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	06/30/2026

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. This citation pertains to Intakes #3036506 and #3042881. Based on interview and record review, the facility failed to report within 24 hours to the State Agency 1) an incident of neglect, residents' unadministered medications found in a pharmacy bag with trash in it at the nurses' station on approximately 5/25/26 and 2). Timely report a second incident of neglect of residents' medications not being administered and found unadministered in a dumpster. Findings include:Review of the MI FRI (Michigan Facility Reported Incident) revealed . On June 7, 2026, the administrator {Nursing Home Administrator (NHA) C}received a call from the day shift nurse, {Licensed Practical Nurse (LPN) R}, stating that a pharmacy bag of medications was retrieved from the dumpster and she had concern that {Director of Nursing (DON) D}threw them out. The Administrator immediately went to the facility to begin an investigation. LPN R states that before leaving her shift (on June 6th), she brought to (DON D's) attention that he still had medications left in the cart to pass however his medications were already charted off in the electronic medical record. (DON D) admitted that he had charted the medications; however, had not yet administered the medications. (LPN R) reports that the next day (June 7th) she arrived at work and noted the medications were still in the cart when she completed the hand off report. After hand off report was received, (LPN R) also noted (DON D) to be carrying a pharmacy bag that appeared to be full. (LPN R) was at the nurse's station when she overheard (DON B) ask the unit manager, (LPN I) if she had any duplicate medications, (LPN R) states that (DON D) took a couple of medications that needed to be removed from the cart.then walked down the hall toward the back door, with his personal items and pharmacy bag in hand and said goodbye to the staff. The medication bag was retrieved from the dumpster by housekeeper (H) G . Review of the MI FRI system revealed that the allegation was discovered on 6/7/2026 at 10 AM and it was reported to the State Agency on 6/9/2026 at 12:07 PM. Of note, the incident was reported 2 days after it was discovered. During an interview on 6/26/2026 at 3:35 PM, LPN Q she suspected that DON D didn't pass resident medications multiple times and she along with other staff told NHA C that they thought this was going on for a while, but NHA C stated that she needed proof. LPN Q stated before the incident on the morning of 6/7/2026, there was another incident a few weeks before (wasn't sure of the date) when DON D worked overnight and he put trash in with medications and left it by trash can in a pharmacy bag at the nurses' station and said he was going home. LPN R found the bag of medications, and she wasn't sure if he was hiding unpassed medications or throwing them away. LPN R called the manager LPN I' at the time and LPN I called NHA C. LPN Q stated that NHA C was told about the incident before 6/7/2026 and she acted like no one reported the previous incident to her. LPN Q said she was very upset and the other nurses were too since NHA C didn't do anything about it before so she told NHA C that something had to be done and DON D's license had to be reported and if she didn't do anything about it she would. During an interview on 6/26/2026 at 4:18 PM, LPN R stated that DON D admitted that he didn't give lots of people their medications and then said he probably made mistakes before like some other nurses. LPN R stated there was another incident a few weeks before the incident on 6/7/2026 (couldn't remember the date) where DON D had trash on top of medications by the trash can and this was reported to LPN I who notified NHA C. LPN R stated that (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

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	06/30/2026

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	she was told by NHA C that there was no proof that he was going to throw them away and these medications could be duplicates. During an interview on 6/30/2026 at 7:05 AM, LPN I stated there was another incident a few weeks before the incident on 6/7/2026 that was brought to her attention where DON D had medications in a pharmacy bag with trash on top and she reported this to NHA C and NHA C stated those were duplicates because she talked to him. NHA C said she would keep an eye on DON D. During an interview on 6/30/2026 at 8:37 AM, LPN J was asked about any other incidents with DON D besides the one that was reported on 6/7/2026 and she stated Yes, on 5/25/2026. Memorial Day. LPN J reported that the same thing as 6/7/2026 occurred where there was a pharmacy bag with medications and trash on top at the nurses' station by the trash can. LPN J stated that NHA C mentioned before that she needed proof that DON D wasn't passing medications and this was the first time they had proof. It was reported to LPN I who then reported it to NHA C. LPN J stated that she didn't know what NHA C did about it. LPN J also reported that residents complained of not getting medications on nights before that when DON D worked, but NHA C said again that she needed proof this was occurring. On 6/30/2026 at 9:27 AM, a text communication was received from NHA C .There were no other incidents of the DON throwing out medication that I am aware of.During an interview on 6/30/2025 at 9:45 AM, RNC AA stated that there was another incident related to DON D not passing medications and LPN I told NHA C about it. RNC AA reported that the medications were locked in LPN I's office until they could review them. RNC AA stated that NHA C and her talked with DON D and he said those medications were duplicates and there weren't any narcotics. RNC AA said she then contacted Pharmacist (P) EE who said she would look at the medications. During a follow up interview on 6/30/2026 at 10:00 AM, RNC AA stated that the conversation she had with NHA C and DON D wasn't documented and the date was 5/22/2026. During an interview on 6/30/2026 at 12:31 PM, P EE stated that DON D did not call her about duplicate resident medications on 5/22/2026, 5/25/2026 or 6/6/2026 but she spoke to him when she was there for the monthly QAPI (Quality Assurance and Performance Improvement) meeting on 5/12/2026 before both incidents and DON D expressed concerns about duplicate medications and asked her to talk to the floor nurses. P EE reported that in June, RNC AA reached out to her regarding looking at duplicate resident medications and she couldn't find any evidence of duplicate medications besides an antibiotic medication since the nurse and doctor both wrote orders. During an interview on 6/30/2026 at 2:03 PM, RNC AA stated that she was told by P EE that there were duplicate medications when she did a review of the resident medications on 6/10/2026. Review of the Abuse Prohibition Policy with a revision date of 9/9/2022 revealed .Misappropriation of guest/resident property means that deliberate misplacement, exploitation, or wrongful, temporary or permanent use of guest's/resident's belongings or money without the guest's/resident's consent. G. Reporting abuse and facility response to the allegation: 1. The staff will report any allegations or suspicions of mistreatment, abuse, neglect, exploitation, misappropriation of property, and injuries of unknown source to the Administrator and DON immediately. 2. The Administrator or designee will notify the guest's/resident's representative. Also, any State or Federal agencies of allegations per state guidelines (2 hours if abuse allegation or serious injury; all others not later than 24 hours). At the conclusion of the investigation, and no later than 5 working days of the incident, the facility must report the results of the investigation and if the alleged violation is verified, take corrective action.4. In cases of abuse, neglect, misappropriation of guest/resident property, and exploitation, the Quality Assurance Performance Improvement Committee will review the circumstances to determine if changes in policies and procedures are necessary to provide further preventative measures. All cases will be reviewed at the QAPI meetings.

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	06/30/2026

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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake #2988597.Based on interview and record review, the facility issued an against medical advice (AMA) form when transferring a resident to the hospital and failed to permit 1 resident (Resident #3) of 3 residents reviewed for discharges to return to the facility resulting in the guardian having to find placement elsewhere.Findings include: Resident #3 (R3)Review of the admission Record and Minimum Data Set (MDS) dated [DATE] revealed R3 was a [AGE] year-old man who had an initial admission date of 3/4/2026 with pertinent diagnoses including dementia (a group of symptoms including memory loss, confusion, and impaired reasoning that interferes with daily life), anxiety, depression and right BKA (below knee amputation). Brief Interview for Mental Status (BIMS) reflected a score of 15 out of 15 which indicated R3 was cognitively intact. During an interview on 6/25/2026 at 9:01 AM, Hospital Social Worker (HSW) U stated on 5/11/2026 R3 went to the hospital from the facility, and he signed himself out when he wasn't his own decision maker. HSW U reported that the facility refused to take him (R3) back which is against the rules since he isn't his own decision maker and needed the guardian to sign off on it.Review of R3's chart revealed that Family Member (FM) GG was his court appointed guardian as of 5/19/2025.Review of R3's chart revealed that he was in and out of the hospital during his stay at the facility with his last transfer to the hospital on 5/11/2026. Review of R3's Discharge AMA form dated 5/11/2026 revealed .The resident/Legal Representative understands the following with regard to this decision: 1) The resident's physician and the IDT (Interdisciplinary Team) DO NOT RECOMMEND THIS COURSE OF ACTION. 2) The physician and IDT believe that there is a HIGH RISK that the resident may suffer a SERIOUS NEGATIVE HEALTH OUTCOME without the recommended care and services. 3) Such serious negative health outcomes may include, but are not limited to: [Describe below the specific risks related to the resident's diagnosis - e.g., the resident requires assistance to transfer and has a high risk of falls, etc.]. 4) The resident and/or the Resident's Legal Representative has had the opportunity to meet with representatives of the Facility. The Facility has explained the reasons why it advises against the resident discharging the community AMA, and the resident/Legal Representative has had the opportunity to ask questions about the consequences of the decision that he/she is making. The resident/Legal Representative has had all of his/her questions answered to his/her satisfaction. 5) Discharge Planning: Discharge planning was attempted, and the resident was provided with a copy, or Discharge planning was attempted, and the resident refused to participate and/or take a copy. The form was not filled out besides R3's name and signature, a written statement (FM GG) guardian aware of decision and Registered Nurse (RN) DD signature.Review of R3's transfer to the hospital paperwork dated 5/11/2026 included a Bed Hold Authorization form that R3 signed upon transfer to the hospital, and it was signed by RN N. The daily rate for the bed hold was blank and there was no notation that the guardian was notified of the bed hold.Review of R3's progress noted dated 5/11/2026 documented by RN DD revealed Resident (R3) yelling at staff stating I'm f******calling 911.I don't feel good and the hospital I was just at didn't do anything for me.I'm leaving and no one is stopping me. This writer attempted to assess resident and he continued to yell. VS (vital signs) were taken as resident allowed, they are stable. Phone call to guardian, (FM GG) to discuss. Explained situation and explained resident states he is going to the hospital AMA. Guardian states he will call his dad to discuss but his dad might not listen and guardian states it is his decision if he wants to go. This writer explained if resident goes AMA, he will have to find another placement. Resident called 911 for ambulance. Resident signed AMA form, guardian aware of AMA status and need to find new placement.on call manager and administrator aware.Review of R3's Care Plan revealed .Focus: (R3) has an actual behavior problem AEB (as evidenced by) yelling/screaming at staff, making inappropriate comments, refusing care r/t (related to) dx (diagnosis) dementia with (continued on next page)

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	06/30/2026

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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	agitation.During an interview on 6/25/2026 at 12:16 PM, FM GG stated on 5/11/2026 the facility called him and said R3 was unhappy and didn't feel good, so he called 911. FM GG reported that the nurse (RN DD) said since R3 was going to the hospital and they didn't think he needed to go, it was going to be AMA. FM GG reported that he thought R3 signed a bed hold form even though he was the guardian, but he didn't think he was called about it. FM GG said he didn't know why the bed hold form was given when the facility didn't take him back. FM GG stated that he wasn't sure why the facility didn't take him back and he wanted R3 to go back to the facility since it was close for him to visit instead of any other facility. During an interview on 6/25/2026 at 2:12 PM, previous Social Worker (SW) O stated on 5/11/2026, R3 was having behavior difficulties and demanded to go to hospital and came back and then wanted to go again to another hospital. SW O reported that the previous Nursing Home Administrator (NHA) C stated that R3 could go to the hospital, but it would be AMA and they wouldn't take him back. SW O stated that she wasn't sure why NHA C said R3 couldn't come back from the hospital, but she thought it was because of his behaviors. When discussing R3's need for FM GG to be his guardian, SW O stated R3's couldn't make good decisions due to his behaviors and mental illness. SW O reported that she couldn't find a pattern with what made R3 unhappy and he needed a lot of attention so that could have been hard for the staff. SW O mentioned that the AMA policy and form should not be used when a resident goes to the hospital, but when they go home AMA. During an interview on 6/26/2026 at 10:57 AM, NHA C stated that R3 had behaviors and was noncompliant and didn't want to follow the rules when he was at the facility. NHA C reported that on 5/11/2026 she thought R3 signed AMA paperwork by his choice and that he didn't want to come back. NHA C said there was no one in admissions at that time and the facility would consider not taking a resident back if they were in and out of the hospital a lot. NHA C thought that they allowed R3 to come back to the facility. During an interview on 6/26/2026 at 12:27 PM, Nurse Practitioner (NP) CC stated that R3 was in and out of the hospital a few times since admission and requested to go sometimes. She stated that R3 had a left BKA recently and it was being treated with antibiotics due to an infection. NP CC reported on 5/11/2026 R3 was upset so he called 911 to be taken to the hospital, When discussing R3 and the AMA papers, NP CC stated that AMA paperwork wasn't typically filled out when a resident went to the hospital. NP CC said she was told that R3 went to the hospital AMA and wasn't really involved with it. During an interview on 6/26/2026 at 1:38 PM, RN DD stated that R3 had behaviors and would cuss and yell at staff and wanted things a certain way. RN DD reported on 5/11/2026, R3 said he wanted to go to hospital so she talked to management (couldn't remember who it was and if it was on the phone or in person) and she was told to fill out AMA paperwork and to tell FM GG that they couldn't take him back without another referral. During an interview on 6/26/2026 at 2:05 PM, Regional Director of Operations (RDO) S stated that AMA paperwork was done when it wasn't safe for a resident to leave the facility. RDO S reported that R3 wanted to go to the hospital, but the facility should have accepted him back. During an interview on 6/29/2026 at 8:50 AM, Medical Director (MD) BB stated that she didn't think an AMA form should be completed when a resident went to the hospital and she wasn't aware of the situation with R3. During an interview on 6/30/2026 at 7:05 AM, Licensed Practical Nurse (LPN) I stated that R3 wanted to go to the hospital on 5/11/2026 and as far she knew he was allowed to come back to the facility. When discussing AMA paperwork for R3, LPN I said AMA paperwork should be filled out when they went home and if it wasn't safe for them, not when they go to the hospital.During an interview on 6/30/2026 at 9:58 AM, RN N stated that she couldn't remember what happened on 5/11/2026 with R3 and she didn't remember doing the bed hold form with R3. RN N reported that RN DD was the charge nurse that day. During an interview on 6/30/2026 at 10:21 AM, previous Director of Nursing (DON) D stated that he thought the decision from NHA C was to not take R3 back from the hospital. Review of the Resident Leave of Absence Policy with a review date of 11/16/2022 revealed .V. Possible Discharge. 1. A Resident's Leave of Absence, including a Leave of Absence Against Medical Advice, shall not be considered a discharge from the Facility unless the Resident him/herself provides a (continued on next page)

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	06/30/2026

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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	verbal or written notice of his/her intention to leave the Facility permanently. If a Resident and/or a Resident's Responsible Party desires to Discharge Against Medical Advice, and the Resident has the capacity to make healthcare decisions, the Resident shall be educated regarding the reasons why the discharge is not recommended and the potential risks involved, and be given the opportunity to ask questions regarding the consequences of his/her decision. The Resident and/or Resident's Responsible Party shall also be asked to sign the Discharge Against Medical Advice form.

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	06/30/2026

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake numbers 3036506 and 3042881. Based on interview and record review, the facility failed to maintain the highest practicable resident well-being by ensuring facility staff administered resident medications as ordered by the physician in 11 of 18 residents (Resident #8, #11, #6, #12, #13, #10, #16, #17, #18, #14, and #15) reviewed for medication administration, resulting in unmet medical needs and the potential for medical complication for affected residents. Findings include:Review of the MI FRI (Michigan Facility Reported Incident) revealed . On June 7, 2026, the administrator {Nursing Home Administrator (NHA) C}received a call from the day shift nurse, {Licensed Practical Nurse (LPN) R}, stating that a pharmacy bag of medications was retrieved from the dumpster and she had concern that {Director of Nursing (DON) D}threw them out. The Administrator immediately went to the facility to begin an investigation. LPN R states that before leaving her shift (on June 6th), she brought to (DON D's) attention that he still had medications left in the cart to pass however his medications were already charted off in the electronic medical record. (DON D) admitted that he had charted the medications; however, had not yet administered the medications. (LPN R) reports that the next day (June 7th) she arrived at work and noted the medications were still in the cart when she completed the hand off report. After hand off report was received, (LPN R) also noted (DON D) to be carrying a pharmacy bag that appeared to be full. (LPN R) was at the nurse's station when she overheard (DON B) ask the unit manager, (LPN I) if she had any duplicate medications, (LPN R) states that (DON D) took a couple of medications that needed to be removed from the cart.then walked down the hall toward the back door, with his personal items and pharmacy bag in hand and said goodbye to the staff. The medication bag was retrieved from the dumpster by housekeeper (H) G . According to [NAME], [NAME] A.; [NAME], [NAME] Griffin; Stockert, [NAME]; Hall, [NAME]. Fundamentals of Nursing.Health care provider- initiated interventions are dependent nursing interventions, or actions that require an order from a health care provider. The interventions are based on the health care provider's response to treating or managing a medical diagnosis .As a nurse you intervene by carrying out the health care provider's written and/or verbal orders. Administering a medication. Accessed from: Kindle Locations 16678-16684). Elsevier Health Sciences. Kindle Edition During an interview on 6/26/2026 at 8:18 AM, Certified Nursing Assistant (CNA) F stated that she worked the morning of 6/7/2026 and she heard the nurses talking with each other and they put things together that DON D did not administer medications overnight. When asked if there were complaints from residents or if she noted any changes in residents that morning, CNA F reported that some residents had behaviors/hallucinations from not getting medications or were in pain and some residents complained of not receiving medications, so she told her nurse (Agency LPN P). CNA F stated that Resident #8 was hallucinating from not receiving his medications he saw spiders that were trying to eat him and he was screaming. CNA F said Resident #8 was taken out of his room since he was bed bound. CNA F stated that residents eventually got their medications later on 6/7/2026 and they started to calm down but it took 2 to 3 days to get back to normal. CNA F mentioned that there was a list of resident complaints from that night due to them not getting their medications but she didn't know what happened to it. During an interview on 6/26/2026 at 8:48 AM, LPN P stated on the morning of 6/7/2026, she was told that residents didn't get their night medications so one of the nurses (LPN) R reported it to NHA C. LPN P stated that Resident #10 stated she was in pain that morning since she didn't receive her pain medication overnight, so she was given it and was okay. (continued on next page)

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	06/30/2026

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/26/2026 at 8:55 AM, Regional Director of Operations (RDO) S stated that NHA C called her on 6/7/2026 at 9:22 AM and reported that there was an issue with resident medications and they were retrieved from the dumpster. RDO S stated that NHA C came into the building to start the investigation and then suspended and terminated DON D. She said the interim DON (DON) B who was currently the MDS (Minimum Data Set) nurse was filling in until the new DON started. During an interview on 6/26/2026 at 10:57 AM, NHA C stated on 6/7/2026, LPN R reported to her that medications were not passed by DON D the night before and he threw them in the dumpster. So, NHA C came in that day to start an investigation. NHA C stated that this was the first time she heard of DON D not passing medications and throwing them out. NHA C reported that no residents had negative effects from the missing medications since she went over the medications prescribed, determined what was not given and didn't think anything else needed to be done since the residents were monitored by the nurses on the floor. NHA C said she called Medical Director (MD) BB, and she said she wasn't concerned about missing 1 medication and had no new orders to give. When asked what medications were not given, NHA C stated some vitamins, Tylenol, blood thinners, behavioral and pain medications but she didn't think residents had negative outcomes from it. During an interview on 6/26/2026 at 12:27 PM, Nurse Practitioner (NP) CC reported that she heard about the incident overnight on 6/6/2026 but she wasn't involved with it since MD BB was called about it. NP CC stated she didn't know the names of residents and the medications that were not given. During an interview on 6/26/2026 at 3:35 PM, LPN Q stated that she worked on the morning of 6/7/2026 when the medications were found to not be passed by DON D and he threw them in the dumpster. LPN Q said that she suspected that DON D didn't pass resident medications multiple times and she along with other staff told NHA C that they thought this was going on for a while, but NHA C stated that she needed proof. LPN Q stated before the incident on the morning of 6/7/2026, there was another incident a few weeks before (wasn't sure of the date) when DON D worked overnight and he put trash in with medications and left it by trash can in a pharmacy bag at the nurses' station and said he was going home. LPN R found the bag of medications, and she wasn't sure if he was hiding unpassed medications or throwing them away. LPN R called the manager LPN I' at the time and LPN I called NHA C. The 2nd time this happened on 6/7/2026 in the morning, LPN Q told H G to get the medications out of the dumpster that DON D threw out, and LPN R called NHA C to report what happened. LPN Q reported that DON D clicked that medications were given in the computer when they were not. LPN Q stated that NHA C was told about the other incident before 6/7/2026 and she acted like no one reported the previous incident to her. LPN Q said she was very upset and the other nurses were too since NHA C didn't do anything about it before so she told NHA C that something had to be done and DON D's license had to be reported and if she didn't do anything about it she would. During an interview on 6/26/2026 at 3:54 PM, H G stated on 6/7/2026 in the morning DON D left with a pharmacy bag and said he would see everyone later since he was working 3rd shift that night. H G reported that LPN Q asked him to get the pharmacy bag out of the dumpster. H G stated that the bag was placed in the back of dumpster and it was open and upside down, so he had to get something to get it out of the dumpster. Then, he took the bag to LPN Q and LPN R and he saw several packages of unopened resident medications since there were some names on them, and it was dated 6/6/2026. Then, H G said NHA C came to the facility to investigate. During an interview on 6/26/2026 at 4:18 PM, LPN R stated that she worked until 10pm on 6/6/2026 (continued on next page)

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	06/30/2026

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and DON D came in at 6pm and they shared a cart until 10pm. Before LPN R left at 10pm, she counted medications with DON D and noted that DON D still had all the medications on A hall to pass since they were still sitting in the cart and she reminded him to pass them and he said he would do it. Then, when she came in the next morning on 6/7/2026, LPN R spoke with LPN I and mentioned that she thought he didn't go back and pass the medications to the residents on A hall. LPN I told LPN R that sometimes DON D got ahead of himself and clicked the medications before they were given. Then, LPN R observed DON D walk over with a pharmacy bag and put it by the trash. DON D then asked LPN I if she had duplicate medications and she handed him some and he put it in the bag and said he would show NHA C that he didn't throw any medications away. LPN R reported that DON D admitted that he didn't give lots of people their medications and then said he probably made mistakes before like some other nurses then walked away with the pharmacy bag, went out to the dumpster and that was when H G retrieved the pharmacy bag from the dumpster. Then, LPN R called to report this to NHA C and she said she would come in. LPN R stated there was another incident a few weeks before (couldn't remember the date) where DON D had trash on top of medications by the trashcan and this was reported to LPN I who notified NHA C. LPN R stated that she was told by NHA C that there was no proof that he was going to throw them away and that these medications could have been duplicates. During an interview on 6/26/2026 at 5:00 PM, Regional Nurse Consultant (RNC) AA stated that she thought there was a list of residents who didn't get their medications overnight on 6/6/2026 and what the medications were but she couldn't find it and then said maybe she was thinking about another building. During an interview on 6/29/2026 at 8:50 AM, MD BB stated that NHA C called her on 6/7/2026 and told her that DON D worked the previous night and ended up not giving medications and signed out that he gave them and put them in the trash. MD BB asked if this surveyor spoke with NP CC' about the details of this incident because she might have more information and this surveyor stated that NP CC told her that she only knew about the incident but wasn't involved with it. MD BB reported that she sent an email on 6/8/2026 when she was on vacation to all the NPs about the missed medications and said most likely nothing needs to be done but to get a list of all the residents and the medications. MD BB stated that she also asked NHA C to provide a list of the residents and the medications that were missed and she didn't hear anything more after that, and when she came back from vacation there were management changes. During an interview on 6/30/2026 at 7:05 AM, LPN I stated that she worked many night shifts and on opposite halls as DON D when he worked nights and she didn't see anything that night. On 6/7/2026 in the morning, the day shift nurses reported to her that DON D took resident medications, put them in the trash, and then LPN R reported this to the NHA. LPN I stated there was another incident a few weeks before that was brought to her attention where DON D had medications in a pharmacy bag with trash on top and she reported this to NHA C, and NHA C stated those were duplicates because she talked to him. NHA C said she would keep an eye on DON D. During an interview on 6/30/2026 at 8:30 AM, RNC AA showed this surveyor a 1-page list of resident names and a comment about their missed medications on 6/6/2026. This was completed on 6/29/2026 by RNC AA. RNC AA said she couldn't find the list of residents and the medications that were missed that NHA C had and she knew there was a list. During an interview on 6/30/2026 at 8:37 AM, LPN J was asked about any other incidents with DON D besides the one that was reported on 6/7/2026 and she stated Yes, on 5/25/2026. Memorial Day. LPN J reported that the same thing as 6/7/2026 occurred where there was a pharmacy bag with (continued on next page)

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	06/30/2026

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	medications and trash on top at the nurses' station by the trash can. LPN J stated that NHA C mentioned before that she needed proof that DON D wasn't passing medications and this was the first time they had proof. It was reported to LPN I who then reported it to NHA C. LPN J stated that she didn't know what NHA C did about it. LPN J also reported that residents complained of not getting medications on nights before that when DON D worked, but NHA C said again that she needed proof this was occurring. On 6/30/2026 at 9:27 AM, a text communication was received from NHA C that revealed .I printed the MARs (Medication Administration Record) and reviewed and compared it with each medication that was found. They were in my office. I gave the Medical Director (MD CC) an overview of the medications verbally over the phone. There were no other incidents of the DON throwing out medication that I am aware of. During an interview on 6/30/2025 at 9:45 AM, RNC AA stated that there was another incident related to DON D not passing medications and LPN I told NHA C about it. RNC AA reported that the medications were locked in LPN I's office until they could review them. RNC AA stated that NHA C and her talked with DON D and he said the medications were duplicates and there weren't any narcotics. RNC AA said she then contacted Pharmacist (P) EE who said she would look at the medications. During a follow up interview on 6/30/2026 at 10:00 AM, RNC AA stated that the conversation she had with NHA C and DON D wasn't documented and the date was 5/22/2026. During an interview on 6/30/2026 at 10:21 AM, DON D stated that he worked the night shift from 6/6/2026 to 6/7/2026 and left in the morning and then NHA C called him and said he didn't give medications to residents overnight. DON D reported that he gave all the residents their medications and I have a problem with the nurse (LPN Q) that went to her (NHA C). DON B stated that he did everything by the book that night, passed meds and signed out everything in the MAR. DON D said that he signed out medications before giving it to the residents but ended up giving it to them before he left at the end of his shift. DON D stated that Resident #10 was the only resident with a complaint that she didn't receive her medications yet and he ended up giving them to her. When further queried about medications, DON D reported that the pharmacy sent duplicate medications many times, so he saved them to return to the pharmacy, and he called to let the pharmacy know (he wasn't sure of the date he called them). DON D said he left the duplicate medications in NHA C's office and they were supposed to start a log of duplicate medications, but they didn't. When asked about the medications found in the dumpster on 6/7/2026 in the morning, DON D stated that he did not put it there and I don't recall putting it in there. When queried about Resident #8's medications including behavioral medications that were not administered and the medications were sealed in a package, DON D stated that he did administer them and not sure why the medications were sealed. When further discussion occurred regarding 20 medication packs that were dated 6/6/2026 and were sealed and not administered, DON D stated that he wasn't sure why they were sealed and said, I gave them all. When discussing again that the night medications were to be given to the residents under his watch and 20 packs of medications were sealed and not given and whether it was fair to say those medications weren't administered, DON D said Yes. During an interview on 6/30/2026 at 12:31 PM, P EE stated that DON D did not call her about duplicate resident medications on 5/22/2026, 5/25/2026 or 6/6/2026 but she spoke to him when she was there for the monthly QAPI (Quality Assurance and Performance Improvement) meeting on 5/12/2026 before both incidents occurred and DON D expressed concerns about duplicate (continued on next page)

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	06/30/2026

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	medications and asked her to talk to the floor nurses. P EE reported that in June RNC AA reached out to her regarding looking at duplicate resident medications and she couldn't find any evidence of duplicate medications besides an antibiotic medication since the nurse and doctor both wrote orders. During an interview on 6/30/2026 at 2:03 PM, RNC AA stated that she was told by P EE that there were duplicate medications when she did a review of the resident medications on 6/10/2026. Resident #10 Review of the June 2026 Medication Administration Record (MAR) revealed Resident #10 was scheduled to receive Percocet 5/325mg on 6/6/26 at 8:00pm. The medication was documented as administered by Previous Director of Nursing (DON) D. Review of the Controlled Drug Disposition form, June 2026 revealed Resident #10's Percocet was not signed out by DON D as administered and the document had accurate medication counts, indicating it was never administered on 6/6/26 at 8:00pm. Resident #16 Review of the June 2026 MAR revealed Resident #16 was scheduled to receive Morphine Oral Concentrate 20mg/ml, 15mg every 4 hours for pain on 6/6/26 at 9:00pm and documented as administered by DON D. Review of the Controlled Drug Disposition form, June 2026 revealed Resident #16's Morphine was not signed out by DON D as administered and the document had accurate medication counts, indicating it was never administered on 6/6/26. Resident #17 Review of the June 2026 MAR revealed Resident #17 was scheduled to receive Lacosamide 100mg (anticonvulsant) at bedtime on 6/6/26 and was documented as administered by DON D. Review of the Controlled Drug Disposition form, June 2026 revealed Resident #17's Lacosamide was not signed out by DON D as administered and the document had accurate medication counts, indicating it was never administered on 6/6/26. Resident #18 Review of the June 2026 MAR revealed Resident #18 was scheduled to receive Ativan 0.5mg (for anxiety) on 6/6/26 at 8:00pm and was documented as administered by DON D. Review of the Controlled Drug Disposition form, June 2026 revealed Resident #18's Ativan was not signed out by DON D as administered and the document had accurate medication counts, indicating it was never administered on 6/6/26. Resident #14 Review of the June 2026 MAR revealed Resident #14 was scheduled to receive Clonazepam 0.5mg (for anxiety) on 6/6/26 at bedtime and was documented as administered by DON D. (continued on next page)

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	06/30/2026

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Controlled Drug Disposition form, June 2026 revealed Resident #14's Clonazepam was not signed out by DON D as administered and the document had accurate medication counts, indicating it was never administered on 6/6/26. Resident #15 Review of the June 2026 MAR revealed Resident #15 was scheduled to receive Tramadol HCl 50mg (for pain) on 6/6/26 at 8:00pm and was documented as administered by DON D. Review of the Controlled Drug Disposition form, June 2026 revealed Resident #15's Tramadol was not signed out by DON D as administered and the document had accurate medication counts, indicating it was never administered on 6/6/26. Resident #13 – controlled medication Review of the June 2026 MAR revealed Resident #13 was scheduled to receive Ativan 0.5mg (for anxiety) on 6/6/26 at 8:00pm, documented as administered by DON D on 6/6/26 at 9:16pm. Review of the Controlled Drug Disposition form, June 2026 revealed Resident #13's Ativan was not signed out by DON D as administered and the document had accurate medication counts, indicating it was never administered on 6/6/26. Review of an email correspondence from Previous Nursing Home Administrator (NHA) C revealed DON D had documented in PCC (Electronic Medication Administration Record) (the administration of the scheduled medications) however NEVER PULLED the narcotic. All medications documented below were located in a bag in the dumpster by facility staff and were sealed in plastic bags labeled with the residents' names and were unopened and unadministered by DON D. Resident #13 Review of the Face Sheet revealed Resident #13 was admitted with diagnosis that included peripheral vascular disease, history of a heart attack, transischemic attacks (brief blood blockage to brain causing stroke-like symptoms) and stroke. Resident #13's Blood Pressure Graph indicated her average blood pressure was 120/70mm/Hg. Review of the June 2026 MAR revealed Resident #13 was scheduled to receive Ticagrelor 90mg (antiplatelet medication used to prevent clots after heart stent placement) and Metoprolol Tartrate 25mg (blood pressure medication) on 6/6/26 at 8:00pm, documented as administered by DON D on 6/6/26 at 9:16pm. Review of the Blood Pressure Summary dated June 2026 revealed Resident #13's blood pressure was 127/71mm/Hg on 6/6/26 at 9:58am, on 6/7/26 at 10:22am and 10:23am, it was 163/87mm/Hg (elevated). Resident #8 Review of the Face Sheet revealed Resident #8 was admitted to the facility with diagnosis that (continued on next page)

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	06/30/2026

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	included bipolar disorder, dementia, schizophrenia, benign prostate hyperplasia (enlarged prostate), depression, high blood pressure, and post traumatic stress disorder (PTSD). Review of the June 2026 MAR revealed Resident #8 was scheduled to receive Divalproex Sodium 500mg (for bipolar disease), Flomax 0.4mg (for enlarged prostate) and Amitiza 24mcg (for constipation) on 6/6/26 at 7:00pm, documented as administered on 6/6/26 at 9:11pm. Seroquel 400mg (antipsychotic mood stabilizer), Jardiance 10 mg (diabetic medication) on 6/6/26 at 8:00pm, documented as administered on 6/6/26 at 9:11pm. Metformin MCI 500mg (diabetic medication) Ezetimibe 10mg (cholesterol medication) and Paliperidone ER 3mg (treats schizophrenia) on 6/6/26 at 9:00pm, documented as administered on 6/6/26 at 9:11pm. Review of the Laboratory report dated 12/10/25 revealed Resident #8's Depakote level was low at 32.5 ug/ml (normal 50-100 ug/ml). There were no other laboratory documents for Depakote levels in the resident's medical record. Resident #11 Review of the June 2026 MAR revealed Resident #11 was scheduled to receive Levetiracetam 500mg (seizure medication) on 6/6/26 at 7:00pm. Carbamazepine 200mg (seizure medication), Aricept 10mg (for dementia), Mirtazapine 15mg (appetite stimulant) and Bupropion HCl 100mg (for depression) on 6/6/26 at 8:00pm. All medications were documented as administered by DON D on 6/7/26 at 1:37am except Carbamazepine 200mg which was documented as administered by DON D at 9:14pm on 6/6/26. There was no indication why the other 8:00pm medications were not administered at the same time. Review of the Laboratory report dated 4/8/26 revealed Resident #11's Carbamazepine level was 10.1ug/ml (normal range 4.0-12.0 ug/ml). There were no other documents to indicate whether Resident #11's medication levels were rechecked after 6/6/26. Resident #6 Review of the Face Sheet revealed Resident #6 was admitted to the facility with diagnoses that included history of a stroke, long term use of anticoagulants, venous thrombosis (blood clot), diabetes with polyneuropathy (nerve pain), and breast cancer. Review of the June 2026 MAR revealed Resident #6 was scheduled to received Gabapentin 600mg (for nerve pain), Apixaban 5 mg (anticoagulant), and Clopidogrel Bisulfate 75mg (anticoagulant – resident history of venous thrombosis) on 6/6/26 at 8:00pm. The medications were documented as administered on 6/6/26 at 9:04pm by DON D. Resident #12 Review of the Face Sheet revealed Resident #12 was admitted with diagnoses that included [NAME] syndrome (endocrine medical condition causes high blood pressure), and heart failure. Resident #12's Blood Pressure Graph indicated her average blood pressure was 140/75mm/Hg. Review of the June 2026 MAR revealed Resident #12 was scheduled to receive Hydralazine HCl 100mg (blood pressure medication) and Metoprolol Succinate 25mg (blood pressure medication) on 6/6/26 at 9:00pm, documented as administered by DON D on 6/6/26 at 9:17pm and 10:38 pm (continued on next page)

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	06/30/2026

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	respectively. Review of the Blood Pressure Summary dated June 2026 revealed Resident #12's blood pressure was elevated at 169/73mm/Hg on 6/7/26 at 8:24 am, checked twice by facility staff for accuracy. It was documented on 6/6/26 as 133/76mm/Hg at 10:12am. There was no documentation in the Progress Notes or any other location in the medical record to indicate that any residents who did not receive their scheduled medications were thoroughly monitored by facility staff or a medical practitioner after the failure to administer medication occurred on 6/6/26 to ensure medical complications did not occur. Review of the Medication Management Policy with a revision date of 9/22/2023 revealed Medications are stored, dispensed and destroyed in a manner to ensure safety and conformance with state federal laws. 5. Medications discontinued are maintained in a secured area until returned to pharmacy or destroyed.8. Non- controlled medications prepared, but not administered, are disposed of according to state law/guidelines. Controlled medications prepared, but not administered must be witnessed and countersigned by a licensed nurse on the controlled drug inventory sheet. 11. Medications will be dated and discarded per manufactures guidelines.

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	06/30/2026

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 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on interview and record review the facility failed to ensure the Director of Nursing (DON) of record worked full time defined as 40 hours a week and to fulfill DON duties for 3 weeks (from 5/4/2026 to 5/24/2026) resulting in the potential for unmet care needs for all residents who resided in the building during those weeks. Findings include:Review of DON D's timesheet for May 2026 revealed the following during the Monday through Friday work week with DON D working as a charge nurse and the shifts being anywhere from 7-16 hours long:From 5/4/2026 to 5/8/2026, DON D worked 4 of the 5 days on the floor on day/night shiftFrom 5/11/2026 to 5/15/2026, DON D worked 3 of the 5 days on the floor on day/night shiftFrom 5/18/2026 to 5/22/2026, DON D worked 4 of the 5 days on the floor on day/night shiftDuring an interview on 6/25/2026 at 12:40 PM, Registered Nurse (RN) M stated that DON D had to work as a charge nurse on all different shifts when he was the DON at the facility. RN M stated that they don't have any unit managers anymore since they are working as a floor/charge nurse. RN M said that the interim DON was the MDS (Minimum Data Set) nurse (DON) B and she had been pulled to the floor too but not as much as DON D was. During an interview on 6/25/2026 at 1:09 PM, Certified Nursing Assistant (CNA) E stated that DON D worked as a charge nurse a lot on different shifts and wasn't available as a DON. During an interview on 6/25/2026 at 2:12 PM, previous Social Worker (SW) O stated that DON D worked the floor as a charge nurse on different shifts including the night shift because if he didn't work them no one would. SW O said that the only consistent nurse during the day was the MDS nurse who was now covering as interim DON (DON B). SW O reported that DON D could not fulfill DON duties when working all different shifts on the floor. During an interview on 6/26/2026 at 8:18 AM, CNA F stated that DON D worked nights as a charge nurse for at least 1 month. CNA F reported there is no way he could work the floor as a charge nurse and ensure he could do still complete his DON duties.During an interview on 6/26/2026 at 10:57 AM, previous Nursing Home Administrator (NHA) C stated that it was hard to do the residents and staff justice when DON D worked the floor as a charge nurse and he couldn't do his normal DON duties when he was working 8-12-hour shifts. NHA C reported DON D was working the floor as a nurse consistently which included the night shift. During an interview on 6/26/2026 at 1:24 PM, DON B stated that she was the MDS nurse and was working as the interim DON for a few weeks until the new DON started. DON B reported since she didn't have DON experience and was the MDS nurse, corporate staff had been helping her out. DON B said she had to work the cart that afternoon for a few hours and was trying to get a nurse to take over the cart. During an interview on 6/26/2026 at 1:38 PM, RN DD stated that DON D had to cover many empty shifts in the last month before he left the facility and it was tough for him to fulfill his DON duties. During an interview on 6/26/2026 at 2:50 PM, RN L stated that DON D had to cover many shifts on the floor as a nurse and she had to cover shifts too which was why she ended up resigning. During an interview on 6/30/2026 at 7:05 AM, Licensed Practical Nurse (LPN) I stated that DON D worked the night shift as a charge nurse and there was no way he could fully work days or nights as he did for several weeks as a charge nurse and then complete his DON duties. During an interview on 6/30/2026 at 10:21 AM, DON D reported that having enough nurses was challenging so he had to work any open shift whether it was day shift or night shift. When discussing his DON duties, DON D stated he wasn't necessarily able to do much as a DON and couldn't complete risk management duties since he was often working the floor. Review of the DON Job Description signed by DON D on 2/18/2026 revealed .Position Summary: The Director of Nursing plans, coordinates and manages the nursing department. Responsible for overall direction, coordination and evaluation of nursing care and services provided to the residents.For additional information, see F684.