STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235264	A. Building B. Wing	08/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ely Manor	1200 Ely St Allegan, MI 49010

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. (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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake # 2568748.Based on interview, and record review, the facility failed to provide showers/baths per resident preference and plan of care in 1 of 3 residents (Resident #102) reviewed for Activities of Daily Living (ADL) care, resulting in dissatisfaction with care, and the potential for skin complications and infection due to impaired hygiene.Findings include:In an interview on 8/19/25 at 4:18 PM, Family Member X reported they initiated a discharge for Resident #102 in May of 2025 due to concerns with poor care. Family Member X reported Resident #102 rarely received a shower/bath while at the facility and stated Resident #102 would get a shower/bath .maybe once per month .Resident #102Review of an admission Record revealed Resident #102 was a female, with pertinent diagnoses which included obstructive lung disease, heart failure, anemia, depression, anxiety, venous insufficiency, diabetes, high blood pressure, and arthritis. Noted the resident discharged from the facility on 5/23/25.Review of a Minimum Data Set (MDS) assessment for Resident #102, with a reference date of 3/11/25, revealed a Brief Interview for Mental Status (BIMS) score of 2, out of a total possible score of 15, which indicated severe cognitive impairment. Further review of this assessment revealed cognitive symptoms which included inattention, disorganized thinking, and altered level of consciousness, and behavioral symptoms which included verbal behavioral symptoms directed toward others and rejection of care.Review of a Care Plan for Resident #102 revealed the focus .(Resident #102) has a functional ability deficit and requires assistance with self care/mobility R/T (related to): Fatigue/Weakness, Activity Intolerance, Impaired Balance, Impaired Cognition, Impaired Mobility, Pain . with interventions which included .BATH/SHOWER .Resident .requires . Substantial/maximal assistance . initiated 1/6/25.Review of Resident #102's Shower/Bathing documentation for March 2025 revealed shower/bathing documentation on 3/1/25, 3/5/25, 3/8/25 (resident refused), 3/12/25 (resident refused), 3/15/25, and 3/16/25 which was PRN (as needed). No additional shower/bath documentation provided for March 2025 prior to survey exit.Review of Resident #102's Shower/Bathing documentation for April 2025 revealed only one shower/bath documented for the entire month, on 4/17/25, which was PRN. No additional shower/bath documentation provided for April 2025 prior to survey exit. Review of Resident #102's Shower/Bathing documentation for May 2025 revealed no shower/bath documentation for the entire month prior to the resident's discharge on [DATE]. No additional shower/bath documentation provided for May 2025 prior to survey exit.In an interview on 8/20/25 at 2:45 PM, Regional Clinical Coordinator (RCC) V reported the documentation provided was the only shower/bath documentation available for Resident #102 for March, April, and May 2025.In an interview on 8/21/25 at 11:06 AM, Director of Nursing (DON) B reported the master shower schedule was posted on the top of the nursing carts. DON B reported there was previously a glitch identified with the electronic medical record system where if a resident transferred out of the facility and later returned, the shower schedule/documentation information did not re-populate. DON B reported the facility had the IT department (internal team/service responsible for managing technical infrastructure/software) address the issue in May/June 2025. DON B reviewed Resident #102's shower documentation and reported only one shower/bath was documented as completed in April 2025, and no showers/baths were documented as completed in May 2025. DON B reported residents should be offered showers/baths generally twice per week, per their preference.Review of the policy/procedure Routine Resident Care, dated 3/12/25, revealed .Residents receive the necessary assistance to maintain good grooming and personal/oral hygiene .Showers, tub baths, and/or shampoos are scheduled according to person centered care or state specific guidelines .Additional showers are given as requested .

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	This citation pertains to intake # 2592873.Based on interview, and record review, the facility failed to provide adequate supervision to prevent elopement and respond appropriately to an alarming exit door to ensure resident safety in 1 of 5 residents (Resident #101) reviewed for elopement/supervision, resulting in an Immediate Jeopardy when on 8/13/25 between 8:30 PM and 8:45 PM, Resident #101, who was an elopement risk with a prior recent history of elopement, exited the facility, unbeknownst to facility staff, and was found by a Certified Nursing Assistant (CNA) approximately 0.3 miles away from the facility, sitting on the front porch of a residential home. This deficient practice placed all residents, identified as at risk for elopement, at risk for serious harm, injury, and/or death.Findings include:The facility failed to provide adequate supervision to prevent elopement for an exit seeking resident, Resident #101, who was an elopement risk with a prior recent history of elopement, and respond appropriately to an alarming exit door to ensure resident safety. Resident #101 was found by a Certified Nursing Assistant (CNA) approximately 0.3 miles away from the facility, down a 35 MPH (miles per hour) road, sitting on the front porch of a residential home on the opposite side of the street.The Immediate Jeopardy began on 8/13/25 when the facility failed to supervise Resident #101 and he eloped from the facility between 8:30 PM-8:45 PM. The Director of Nursing (DON) B and Regional Clinical Coordinator (RCC) V were notified of the Immediate Jeopardy on 8/19/25 at 3:28 PM. The surveyor confirmed by observation, interview, and record review that the Immediate Jeopardy was removed on 8/19/25, but noncompliance remains at a scope of isolated and severity of no actual harm with potential for more than minimal harm that is not immediate jeopardy due to sustained compliance has not been verified by the State Agency.In an observation on 8/19/25 at 9:25 AM, completed a tour of the facility with DON B to review placement/functioning of wander guard devices for current residents identified as At Risk for elopement. Noted one resident within the facility wore a Fitbit style wander guard device on their right wrist.In an observation and interview on 8/19/25 at 9:42 AM, the front door/main entrance wander guard alarm system was tested, accompanied by Environmental Service Director I. Environmental Service Director I reported the door alarm/wander guard system was checked daily for appropriate functioning. Environmental Service Director I reported the front doors are unlocked during the day (between 7:00 AM-7:00 PM), however, if a resident wearing a wander guard were to approach the doors they would automatically lock. Environmental Service Director I reported an alarm would sound if a resident wearing a wander guard device were to attempt to exit the facility through the front doors while the door was ajar, or by pushing on the door for 15-seconds. This surveyor tested the front door wander guard locking system while holding an active Fitbit style wander guard device. Noted the front doors initially locked when approached with the Fitbit style device, however, after 3-4 approaches the automatic lock did not activate and this surveyor was able to open the front door without an alarm sounding. Regional Clinical Coordinator (RCC) V reported the Fitbit style device was an older device, no longer used by the facility. RCC V provided the newer style wander guard device, which appeared much more sensitive during observation and locked down every time when approached.In an observation on 8/19/25 at 10:22 AM, the fire exit door within the main dining room was observed with Environmental Service Director I. Noted the exit door must be pushed for 15-seconds to open which would activate an alarm (no code required to open the door by using the 15 second egress). No wander guard system noted on this exit door. Observed a keypad on the wall to the right of the main dining room fire exit door, with a grey flip-open panel labeled CODE FOR EMERGENCY EXIT. The box was easily opened and at eye level. Noted the code to exit the door posted within the flip-open panel.In an observation and interview on 8/19/25 at 11:26 AM, the fire exit door within the main dining room was observed with Environmental Service Director I. Again, noted the flip-open panel which contained the code to exit the door, posted on the wall to the right of the door at eye level. Environmental Service Director I entered the code and was able to open the door without activating the alarm system. Environmental Service Director I reported there was no wander guard system installed on this exit door, and he was unsure why the exit code was posted.Resident #101Review of an admission Record revealed Resident #101 was a male, with pertinent diagnoses which included cognitive communication deficit (a communication problem resulting from difficulties with cognitive function), dementia, depression, anxiety, arthritis, and insomnia. Further review of the admission Record revealed Resident #101 was not his own responsible party.Review of a Minimum Data Set (MDS) assessment for Resident #101, with a reference date of 7/24/25, revealed a Brief Interview for Mental Status (BIMS) score of 2, out of a total possible score of 15, which indicated severe cognitive