diagnoses that included vascular dementia, unspecified fracture of lower end of right femur (9/3/25), periprosthetic fracture around internal prosthetic right knee joint (9/3/25) and Alzheimer's. The Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/16/25, reflected R5 scored three out of 15 (severe cognitive impairment) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool). R5's Risk for Falls Care Plan reflected an intervention, which was initiated 2/25/24 and revised 1/7/25, that R5 and their Power of Attorney (POA) desired to have R5's bed against the wall to provide more living space and decrease clutter, and the bed height was to be in the lowest position. The same Care Plan reflected an intervention, which was initiated 3/6/23 and revised 1/7/25, that R5's bed was to be kept in a low position at night. An intervention dated 10/31/25 reflected to keep R5's bed in a low position. Additionally, the Risk for Falls Care Plan included an intervention, which was initiated 12/6/24 and revised 1/7/25, to offer and encourage R5 to keep their walker in reach. On 01/29/2026 at 11:28 AM, R5 was observed lying in bed. The bed height was noted to be in a low position. An over-bed table was located at the left bedside. A nightstand and folding chair were observed at the right bedside. A walker was not observed in R5's room. Their bed was not observed to be positioned against the wall. In an interview on 01/29/2026 at 11:52 AM, Director of Nursing (DON) B described that Care Plans were multidisciplinary, and each department updated their part of the Care Plan. The MDS nurses also reviewed and updated Care Plans quarterly, as MDS assessments were completed. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #2 (R2) Review of the medical record reflected R2 readmitted to the facility on [DATE], with diagnoses that included chronic obstructive pulmonary disease (COPD) and vascular dementia. The admission MDS, with an ARD of 11/12/25, reflected R2 scored 14 out of 15 (cognitively intact) on the BIMS. R2's Care Plan, which was initiated 10/18/25, reflected they had Clostridioides difficile (C. diff-a highly contagious bacterium that causes diarrhea and colitis/inflammation in the colon). Interventions on the Care Plan included but were not limited, CONTACT ISOLATION: Wear gowns and masks when changing contaminated linens. Place soiled linens in bags marked biohazard. Bag linens and close bag tightly before taking to laundry. and Disinfect all equipment used before it leaves the room. On 01/27/2026 at 3:07 PM, R2 was observed seated in a chair, in their room. Contact precautions were not noted to be in place for R2. R2's medical record did not reflect active Clostridioides difficile infection, nor that contact precautions were in place. In an interview on 01/29/2026 at 11:52 AM, DON B reported R2 did not currently have Clostridioides difficile. DON B acknowledged R2's Care Plan should have been revised, as there was not an active infection. Resident #91 (R91) Review of the medical record revealed R91 was admitted to the facility on [DATE] with diagnoses that included dementia and major depressive disorder. Review of the Physician's Order dated 1/14/26 revealed an order for Quetiapine Fumarate (antipsychotic medication) 25 milligrams (mg) give one tablet by mouth at bedtime for depression. The medication was discontinued on 1/21/26. Review of R91's care plan initiated 1/12/26 and revised 1/19/26 revealed [R91] uses the psychotropic medications antidepressant and antipsychotic. R91's care plan was not updated to reflect the discontinuation of their antipsychotic medication. In an interview on 01/28/2026 at 12:29 PM, Social Worker (SW) I reported care plans were typically updated within two days to reflect medication changes. SW I agreed R91's antipsychotic had been discontinued and R91's care plans still reflected antipsychotic use. In an interview on 01/29/2026 at 11:03 AM, Director of Nursing (DON) B reported care plans should be updated to reflect medication changes. DON B reported each department was responsible for updating the care plans along with Minimum Data Set (MDS) nurses.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to preserve the dignity of two residents (resident #78 and resident # 86) of three residents reviewed. Findings include: Findings Include Resident # 78 (R78) Review of the medical record reflected that R78 was admitted to the facility on [DATE]. Diagnoses of Friedreich Ataxia, Dysphagia, Spinal Stenosis Cervical Region, Major Depression, Anxiety, Sensorineural Hearing Loss Bilateral, Expressive Language Disorder, irritability and anger. The most recent Minimum Data Set (MDS) dated [DATE] with an Assessment Reference Date (ARD) revealed R78 had a Brief Interview of Mental Status (BIMS) of 15 (Cognitively intact) out of 15. Under section G0100, Activities of Daily Living (ADL) Assistance reveals R78 was dependent of all personal care. During an interview on 01/27/2026 at 11:03, R78 stated they do treat her with respect and dignity, and some don't. R78 stated she had reported it, but nothing is done. R78 stated she had been there a long time and didn't want to make things worse. There are day CNA's and afternoon CNAs are not always nice. R78 had a hard time getting these words out with her disease process. During an interview on 01/28/26 at 12:28 PM, CNA AA stated R78 did not have a communication board, stated she has worked with R78 long enough she can understand most of her words. During an interview and observation on 01/28/26 at 12:30 PM, there was a red binder on the medication cart with R78's name on it labeled reference book. The binder included specific instructions on providing R78 care from getting up in the morning, showering, lotion, teeth brushed, dressed, setting up computer for her to use. Also in this binder was a stress relief exercise suggestions when R78 gets upset. During this interview and observation, LPN BB stated she cannot provide care for R78 due to things R78 said to her, another nurse from another floor comes down here to provide care. During an interview on 01/28/26 at 1244 PM, LPN CC stated she was the one caring for R78 today. LPN CC stated R78 was particular with who and how care is provided. During an interview and observation on 01/28/26 at 1:00 PM, Writer asked permission to go into R78's room, walked in to see CNA AA feeding her lunch, R78 asked this writer to come back in 30 mins so she could finish her lunch. During an interview and observation on 01/28/26 at 2:06 PM, R78 stated she turned on her call light last night, and they came in, turned her light off and left her room. Neither nurse nor CNA provided any care, just left her room. R78 stated many CNAs don't know her or her routine. R78 stated it upset her that she didn't know these staff members, she wants to make sure they are trained to care for her. R78 stated she gets mad at staff when they don't listen to her, she doesn't like to wear her shoes, and they won't let her keep them off. As the day goes on and she gets tired, her speech is harder to understand. Writer asked R78 if she had a communication board in the past. R78 stated she did but staff complained that it took too long to understand her. R78 stated a while back, she told the Social (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Worker about her concerns. R78 stated staff got burnt out, got a T-shirt for showing up to work, but nothing that would make their job easier. R78 stated management has no idea. During an interview on 01/29/2026 at 12:20 PM, LPN/Unit Manager F stated she had only been in her role for a couple of months. LPN/Unit Manager F stated she was aware of R78 having concerns about the staff caring for her that she doesn't know them, and they do not know her needs. LPN/Unit Manager F stated R78 would refuse to allow staff to care for her if they have not taken care of her before, she has that binder with care instructions on the medication cart. LPN/Unit Manager F stated the binder helps tell staff how to care for her the way she likes it done. Writer asked if R78 still had a communication board so she can communicate with staff, LPN/Unit Manager F stated she had not seen one since she started a couple of months ago. LPN/Unit Manager F stated R78 had a computer that she could communicate by the computer reading her eyes. LPN/Unit Manager F stated R78 was now on hospice and was declining in ways that make it hard for her to communicate, give instructions for her care and to make decisions r/t care with her being her own person, BIMBS of 15. Writer asked if R78 had ever voiced any concerns to her about this in the past, LPN/Unit Manager F stated yes, but hadn't followed up on it with SW and management yet. Writer asked what additional services hospice was providing to R78, assisting with care? LPN/Unit Manger F stated she didn't know what hospice was providing and would call the hospice nurse to discuss this. Writer asked if anyone does any activities with her, LPN/Unit Manager F stated she didn't know, that would be an activity question. LPN/Unit Manager F stated that R78 was declining and had very little control over herself anymore. Writer added that this is why it's a concern for R78, it's the only control she had left, was her care, her food, care and activity. Record review of the grievance log did not reveal this concern had been reported or addressed. Resident 86 (R86) Review of the clinical record, including the Minimum data Set (MDS) dated [DATE] revealed Resident 86 (R86) was an [AGE] year-old male admitted to the facility with diagnoses that include dementia and Parkinson's. R86 scored 3 out of 15 (severe cognitive impairment) on the Brief Interview for Mental Status (BIMS). On 01/27/2026 at 10:57 AM, Resident 86 was initially observed for 13 minutes wandering up and down B hall in his wheelchair. R86 was observed to have a line of chocolate dripping down his bottom lip to center of his chin and down his neckline coupled with a toothbrush style mustache. R86 stopped by Licensed Practical Nurse (LPN) D who pointed out to R86 that there was chocolate all over his face. LPN D did not offer to assist R86 in removing the food from his face, of note multiple staff were observed walking by R86, none of which offered to assist R86. At 11:20 am R86 was observed on the B hall same toothbrush mustache and cholate dribble from the bottom lip down his neck. On 01/28/2026 at 12:15 PM, R86 was observed sitting in the atrium area, a large ring of chocolate was observed dried around his mouth. An unknown staff member told R86 it was time to eat and transported R86 back to B hall. At 1:31 pm R86 was observed in hallway with the same chocolate ring around his mouth and face. On 01/29/2026 at 12:05 PM, LPN /Unit Manager F, stated R86 had a diagnosis of Parkinsons disease and drooled, then offered that R86 was constantly in food and like chocolate pudding. When queried what the expectation was of staff when they pass R86 in hall or do routine checks, LPN/Uni manager F stated the expectation of staff would be to assist R86 in cleaning his face.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** During an interview and observation, the facility failed to maintain privacy and confidential records for one resident (R#135) of one resident investigated.Findings IncludeResident #135 (R135)Review of the medical record reflected that R135 was admitted to the facility on [DATE]. Diagnoses of Cellulitis of Face, weakness, Chronic Kidney Disease, Muscle weakness and history of falls.The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) was still being completed due to new admission and data was not available.During an observation and interview on 01/28/2026 at 7:20 AM, phlebotomist W was in the resident's room finishing a lab draw and writer noticed R135's personal health information laying open on the top of the lab draw cart outside of the resident's room. This information was visible to anyone walking by the cart and resident's room, which was not met for the public eye. This writer read the residents' name, date of birth , diagnosis, physician orders, and labs being drawn at this visit.During this same observation and interview, writer asked phlebotomist W if this personal information should be laying out on the top of her lab draw cart for anyone to see. Discussed Health Insurance Portability and Accountability Act (HIPPA) was put in place to protect residents. Phlebotomist W stated, she was just the phlebotomist, she didn't work there. During an interview on 01/28/2026 at 8:00 AM, Licensed Practical Nurse (LPN) Unit Manager C stated she would follow up on this incident as phlebotomist W was a (name of lab) employee and comes in to do their lab draws. LPN Unit Manager C stated the employee's name, and she would address it at this time.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to provide impactful and meaningful activities for four of four residents reviewed (Resident #'s 32, 56,86 and 101).Findings include: Resident # 32 (R32) Review of the clinical record, including the Minimum Data Set (MDS) with an Assessment Reference (ARD) date of 11/15/25 revealed Resident #32 (R32) was a [AGE] year-old female admitted to the facility on [DATE] with a diagnoses epilepsy and delayed psychological development. R32 scored 5 out of 15 (severe cognitive impairment) on the Brief Interview for Mental Status (BIMS). On 01/27/2026 11:05 AM R32 observed in her room sitting up in bed wearing a gown. The room was dark, no television was on, no radio, no books, puzzles or any type of leisure activity observed in room/bedside. Upon approach R32 was engaged in conversation easily and was very, friendly. On 01/28/2026 at 12:15 PM, R32 was observed sitting up in bed, no television, no radio on, no books or other type of leisure activity observed at bedside. At 1:32 PM R32 was observed sitting in the B unit hallway in her wheelchair. Review of R32's activity assessment dated [DATE] revealed R32 like to watch television, coloring, spend time with friends and family and music by Bon Jovi. On 1/29/2026 at 9:51 am during an interview with Life Enrichment Director (LED) E reported R32 liked to attend anything and everything if nursing got her up and dressed. LED E further reported R32 was very social and had friends in activities that she regularly would socialize with. R32 needed to be transported by staff to and from the activity room and needed regular reminders of planned activities. B hall was known to have lower cognitive functioning residents on the unit, the double doors to enter the hallway are consistently shut. At the end of B hall a large living room/dining room type was observed, the room was airy, well lit, and furnished with a television, tables, chairs recliners. The doors to the lounge are was observed closed throughout 1/27 and 1/28/26. On 01/29/2026 12:19 PM, during an interview with Licensed Practical Nurse (LPN) F who also serves as Unit Manager for B, it was queried why the lounge/living rooms/ding room area at the end of the hall was observed to have the doors closed and no residents using the space. LPN F stated residents were not allowed to watch television or use that room at all unless staff were in the room with them. When queried why it was permissible for B hall residents to sit alone in their room unsupervised but not allowed to gather, socialize or watch television in the lounge area unsupervised. LPN F offered no explanation. Resident #86 (R86) Review of the clinical record, including the Minimum data Set (MDS) dated [DATE] revealed Resident 86 (R86) was an [AGE] year-old male admitted to the facility with diagnoses that include dementia and Parkinson's. R86 scored 3 out of 15 (severe cognitive impairment) on the Brief Interview for Mental Status (BIMS). On 01/27/2026 at 10:55 AM, R86 was observed wandering up and down B hall, the lounge at the end of the hall was closed, multiple residents on the unit were in bed and in their room. On 01/28/2026 (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	9:10am, Resident #86 sitting alone in the atrium. R86 was again observed sitting in the atrium at 12:15 pm. Review of R86's activity assessment dated [DATE] revealed R86 was at ease interacting with others and at ease doing scheduled activities. The assessment further revealed R86 particularly enjoyed bingo and entertainment. On 01/28/2026 2:33 PM, during an interview with Certified Nursing Assistant (CNA) X stated B hall residents were no longer able to use the dining/living/activity area on the unit unless a staff member was going to be in the room the whole time with them. CNA X explained how this was not feasible as there were other tasks duties. It was pointed out to CNA X that most residents on B unit were in there room alone with no CNA or Nurse present so what would be different? CNA X stated the B hall residents including R86 used to congregate there but the Director of Nursing made the rule that no residents were allowed if staff were not present and they needed to follow her directive. R86 was observed in his room at this time. Of note, Bingo was beginning in the life enrichment room. On 1/29/2026 at 9:51 am during an interview with Life Enrichment Director (LED) E reported R32 liked to attend anything and everything if nursing got her up and dressed. LED E further reported R32 was very social and had friends in activities that she regularly would socialize with. R32 needed to be transported by staff to and from the activity room and needed regular reminders of planned activities. B hall was known to have lower cognitive functioning residents on the unit, the double doors to enter the hallway are consistently shut. At the end of B hall, a large living room/dining room type was observed, the room was airy, well lit, and furnished with a television, tables, chairs recliners. The doors to the lounge area was observed closed throughout 1/27 and 1/28/26. LED E stated the living room area on B hall was no longer able to use unless nursing staff were in the room. when queried if nursing staff was in each resident room with residents, LED E stated she believe so. When queried what the difference was with staff not present in a room or staff not present in living room area? LED E stated she didn't know. When queried about R86, LED E stated R86 enjoyed activities and would usually come in and out with the exception of bingo and entertainment, both of those activities grabbed his attention, and he'd stay the full time for those. When queried why R32 did not attend bingo on 1/28/26 (record review revealed R86 did not refuse to attend) LED E stated she was not sure. Review of the January 2026 activity calendar revealed the facility offered no weekend or evening activities. LED E stated they haven't head evening or weekend activities in 2 years. When queried if she had complaints from residents about nothing being offered at night or weekends, LED E said yes. The Activity calendar offered Monday through Friday at 9:00 am was Morning visits and at 3:30 was 1:1 room visit. LED E stated morning visit was activity staff going to rooms to tell residents what is happening and doing checks, when queried what the 3:30 1:1 visit was, LED E said the same thing, but those were in place when she started working at the facility. On 01/29/2026 12:19 PM, during an interview with Licensed Practical Nurse (LPN) F who also serves as Unit Manager for B, it was queried why the lounge/living rooms/ding room area at the end of the hall was observed to have the doors closed and no residents using the space. LPN F stated residents were not allowed to watch television or use that room at all unless staff were in the room with them. When queried why it was permissible for B hall residents to sit alone in their room unsupervised but not allowed to gather, socialize or watch television in the lounge area unsupervised. LPN F offered no explanation. Resident #56 (R56) (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the medical record reflected that R56 was admitted to the facility on [DATE]. Diagnoses of Hemiplegia and Hemiparesis following Cerebral Infarction affecting the right dominate side, Dysarthria following Cerebral Infarction, Expressive language disorder, major depression, Hearing loss bilateral and chronic instability of right knee. The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) revealed R56 had a Brief Interview of Mental Status (BIMS) of 14 (Cognitively intact) out of 15. Under section G0100, Activities of Daily Living (ADL) Assistance reveals R56 was 1 to 2 people for personal care. During observation and interview on 01/27/2026 at 3:58 PM, R56 was sitting in her wheelchair staring at her TV. R56 had her over the bed table beside her and she did not have anything meaningful to do to help add value to her day. No observation of an activity calendar present, no observation of activities that she could do independently. R56 stated she just has TV, not aware of anything else going on. During observation and interview on 01/28/2026 at 12:00 PM, R56 had finished her lunch and was sitting in her wheelchair parked in front of the TV. No visible activities or items to work on for entertainment. R56 stated she didn't have anything to do but watch TV. During observation on 01/28/2026 at 2:00pm, Bingo was scheduled for 2:15 PM today, R56 was not taken to the activity room to participate in Bingo. During an observation and interview on 01/28/2026 at 2:44 PM, Activity Director (AD) E stated they had Bingo scheduled two times a week, for 30-45 minutes. AD E stated they go and ask every resident if they want to join, they pretty know who wants to play. Writer asked AD E about the residents that can't get down there and want to participate. AD E stated they do one on one visits and during that time they can talk with the residents, do puzzles, work on things in their rooms. AD E stated they do not have any activities in the evenings, they don't have the staff to do that. AD E also stated they do not have any activities all weekend, because they do not have staff to do so. Record review revealed R56 had received three short one on one visits during the last 30 days. R56 had received four short activity rounds in the last 30 days. The last life enrichment progress note was dated 10/15/2024. No other progress notes were available to reflect visits, participation, or time spent with R56. During an interview and record review on 01/29/2026 at 8:51 AM, AD E stated she had been in this role for one year. AD E stated she had four other staff besides herself to provide activities to residents. Two activity staff work full time, and two activity staff work part time. AD E stated they worked from 8:00 AM to 4:30 PM, Monday through Friday. AD E stated at 9:00 AM, the staff go down and talk to the residents, ask if they want to join the activity today or see if they need anything at that time. Writer asked where that would be documented and AD E stated she didn't know, it should be in plan of care (POC), or in her binder, she went to her office to get it. Record review of this binder did reveal one on one documentation for some residents; does not reflect how long they are spending with the residents. Several residents were not visited, and no documentation to validate they were visited, spent valuable time together, or any participation in meaningful conversation or proof that a activity calendar was provided, or if any activities were left for the resident to do independently. AD E stated their first activity of the day was a movie, added that movies were randomly selected (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	based on how long the movie ran and the amount of time allowed for this activity. AD E then stated selection was not based on age appropriate for these residents. AD E also stated that she keeps those logs in her binder and monthly she will empty the binder and start over for the next month and saved them in her office, not scanned into the resident's electron medical record. Writer asked if certain other residents had received a one-on-one visit, and AD E stated no, if there wasn't a one-on-one documentation sheet filled out. AD E also stated she was the one responsible for updating the care plans. Record review revealed R56 did not have a one-on-one visit documented for the month of January 2026. Record review revealed R56's care plan has not been updated, revised or new interventions added since 2020, six years ago. Encourage to participate in unit activities. Date Initiated: 12/17/2016 Revision on: 04/15/2020 Provide and document 1:1 visits - enjoys conversation, dogs, her family, etc. Date Initiated: 04/15/2020 Provide pet visits when available – R56 really loves dogs. Date Initiated: 04/09/2019 Revision on: 04/12/2021 Provide weekly schedules and in-room activity handouts. Date Initiated: 05/30/2020 R56 will participate in on unit activities as desired through review date. Date Initiated: 12/17/2016 Revision on: 05/05/2025 Target Date: 04/06/2026 R56 will participate in 1:1 visits. Date Initiated: 04/15/2020 Revision on: 05/05/2025 Target Date: 04/06/2026 R56 enjoys activities when available and 1:1 visits with staff. Date Initiated: 12/17/2016 Revision on: 04/15/2020. During an observation on 01/29/2026 at 2:30 PM, there were 10 residents that joined Bingo today out of a census of 108 residents. Promptly at 2:45 PM, Bingo was stopped and residents were taken back to their rooms. Bingo began at 2:15 PM and ended at 2:45 PM. Resident #101 (R101) Review of the medical record reflected that R101 was admitted to the facility on [DATE]. Diagnoses of Chronic Respiratory Failure, Diabetes Mellitus, Chronic Obstructive Pulmonary Disease, Chronic Kidney Disease, Depression, Anxiety and Chronic Pain. The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) revealed R101 had a Brief Interview of Mental Status (BIMS) of 14 (Cognitively intact) out of 15. Under section G0100, Activities of Daily Living (ADL) Assistance reveals R101 was dependent of all personal care. During an observation and interview on 01/28/2026 at 9:18 AM, R101 stated he usually watches TV, there was no activity calendar visible, no activity items that would have been brought into his room (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	for him to do at his leisure, R101 stated that nobody had brought anything in for him to do. During an observation and interview on 01/28/2026 at 11:45 AM, R101 sat up in his bed eating lunch, with the TV on. Record review revealed R101 had not had a one-on-one visit in the last 30 days. R101 had three activity rounds in the last 30 days. Care Plan revealed R101 had no interest to attend OOR group activities. Date Initiated: 02/05/2024 Revision on: 02/05/2024 R101 will continue to enjoy independent activities of choice through review date. Date Initiated: 02/05/2024 Revision on: 04/21/2025 Target Date: 03/22/2026 Compile and provide R101 with materials for independent in-room activity participation. Date Initiated: 02/05/2024 Revision on: 02/05/2024 Encourage and guide R101 to OOR group activities of interest. Date Initiated: 02/05/2024 Revision on: 02/05/2024 Provide and document 1:1 visits, per request. Date Initiated: 02/05/2024. R101's care plan had not been updated for two years to see what this resident may or may not enjoy. During an interview and record review on 01/29/2026 at 8:51 AM, AD E stated she had been in this role for one year. AD E stated she had four other staff besides herself to provide activities to residents. Two activity staff work full time, and two activity staff work part time. AD E stated they worked from 8:00 AM to 4:30 PM, Monday through Friday. AD E stated at 9:00 AM, the staff go down and talk to the residents, ask if they want to join the activity today or see if they need anything at that time. Writer asked where that would be documented and AD E stated she didn't know, it should be in plan of care (POC), or in her binder, she went to her office to get it. Record review of this binder did reveal one on one documentation for some residents; does not reflect how long they are spending with the residents. Several residents were not visited, and no documentation to validate they were visited, spent valuable time together, or any participation in meaningful conversation or proof that a activity calendar was provided, or if any activities were left for the resident to do independently. AD E stated their first activity of the day was a movie, added that movies were randomly selected based on how long the movie ran and the amount of time allowed for this activity. AD E then stated selection was not based on age appropriate for these residents. AD E also stated that she keeps those logs in her binder and monthly she will empty the binder and start over for the next month and saved them in her office, not scanned into the resident's electron medical record. Writer asked if certain other residents had received a one-on-one visit, and AD E stated no, if there wasn't a one-on-one documentation sheet filled out. AD E also stated she was the one responsible for updating the care plans. AD E also stated R101 refuses, only likes pet visits. Doesn't have the pet visits on a routine basis.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure two (R72, R101) of four residents reviewed received care and services in accordance with professional standards of practice and the care plan. Findings include: Resident #101 (R101) Review of the medical record reflected that R101 was admitted to the facility on [DATE]. Diagnoses of Chronic Respiratory Failure, Diabetes Mellitus, Chronic Obstructive Pulmonary Disease, Chronic Kidney Disease, Depression, Anxiety and Chronic Pain. The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) revealed R101 had a Brief Interview of Mental Status (BIMS) of 14 (Cognitively intact) out of 15. Under section G0100, Activities of Daily Living (ADL) Assistance reveals R101 was dependent of all personal care. During an interview on 01/28/2026 at 9:08 AM, R101 stated he did not get any range of motion (ROM) or repositioning like he is supposed to be getting. R101 added he cannot reposition himself, so the staff know they had to do it. During an interview on 01/29/2026 at 7:39 AM, Certified Nursing Assistance (CNA) Y stated R101 required being repositioned every two hours as he cannot reposition himself. During an interview on 01/29/2026 at 7:45 AM, LPN Z stated R101 needed repositioning every two hours since he could not do it himself, adding as the wound care nurse, who completed the treatments and followed up on his red areas from not being repositioned every two hours. Record review revealed it was on the kardex and care planned but was not being done. R101 was only repositioned 3 times a shift, not every 2 hours. R101 received ROM for 10 minutes one time in the last 30 days. Care plan record review for R101; was at risk for falls r/t decreased mobility, chronic respiratory failure and COPD with O2 use, right foot drop and other chronic pain, DMII, MDD with med use, Anxiety and Insomnia. Call light in reach, provide adequate light, keep floor clean, dry, and free of clutter Date Initiated: 01/08/2026 Revision on: 01/08/2026 Fall on 1/29/2024 03:30 Intervention: Bariatric bed in place to allow more room to move around. Date Initiated: 02/01/2024 Transfer status: 2-person mechanical lift. In room mobility with WC extensive. Locomotion in hallway and on unit via WC provided extensive assistance. Unable to sit in WC for transport. Date Initiated: 12/14/2025 Revision on: 12/14/2025 MOBILITY: staff participation required for mobility. Date Initiated: 01/26/2024 Revision on: Revision 09/16/2024 ROM: Active and Passive ROM during ADLs, Date Initiated: 06/26/2024 Revision on: 06/26/2024 (continued on next page)

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	01/29/2026

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

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review did not reveal any updates or new interventions added to reflect any changes in ability to participate. Resident # 72 (R72) Review of the medical record revealed R72 admitted to the facility on [DATE] with diagnoses the included endocarditis, urinary tract infection and chronic respiratory failure with hypoxia. The Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 1/17/26 revealed R72 scored 15 out of 15 (cognitively intact) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool). On 01/27/2026 at 12:14 PM, R72 was observed sitting in a chair in their room. A Peripherally Inserted Central Catheter (PICC line-catheter inserted into a vein in the arm and threaded to a large vein near the heart) was observed in R72's left upper arm. R72 was receiving antibiotics through their PICC line. The dressing over the PICC line insertion site was dated 1/19/26. R72 reported their PICC line dressing was supposed to be changed every week, and they believed it would be changed today. A PICC line dressing kit was observed in R72's room. Review of the Physician's Order dated 1/14/26 revealed an order to measure PICC line arm circumference and external catheter length one time a day ever 7 days for IV maintenance with each dressing change and one time only for an admission or post insertion for 1 day. There were no other PICC line orders that mentioned a dressing change. Review of the eMAR-Medication Administration Note dated 1/22/26 revealed Resident refused IV pic [sic] dressing change. Resident stated, it got done on the 19th and it get [sic] change every 7 days. The medical record did not indicate that R72 was offered another PICC line dressing change. On 01/28/2026 at 11:15 AM, R72 was observed sitting in the chair in their room. R72 reported staff changed their PICC line dressing that morning (9 days since the last dressing change). The dressing was observed with a date of 1/28/26. In an interview on 01/28/26 at 12:05 PM, Licensed Practical Nurse (LPN) J reported they were R72's nurse that day, but only Registered Nurses (RNs) were able to change PICC line dressing changes. LPN J reported PICC line dressing changes were supposed to be done every 7 days. In an interview on 01/28/26 at 12:10 PM, LPN K reported PICC line dressing changes should be completed upon admission and then every 7 days. LPN K reported they changed R72's PICC line dressing change that morning (1/28/26). LPN K was unable to explain why it had been more than 7 days since R72's last dressing change. LPN K reported R72's PICC line dressing should have been changed two days earlier, on 1/26/26 and that it was expected that nurses check the dressing date every day. In an interview on 01/29/2026 at 11:01 AM, Director of Nursing (DON) B reported R72's PICC line dressing change was completed late, and the facility's policy was to change the dressing every five to seven days. Review of the facility's Catheter Insertion and Care PICC/Midline Dressing Changes dated 2013 revealed PICC/Midline catheter dressings will be changed at specified intervals, or when needed, to prevent catheter-related infections associated with contaminated, loosened or soiled catheter-site (continued on next page)

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	235238	A. Building B. Wing	01/29/2026

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	dressings .1. Change PICC/midline catheter dressing 24 hours after catheter insertion, every 5-7 days, or if it is wet, dirty, not intact, or compromised in any way.

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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 interview and record review the facility failed to provide ROM and repositioning to one resident (Resident #101) of two residents interviewed for ROM and mobility. Findings Include:Resident 101 (R101)Review of the medical record reflected that R101 was admitted to the facility on [DATE]. Diagnoses of Chronic Respiratory Failure, Diabetes Mellitus, Chronic Obstructive Pulmonary Disease, Chronic Kidney Disease, Depression, Anxiety and Chronic Pain.The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) revealed R101 had a Brief Interview of Mental Status (BIMS) of 14 (Cognitively intact) out of 15. Under section G0100, Activities of Daily Living (ADL) Assistance reveals R101 was dependent of all personal care.During an interview on 01/28/2026 at 9:08 AM, R101 stated he did not get any range of motion (ROM) or repositioning like he is supposed to be getting. R101 added he cannot reposition himself, so the staff know they had to do it. During an interview on 01/29/2026 at 7:39 AM, Certified Nursing Assistance (CNA) Y stated R101 required being repositioned every two hours as he cannot reposition himself.During an interview on 01/29/2026 at 7:45 AM, LPN Z stated R101 needed repositioning every two hours since he could not do it himself, adding as the wound care nurse, who completed the treatments and followed up on his red areas from not being repositioned every two hours. Record review revealed it was on the kardex and care planned but was not being done. R101 was only repositioned 3 times a shift, not every 2 hours. R101 received ROM for 10 minutes one time in the last 30 days. Care plan record review for R101; was at risk for falls r/t decreased mobility, chronic respiratory failure and COPD with O2 use, right foot drop and other chronic pain, DMII, MDD with med use, Anxiety and Insomnia.Call light in reach, provide adequate light, keep floor clean, dry, and free of clutter Date Initiated: 01/08/2026 Revision on: 01/08/2026 Fall on 1/29/2024 03:30 Intervention: Bariatric bed in place to allow more room to move around. Date Initiated: 02/01/2024Transfer status: 2-person mechanical lift. In room mobility with WC extensive. Locomotion in hallway and on unit via WC provided extensive assistance. Unable to sit in WC for transport. Date Initiated: 12/14/2025 Revision on: 12/14/2025MOBILITY: staff participation required for mobility. Date Initiated: 01/26/2024 Revision on: Revision 09/16/2024ROM: Active and Passive ROM during ADLs, Date Initiated: 06/26/2024 Revision on: 06/26/2024Record review did not reveal any updates or new interventions added to reflect any changes in ability to participate.

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to implement interventions to prevent falls for one (R5) of two reviewed. Findings include:Review of the medical record reflected R5 admitted to the facility on [DATE] and readmitted [DATE], with diagnoses that included vascular dementia, unspecified fracture of lower end of right femur (9/3/25), periprosthetic fracture around internal prosthetic right knee joint (9/3/25) and Alzheimer's. The Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/16/25, reflected R5 scored three out of 15 (severe cognitive impairment) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool). On 01/28/2026 at 11:39 AM, R5 was observed lying awake, in bed. The bed height was noted to be in a low position. An over-bed table was located at the left bedside. R5 was noted to be barefoot on the right foot. Their left foot was beneath the bed linens and unable to be observed. On 01/29/2026 at 11:28 AM, R5 was observed lying in bed. The bed height was noted to be in a low position. An over-bed table was located at the left bedside. A nightstand and folding chair were observed at the right bedside. An Incident Report reflected R5 had an unwitnessed fall on 8/21/25 at 8:45 AM and were found lying on the floor, at the foot of their bed. R5 was near their walker, with the seat up, and was unable to state what occurred. The Incident Report reflected R5 appeared to be reaching for their walker storage compartment, while sitting in bed, and rolled off the foot of the bed. The Predisposing Situation Factors section of the Incident Report reflected R5 asked to use the bathroom at the time of the fall, and their personal items were not in reach. The Incident Report further reflected R5 had last been toileted sometime between the hours of 12:00 AM and 6:00 AM. The intervention was to continue the planof care related to impaired physical mobility/fall risk.In an interview on 01/29/2026 at 11:52 AM, when queried about an intervention for R5's fall on 8/21/25, Director of Nursing (DON) B reportedthey were to continue the plan of care related to impaired physical mobility/fall risk. When asked if there were any changes to R5's Care Plan, DON B stated she was speculating that there were no changes, just to continue what was in the Care Plan related to R5's fall risk. When discussing if there was an expectation for a revised intervention, DON B reported it depended on what was on the Care Plan, as sometimes there were multiple falls, and they could continue to uphold appropriate interventions. An Incident Report reflected R5 had an unwitnessed fall on 8/23/25 at 12:15 AM. R5 was observed lying on the floor, with their head towards the window, facing away from the bathroom door and their feet towards the room entrance. R5 stated a man told them it was time for breakfast, so they were trying to get ready. According to the Incident Report, R5 was not wearing proper footwear at the time of the fall. R5's Risk for Falls Care Plan reflected an intervention, which was initiated 5/17/23 and revised 1/7/25, to offer and encourage gripper socks. An intervention, which was initiated 10/7/24 and revised 1/7/25, reflected to offer and encourage resident to wear proper footwear. An x-ray of the right knee on 8/23/25 revealed R5 had an acute supracondylar periprosthetic distal femur fracture (broken bone near a knee replacement). In an interview on 01/29/2026 at 11:52 AM, when queried about R5's fall on 8/23/25, DON B reported the intervention was to offer and encourage non-skid footwear prior to bed. When discussing R5's prior care planned interventions for footwear, DON B stated they should have said to continue to uphold what was in the Care Plan if the reason for R5's fall was not having appropriate footwear on. When asked if anyone determined why R5 was not wearing appropriate footwear at the time of the fall, DON B stated that conversation may have taken place, but the Unit Manager at the time of the fall was no longer employed by the facility. When asked if that information would be documented, DON B reviewed Progress Notes and stated she did not see anything documented. In a phone interview on 01/29/2026 at 1:31 PM, Registered Nurse (RN) L could not recall what type of footwear R5 had that was improper at the time of the fall on 8/23/25. RN L could not recall if anyone had taken a statement from them (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	after R5's fall. An Incident Report reflected R5 had an unwitnessed fall on 9/30/25 at 8:15 AM. According to the Incident Report, R5 was lying on their left side, pinned between their bed and the adjacent wall. Documentation reflected it appeared R5 rolled in bed and became wedged in the position they were found in. R5 was not able to describe the fall. Additional documentation on the Incident Report reflected that it appeared R5's mattress may have moved as they shifted position, allowing them to slide between the bed and the wall. There was notation to continue with the current fall Care Plan. In an interview on 01/29/2026 at 11:52 AM, when queried about an intervention for R5's fall on 9/30/25, DON B reported they were to continue with the current fall Care Plan and the interventions that were in place. DON B conveyed that interventions for falls needed to match the cause of the fall. If the Unit Manager did not feel an intervention coincided with the cause of a fall, they would not update the interventions.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, record reviews, and 2 (#72, #132) of 22 sampled residents, the facility failed to provide palatable food products affecting 108 residents who consume food, resulting in the increased likelihood for resident decreased food acceptance and nutritional decline.Findings include:On 01/27/2026 at 11:53 A.M., An interview was conducted with Director of Dining Services S regarding the resident food tray delivery schedule. Director of Dining Services S stated: Main Dining Room, C-Wing, D-Wing, B-Wing, East Hall, South Hall, and North Hall. On 01/27/2026 at 11:55 A.M., Lunch meal food trays (19) were observed leaving the food production kitchen, within an insulated food transport cart. On 01/27/2026 at 11:58 A.M., Lunch meal food trays (19) were observed arriving to C-Wing, within an insulated food transport cart. On 01/27/2026 at 12:09 P.M., Lunch meal food trays (23) were observed leaving the food production kitchen, within an insulated food transport cart. On 01/27/2026 at 12:12 P.M., Lunch meal food trays (23) were observed arriving to D-Wing, within an insulated food transport cart. On 01/27/2026 at 12:15 P.M., Lunch meal food trays (24) were observed leaving the food production kitchen, within an insulated food transport cart. On 01/27/2026 at 12:18 P.M., Lunch meal food trays (24) were observed arriving to B-Wing, within an insulated food transport cart. On 01/27/2026 at 12:19 P.M., The B-Wing insulated food transport cart was observed with both access doors wide open between food tray deliveries. On 01/27/2026 at 12:17 P.M., Lunch meal food trays (10) were observed leaving the food production kitchen, within an insulated food transport cart. On 01/27/2026 at 12:20 P.M., Lunch meal food trays (10) were observed arriving to East Hall, within an insulated food transport cart. On 01/27/2026 at 12:32 P.M., Lunch meal food trays (18) were observed leaving the food production kitchen, within an insulated food transport cart. On 01/27/2026 at 12:36 P.M., Lunch meal food trays (18) were observed arriving to South Hall, within an insulated food transport cart. On 01/27/2026 at 12:40 P.M., Lunch meal food trays (12) were observed leaving the food production kitchen, within an insulated food transport cart. On 01/27/2026 at 12:43 P.M., Lunch meal food trays (12) were observed arriving to North Hall, within an insulated food transport cart. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 01/27/2026 at 12:50 P.M., The North Hall insulated food transport cart was observed with both access doors wide open between food tray deliveries. On 01/27/2026 at 12:52 P.M., Food product temperatures were monitored utilizing a ThermoWorks Super-Fast Thermapen model CR2032 digital thermometer. The following food product temperatures were recorded for Resident #132's lunch meal food tray: Pork Loin Fricassee - 133.6* Mashed Potatoes - 117.2* Carrots - 122.6* Chedder Dinner Roll - 118.1 Peach Crisp - 63.1* Beverage (Coffee) - 148.4 Beverage (Lemonade) - 48.0* (*) The 2022 FDA Model Food Code section 3-501.16 states: (A) Except during preparation, cooking, or cooling, or when time is used as the public health control as specified under 3-501.19, and except as specified under ¶ (B) and in ¶ (C) of this section, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD shall be maintained: (1) At 57 degrees C (135 degrees F) or above, except that roasts cooked to a temperature and for a time specified in ¶ 3-401.11(B) or reheated as specified in ¶ 3-403.11(E) may be held at a temperature of 54oC (130oF) or above; or (2) At 5 degrees C (41 degrees F) or less. On 01/27/2026 at 1:01 P.M., An interview was conducted with Resident #132 regarding facility food products. Resident #132 stated: The taste of the food is less than desirable. Resident #132 also stated: The lemonade is generally weak in taste. Resident #132 further stated: The food tends to be on the cool side. Resident #132 additionally stated: The meat is generally dry and somewhat tough. On 01/28/2026 at 11:35 A.M., Lunch meal food trays (11) were observed leaving the food production kitchen, within an insulated food transport cart. On 01/28/2026 at 11:36 A.M., Lunch meal food trays (11) were observed arriving to the Main Dining Room, within an insulated transport cart. On 01/28/2026 at 11:48 A.M., Lunch meal food trays (21) were observed leaving the food production kitchen, within an insulated food transport cart. On 01/28/2026 at 11:51 A.M., Lunch meal food trays (21) were observed arriving to C-Hall, within an insulated food transport cart. On 01/28/2026 at 11:50 A.M., Lunch meal food trays (23) were observed leaving the food production kitchen, within an insulated food transport cart. (continued on next page)

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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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 01/28/2026 at 11:53 A.M., Lunch meal food trays (23) were observed arriving to D-Hall, within an insulated food transport cart. On 01/28/2026 at 12:01 P.M., Lunch meal food trays (24) were observed leaving the food production kitchen, within an insulated food transport cart. On 01/28/2026 at 12:04 P.M., Lunch meal food trays (24) were observed arriving to B-Hall, within an insulated food transport cart. On 01/28/2026 at 12:03 P.M., Lunch meal food trays (4) were observed leaving the food production kitchen, within a stainless steel non-insulated transport cart. On 01/28/2026 at 12:06 P.M., Lunch meal food trays (4) were observed arriving to B-Hall, within a stainless steel non-insulated transport cart. On 01/28/2026 at 12:09 P.M., Lunch meal food trays (11) were observed leaving the food production kitchen, within an insulated food transport cart. On 01/28/2026 at 12:12 P.M., Lunch meal food trays (11) were observed arriving to East Hall, within an insulated food transport cart. On 01/28/2026 at 12:21 P.M., Lunch meal food trays (24) were observed leaving the food production kitchen, within an insulated food transport cart. On 01/28/2026 at 12:24 P.M., Lunch meal food trays (24) were observed arriving to South Hall, within an insulated food transport cart. On 01/28/2026 at 12:28 P.M., Lunch meal food trays (10) were observed leaving the food production kitchen, within an insulated food transport cart. On 01/28/2026 at 12:30 P.M., Lunch meal food trays (10) were observed arriving to North Hall, within an insulated food transport cart. On 01/28/2026 at 12:33 P.M., The North Hall insulated food transport cart was observed with 1 of 2 access doors wide open between food tray deliveries. On 01/28/2026 at 12:48 P.M., Food product temperatures were monitored utilizing a ThermoWorks Super-Fast Thermapen model CR2032 digital thermometer. The following food product temperatures were recorded for Resident #72's lunch meal food tray: Hamburger - 107.4 degrees Fahrenheit* [NAME] Apple Sauce - Room Temperature Cottage Cheese - 63.9 degrees Fahrenheit* Garden Salad - 63.7 degrees Fahrenheit* Pumpkin Pie - 62.9 degrees Fahrenheit* (continued on next page)

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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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Beverage (Coffee) – 130.2 degrees Fahrenheit (*) The 2022 FDA Model Food Code section 3-501.16 states: (A) Except during preparation, cooking, or cooling, or when time is used as the public health control as specified under 3-501.19, and except as specified under ¶ (B) and in ¶ (C) of this section, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD shall be maintained: (1) At 57 degrees C (135 degrees F) or above, except that roasts cooked to a temperature and for a time specified in ¶ 3-401.11(B) or reheated as specified in ¶ 3-403.11(E) may be held at a temperature of 54oC (130oF) or above; or (2) At 5 degrees C (41 degrees F) or less. On 01/29/26 at 08:00 A.M., Record review of the Policy/Procedure entitled: Meal Quality and Temperature dated 5/95 revised 1/26 revealed under Policies: Food and drinks are palatable, attractive, and served at a safe and appetizing temperature to ensure resident satisfaction and to meet nutrition and hydration needs. On 01/29/26 at 08:15 A.M., Record review of the Policy/Procedure entitled: Meal/Tray Assembly Procedures dated 5/95 revised 1/25 revealed under Policies: Meal service is prompt and accurate to ensure temperatures and nutrient content of food is preserved. On 01/29/26 at 08:30 A.M., Record review of the Policy/Procedure entitled: Food Temperatures/Heating dated 06/29/2023 revealed under Policy: It is the policy of this facility to record food temperatures as needed to ensure food is at the proper serving temperature(s) before serving food to the patient. R72 Review of the medical record revealed R72 was admitted to the facility on [DATE] with diagnoses that included endocarditis, urinary tract infection and chronic respiratory failure with hypoxia. The Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/17/26 revealed R72 scored 15 out of 15 on the Brief Interview for Mental Status (BIMS-a cognitive screening tool). On 01/27/2026 at 11:55 AM, R72 was observed sitting in the chair in their room. R72 reported they ate meals in their room, and the food was always cold. R132 Review of the medical record revealed R132 was admitted to the facility on [DATE] with diagnoses that included cellulitis, chronic kidney disease, and moderate protein-calorie malnutrition. R132's MDS assessment was in progress. On 01/27/2026 at 10:32 AM, R132 was observed sitting in a chair in their room. R132 reported they ate all meals in their room, and all meals were served cold. R132 reported they had mentioned to staff that food was cold, and they were told that if the food was cold again, staff could warm it up. Review of a Grievance Form filed by R132 and dated 1/20/26 revealed R132 reported from 1/16/26 to present their meals had frequently been served cold during designated mealtimes. The grievance revealed the facility would review their logs to confirm proper temperature and delivery times. The grievance was listed as resolved on 1/23/26.

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	01/29/2026

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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to administer influenza and pneumococcal immunizations per consent for one (R6) of five reviewed.Findings include: Review of the medical record revealed R6 was admitted to the facility on [DATE] with diagnoses that included acute respiratory failure with hypoxia, pleural effusion, atrial fibrillation, chronic obstructive pulmonary disease, dementia, and pneumonia.Review of the Consent to Administer Pneumonia Vaccination and the Consent to Administer Influenza Vaccination revealed R6 declined both vaccinations. R6 was transferred to the hospital on [DATE] and returned to the facility on [DATE]. Review of R6's Consent to Administer Pneumonia Vaccination and the Consent to Administer Influenza Vaccination revealed R6 consented and wished to receive both vaccinations upon readmission to the facility. Review of the medical record revealed R6 did not receive either vaccination.Review of the Health Status Note dated 1/10/26 revealed R6's chest x-ray results showed pneumonia and they were started on antibiotics. In an interview on 01/29/2026 at 10:30 AM, Infection Preventionist (IP) G was able to review R6's vaccination history through the state's immunization registry and reported R6 received a pneumococcal 23 vaccination in 2011 and an influenza vaccination in 2022. IP G reviewed R6's vaccination consents and reported they did consent to receive the pneumonia and influenza vaccinations and were due for both vaccinations, but the facility did not have record of R6 receiving either.