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	07/11/2024

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46999 Based on observation, interview, and record review, the facility failed to provide an environment that promoted the autonomy in 2 of 20 residents (Resident #334 and Resident #333) reviewed for homelike environment, resulting in emotional distress, loss of independence, and feelings of frustration. Findings include: Review of Older People's Perceived Autonomy in Residential Care: An Integrative Review, Vol. 28 (3), 414-434, published by Nursing Ethics, 2021, revealed: .Older people's perceived autonomy promoted health and quality of life in residential care. However, their autonomy was associated with a number of protective and restrictive individual and environmental factors, which influenced whether autonomy was achieved . limited autonomy led to feelings of confinement and frustration and increased the overall mortality rate .Older people felt that their autonomy in residential care was associated with .the living environment provided by the residential care home. Resident #334 Review of an Admission Record revealed Resident #334, was originally admitted to the facility on [DATE] with pertinent diagnoses which included: major depressive disorder (persistent sadness with feelings of worthlessness, loss of interests), generalized anxiety disorder (health condition that causes persistent worry), hemiplegia (paralysis on one side of the body). Further review revealed Resident #333 was her own responsible party. Review of a Minimum Data Set (MDS) assessment for Resident #334, with a reference date of 5/30/24 revealed a Brief Interview for Mental Status (BIMS) score of 15/15 which indicated Resident #333 was cognitively intact. Section D of the MDS revealed Resident #333 experienced feeling down, depressed, or hopeless 2-6 days of the 14-day assessment period but had had no verbal or physical behaviors. Section F revealed Resident #334 indicated it was very important for her to make choices related to her preferences. (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	07/11/2024

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a Care Plan for Resident #334, with a reference date of 6/13/24, revealed a focus/goal/intervention of: Focus: (Resident #334) has a psychosocial well-being problem actual r/t Depression and Generalized Anxiety Disorder. Goal: Will demonstrate adjustment to nursing home placement. Interventions: . Increase communication between resident/family/caregivers about care and living environment: Explain all procedures and Treatments, Medications, Results of labs/tests, Condition, All changes, Rules, Options. During an observation on 7/9/24 at 10:10am, the loud moaning of another resident could be heard in Resident #334's room. In an interview on 7/9/24 at 10:17am, Certified Nursing Assistant (CNA) RR reported the facility admitted more than 20 residents from a nearby nursing home that was scheduled to close and almost all of them came to the memory care unit regardless of their cognitive abilities. CNA RR reported many of the residents that were admitted were emotionally upset about being placed in a locked memory care unit. In an interview on 7/9/24 at 10:20am, Resident #334 reported she had not slept all night due to the noise level on the memory care unit. Resident #334 reported she wanted to participate in the interview because she had concerns to discuss but needed to rest at this time. In an interview on 7/9/24 at 10:38am Licensed Practical Nurse (LPN) OO reported Resident #334 had becoming increasingly unhappy with her placement at the facility because she was residing in a locked memory care unit. LPN OO reported Resident #334 seemed to be experiencing more anxiety. LPN OO reported Resident #334 and the others that were transferred were stuck back in the locked unit and stated, It hurts my heart to see what's happening now that they've moved here. In an interview on 7/9/24, at 12:03pm, Resident #334 reported she was very unhappy with her room because it was on a locked memory care unit. Resident #334 stated I feel like they threw me in here and it doesn't feel like my home. Resident #334 reported when she arrived at the facility, she learned her room was on a locked memory care unit. Resident #334 reported the unit was loud due to the nature of those that were being cared for and she frequently struggled to sleep at night due to the noise level. Resident #334 reported after she arrived, staff members told her the facility was planning to covert the unit to regular hall within a month but that had not happened. Resident #334 reported she felt trapped on the unit because she could not leave the area on her own and she did not know if/when the issue would be resolved. Resident #334 voiced frustration that she could not take herself to activities of interest to her because the doors were locked. Review of a behavioral health progress note dated 3/22/24 (during which time Resident #334 resided at another facility) revealed: Pt is up in w/c in her room and is well groomed. Calm, pleasant affect and she reports feeling well. She denies complaints. Review of a behavioral health progress note dated 6/19/24 revealed a statement from Resident #334: I don't like being on a lock down unit. I don't need that . Just need to get used to the way things are around here. There's a guy across the hall that just yell's constantly at night. In an interview on 7/11/24 at 9:13am, Certified Nursing Assistant (CNA) GG reported Resident #334 reported frustration with being on a locked unit and became tearful while discussing it. (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	07/11/2024

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 7/11/24 at 9:24am, Certified Nursing Assistant (CNA) L reported Resident #334 had voiced frustration with her placement on the locked memory care unit and had becoming increasingly angry about the situation. CNA L reported seeing Resident #334 having to wait for long periods for staff to come and unlock the doors for her to leave the unit. In an interview on 7/11/24 at 12:37pm, Recreation Aide (RA) X reported several residents that transferred from another facility and went to rooms in the memory care unit had much higher functional abilities than the other residents in memory care. RA X reported Resident #334 was emotional upset about residing on the locked memory care unit. RA X reported Resident #334 lost the ability to come and go freely which made the unit feel less homelike. In an interview on 7/11/24 at 1:43pm, Resident #334 reported she was not told her room would be in a locked memory care unit prior to her admission to the facility, and had she been told, she would not have agreed to come to the facility without exploring other options first. Resident #334 reported she valued being able to make her own informed decisions and she felt frustrated that she was not given the option to do so, and that the facility had not followed through with their commitment to unlocking the unit within a month. Resident #333 Review of an Admission Record revealed Resident #333, was originally admitted to the facility on [DATE] with pertinent diagnoses which included: major depressive disorder (persistent sadness with feelings of worthlessness, loss of interests), anxiety disorder, hemiplegia (paralysis on one side of the body). Further review revealed Resident #333 was her own responsible party. Review of a Minimum Data Set (MDS) assessment for Resident #333, with a reference date of 5/31/24 revealed a Brief Interview for Mental Status (BIMS) score of 13/15 which indicated Resident #333 was cognitively intact. Section D revealed Resident #333 had no symptoms of depression during the 14-day assessment period, and no physical or verbal behaviors. Section F revealed Resident #333 felt it was very important to honor her preferences. In an interview on 7/9/24, at 11:40am, Resident #333 reported she felt like she was cooped up in a tunnel as she referred to her dissatisfaction with being placed on a locked memory care unit upon her admission to the facility. Resident #333 reported she felt she'd lost the ability to have control over her own life because she could not come and go freely around the facility and that she had to find a way to save my sanity. Resident #333 reported she had been using her powerchair to go outside to the enclosed courtyard but couldn't even do that without assistance because of the locked doors. Resident #333 reported she felt overly supervised and was being told every move to make while on the memory care unit. Resident #333 reported she prided herself on being an independent person and felt this was not being supported by the facility. Resident #333 stated I feel like I'm in jail and it's giving me anxiety and depression. Resident #333 reported the facility did not feel like home to her because of her loss of freedom and independence. During an observation on 7/10/24 at 3:04pm, Resident #333 waited at the locked door as she attempted to attend a religious activity being held in another area of the building, that was scheduled to begin at 3:00pm. Resident #333 waited at the door for a total of 7 minutes before staff arrived. (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	07/11/2024

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 7/11/24 at 9:13am, Certified Nursing Assistant (CNA) GG reported Resident #333 was very independent and valued having her preferences honored. CNA GG reported Resident #333 expressed that being on the locked memory care unit was frustrating because she couldn't exercise her independence. In an interview on 7/11/24 at 9:24am, Certified Nursing Assistant (CNA) L reported the independent residents that resided on the locked memory care unit frequently had to wait several minutes for staff to arrive and open the locked doors for them. CNA L report the locked unit did not support the level of independence these residents desired, or their psychosocial well-being. In an interview on 7/11/24 at 12:14pm Admissions Director (AD) S reported during the admission process it was important to discuss the type of room available for the resident prior to their admission to ensure the features and location of the room aligned with the resident's needs and wants, and with that information, the resident could decide if they wanted to move forward with being admitted . AD S reported if a resident was transferring to a locked unit, it would be important to disclose that and describe the safety measures that were in place. AD S reported transitions are stressful and having information about the facility in advance would help minimize the stress. AD S reported he did not meet with any of the residents who were transferred to the facility from another facility that was scheduled to close. AD S added that the Nursing Home Administration met with those residents. In an interview on 7/11/24 at 12:55pm, Nursing Home Administrator (NHA) A reported she could not confirm that Resident #334 and Resident #333 (who could make their own decisions) were told in advance that if they chose to transfer to the facility, their rooms would be in a locked memory care unit in which they would not be able to leave without staff assistance NHA A reported upon their arrival, Resident #334 and Resident #333 were told the doors to the unit would be unlocked as soon as possible. When further queried, NHA A reported the facility was beginning to get estimates for the work that needed to be done prior to being able to leave the doors unlocked. In an interview on 7/11/24 at 1:47pm, Resident #333 reported she was not told prior to her transfer to the facility that she would be residing in a locked memory care unit and would not be allowed to leave the unit with staff assistance. Resident #332 stated I don't like being in here. It feels like people think I don't think I have my wits about me and I have to wait to even go outside. In an interview on 7/11/24 at 2:06pm Social Services Advocate (SSA) N reported she provided emotional support to Resident #334 and Resident #333 prior to their transfer to the facility but did not know they were going to transfer to the locked memory care unit. When asked how the residents were doing following the transfer, SSA N stated (Resident #334) is struggling all around and that both residents reported the did not feel the facility was as homelike as they wanted. Review of a facility policy titled Resident Rights with a reference date of 2/24 revealed: Policy: The facility will inform the resident both orally and in writing .of his or her rights and all rules .governing resident conduct . during the stay in the facility .8. Safe Environment. The resident has a right to a safe, clean, comfortable, and homelike environment .

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	07/11/2024

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41982 Based on observation, interview, and record review, the facility failed to develop and implement a comprehensive, person-centered care plan for 2 (Resident #34 and Resident #332) of 20 sampled residents reviewed for care plans, resulting in inconsistent application of pressure relieving device (heel protectors) for Resident #34 and an incomplete reflection of care needs for both Resident #34 and Resident #332. Findings include: Resident #34 Review of an Admission Record revealed Resident #34 was a female, with pertinent diagnoses which included: Alzheimer's disease (a form of dementia). In an observation/interview on 7/9/24 at 10:41 AM, noted Resident #34 was seated in her room in her broda chair (a high back wheelchair that is used for positioning). Resident #34 was wearing cushioned boots (heel protectors) on both feet. Agency Nurse (AN) TT reported Resident #34 was on hospice and they had just been in and dressed her left heel wound. A review of Resident #34's current Care Plan was conducted on 7/9/24 at 2:29 PM and revealed no care planned focus, goals, or interventions related to Resident #34's left heel wound or heel protectors. In an observation on 7/9/24 at 4:52 PM, Resident #34 was seated in her broda chair in the main dining room. She was wearing gripper socks, but no heel protectors. In an observation on 7/10/24 at 8:22 AM, Resident #34 was seated in her broda chair in the main dining room. She was wearing gripper socks, but no heel protectors. Resident #34 was being fed her breakfast by a staff member. In an interview on 7/10/24 at 11:29 AM, Certified Nurse Aide (CNA) F reported she was caring for Resident #34 that day. CNA F reported Resident #34 had a pressure ulcer on her left heel and had booties (heel protectors) that she was supposed to wear when she was in bed. CNA F reported she was not sure if Resident #34 was supposed to wear the heel protectors (booties) when she was up in her wheelchair and would have to look at the care plan to be sure. CNA F reported every resident had a care plan that outlined the care and interventions they needed. CNA F reviewed Resident #34's care plan with this surveyor and reported she did not see a care plan related to Resident #34's left heel wound or heel protector application. (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	07/11/2024

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 7/10/24 at 11:49 AM, Unit Manager (UM) O reported if a resident had a pressure ulcer, there should be a care plan in place to direct the care and interventions for the wound. UM O reported Resident #34 had a pressure ulcer on her left heel and had heel protectors for her heels and that Resident #34's hospice service provided all the wound care for her at the request of Resident #34's family. UM O reviewed Resident #34's care plan with this surveyor and reported there was no care plan in place for Resident #34's left heel wound or the heel protectors but that there should have been. UM O reported she was responsible for developing the care plan but must have missed the one for Resident #34's left heel wound. UM O reported a care plan was needed to let everyone know how to care for the resident and what to do for them. In an interview on 7/10/24 at 12:55 PM, Hospice Nurse (HN) R reported she had been caring for Resident #34's wound. HN R reported Resident #34's family had requested that hospice manage the wound. HN R reported Resident #34's legs were contracted and if she wasn't wearing the boots, her heel would rub on the wheelchair footrest. HN R reported Resident #34's left heel wound had been improving and that she was supposed to have the boots on whenever she was out of bed and in her broda chair for protection of her heels. In an interview on 7/11/24 at 1:46 PM, Director of Nursing (DON) B reported the expectation was that when somebody developed a new pressure ulcer, a care plan was developed. DON B reported the purpose of the care plan was to make sure everyone was aware that the resident had the pressure ulcer and what to do for it. DON B reported even if the resident was on hospice, and hospice was caring for the wound, the facility still needed to develop a care plan. 46999 Resident #332 Review of an Admission Record revealed Resident #332, was originally admitted to the facility on [DATE] with pertinent diagnoses which included: metabolic encephalopathy (brain disorder caused by a chemical imbalance in the blood), cognitive communication deficit, benign prostatic hyperplasia (enlarged prostate that causes difficulty with urination) and muscle weakness. Review of a Minimum Data Set (MDS) assessment for Resident #332, with a reference date of 6/4/24 revealed a Brief Interview for Mental Status (BIMS) score of 5/15 which indicated Resident #332 was severely cognitively impaired. Section GG of the MDS revealed Resident #332 required moderate assistance (helper does less than half the effort) to roll in bed and to transfer from sitting to lying down. Section H revealed Resident #332 did not have a urinary catheter upon admission to the facility. Review of a Care Plan for Resident #332, with a reference date of 6/14/24, revealed a focus/goal/interventions of: Focus: (Resident #332) has incontinence of bladder and is at risk for skin breakdown .Goal: Will remain free from skin breakdown due to incontinence .Interventions: observe skin with each incontinence episode and report redness, rash .Provide incontinence care with each incontinence episode. Further review revealed no plan of care for management of a urinary catheter, hygiene, positioning, emptying, or monitoring. Review of a Kardex (nursing worksheet that includes a summary of patient information) for Resident #332 with a reference date of 5/28/24 revealed no nursing interventions for urinary catheter care. (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	07/11/2024

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of physician orders revealed a urinary catheter was ordered for Resident #332 on 6/18/24. In an observation on 7/9/24 at 1:23pm, Resident #332 lying in his bed with his eye closed. A urinary catheter bag hung on the bed frame with amber colored urine noted in the bag. In an interview on 7/9/24 at 1:24pm, Family Member (FM) HH reported Resident #332 was transferred back to bed after lunch on this date and a few minutes later began grimacing and pushing down on his lower abdomen. FM HH asked the staff to come check on him and it was determined he was laying on his catheter tubing causing his urine to stop flowing into the bag. FM HH reported the resident had not been admitted to the facility with a urinary catheter but had a history of difficulty emptying his bladder and had a catheter while he was in the hospital before his admission to the facility. FM HH reported staff needed to ensure the tubing on the catheter was not compressed or kinked to avoid Resident #332 experiencing discomfort or potential complications. Review of the Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, v1.16, Chapter 2: Assessments for the Resident Assessment Instrument (RAI), revealed .the resident ' s care plan must be reviewed after each assessment .and revised based on changing goals, preferences and needs of the resident and in response to current interventions .Residents' preferences and goals may change throughout their stay, so facilities should have ongoing discussions with the resident and resident representative, if applicable, so that changes can be reflected in the comprehensive care plan .

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	07/11/2024

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 36221 Based on observation, interview, and record review, the facility failed to revise a comprehensive care plan after a change in resident condition in 1 of 20 residents (Resident #75) reviewed for comprehensive care plans, resulting in an inaccurate reflection of the resident's status, and the potential for unmet medical, physical, mental, and psychosocial needs. Findings include: Review of the policy/procedure Care Planning, dated 2/2022, revealed .The comprehensive care plan is developed from the RAI (Resident Assessment Instrument) scheduled and is reviewed and revised by the IDT (Interdisciplinary Team) as necessary . Review of an Admission Record revealed Resident #75 was a female, with pertinent diagnoses which included stroke with left sided weakness, muscle weakness, and dysphagia (difficulty swallowing). Review of a Minimum Data Set (MDS) assessment for Resident #75, with a reference date of 3/9/24, revealed a Brief Interview for Mental Status (BIMS) score of 14, out of a total possible score of 15, which indicated she was cognitively intact. Review of a current Care Plan for Resident #75 revealed the focus .I am at risk for impaired skin integrity r/t (related to) impaired mobility, left sided weakness, impaired ROM (range of motion) .new PEG (Percutaneous Endoscopic Gastrostomy) placement . revised 3/21/24. Review of a current Care Plan for Resident #75 revealed the focus .functional ability deficit and requires assistance with self care/mobility .(Resident #75) is able to eat with set up assistance. She does receive nutrition by tube and requires dependent assistance with tube feeding . revised 6/24/24. Review of an Order Summary Report for Resident #75 revealed no active physician orders related to a feeding tube. In an observation and interview on 7/9/24 at 10:15 AM, Resident #75 was in her room sitting in her wheelchair with a blanket over her shoulders. No tube feeding observed. Resident #75 reported she used to have a feeding tube but it was accidentally dislodged more than a month ago. Resident #75 reported the feeding tube was no longer in use, so it did not need to be replaced. In an interview on 7/10/24 at 2:17 PM, Licensed Practical Nurse (LPN) G reported Resident #75 does not have a feeding tube at this time. LPN G reported Resident #75 used to have a feeding tube but it was dislodged while she was using the restroom. LPN G reported Resident #75 was already scheduled to have the feeding tube removed, so it was not replaced. LPN G reported the feeding tube was discontinued more than a month ago. In an interview on 7/10/24 at 2:36 PM, Unit Manager O reported Resident #75's feeding tube was removed about a month and a half ago. (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	07/11/2024

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a Medication Administration Note for Resident #75, dated 5/23/24, revealed .Tube d/c (discontinued) . In an interview on 7/11/24 at 2:13 PM, MDS Coordinator J reported care planning and revisions to the care plan are completed by the Interdisciplinary Team (IDT). MDS Coordinator J reported the care plan should be revised with changes in resident condition, and indicated the information related to a tube feeding should have been removed from Resident #75's care plan. Review of the Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, v1.18.11, Chapter 4: Care Area Assessment (CAA) Process and Care Planning, revealed .the comprehensive care plan is an interdisciplinary communication tool. It must include measurable objectives and time frames and must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. The care plan must be reviewed and revised periodically, and the services provided or arranged must be consistent with each resident's written plan of care . According to [NAME], [NAME] A.; [NAME], [NAME] Griffin; Stockert, [NAME]; Hall, [NAME]. Fundamentals of Nursing, Tenth Edition - E-Book (Kindle Location 15861 of 76897). Elsevier Health Sciences.A nursing care plan includes nursing diagnoses, goals and/or expected outcomes, individualized nursing interventions, and a section for evaluation findings .The plan promotes continuity of care and better communication because it informs all health care providers about a patient's needs and interventions and reduces the risk for incomplete, incorrect, or inappropriate care measures. Nurses revise a plan when a patient's status changes . The plan of care communicates nursing care priorities to nurses and other health care providers. It also identifies and coordinates resources for delivering nursing care .

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	07/11/2024

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 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** 47659 Based on observation, interview, and record review, the facility failed to implement interventions to prevent worsening of contractures (hardening of the muscles, tendons, and other tissues) for 1 of 2 residents (Resident #67) reviewed for range of motion resulting in the potential for worsening of right and left hand contractures. Findings include: Resident #67 Review of an Admission Record revealed Resident #67 was originally admitted to the facility on [DATE] with pertinent diagnoses which included right and left hand contractures. Review of Resident #67's current Care Plan revealed no focus or interventions related to the resident's right and left hand contractures. Review of Resident #67's Orders did not reveal any active physician orders in place for resident's right and left hand contractures. Review of Resident #67's Occupational Therapy Discharge Summary dated 3/7/24 revealed, .Discharge recommendations: use of bilateral handrolls (handroll with straps on L (left), without straps on R (right)), PROM (passive range of motion) to neck into right lateral flexion with gentle stretch daily . During an observation on 7/9/24 at 9:54 AM, Resident #67 was in his room lying in bed, with his right and left hands clenched into fists. Noted Resident #67 was not wearing handrolls or any other device to prevent a decline in range of motion. During an observation on 7/09/24 at 12:42 PM, Resident #67 was in his room lying in bed, with his right and left hands clenched into fists. Noted Resident #67 was not wearing handrolls or any other device to prevent a decline in range of motion. During an observation on 7/10/24 at 9:01 AM, Resident #67 was sitting up in his bed, with his right and left hands clenched into fists. Noted Resident #67 was not wearing handrolls or any other device to prevent a decline in range of motion. During an observation on 7/10/24 at 12:40 PM, Resident #67 with his right and left hands clenched into fists. Noted Resident #67 was not wearing handrolls or any other device to prevent a decline in range of motion. During an observation on 7/11/24 at 12:26 PM, Resident #67 was sitting up in his bed, with his right and left hands clenched into fists. Noted Resident #67 was not wearing handrolls or any other device to prevent a decline in range of motion. (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	07/11/2024

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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/11/24 at 9:44 AM, Rehab Director (RD) PP reported that Resident #67 was discharged from therapy services on 3/7/24. RD PP reported that therapy ordered for Resident #67 to wear bilateral handrolls at all times as tolerated. RD PP reported that this order was communicated to the nursing team to enter into Resident #67's electronic health record (EHR). RD PP reported that nurses and certified nursing assistants (CNA's) were responsible for ensuring Resident #67 had the handrolls placed on as tolerated. RD PP reviewed Resident #67's EHR with surveyor and reported that she was not able to find any orders in place related to Resident #67 wearing the bilateral hand rolls. During an interview on 7/11/24 at 9:54 AM, Registered Nurse (RN) AA reported that she was caring for Resident #67 that day. RN AA reported that she was not familiar with Resident #67 and did not know if Resident #67 had any orders in place to care for his bilateral hand contractures. During an interview on 7/11/24 at 9:57 AM, Certified Nursing Assistant (CNA) SS reported that she was the CNA caring for Resident #67. CNA SS reported that she didn't know if Resident #67 had any devices that should be worn to prevent worsening of Resident #67's bilateral hand contractures. CNA SS reported that she had never observed Resident #67 wearing any devices for his bilateral hand contractures. During an interview on 7/11/24 at 12:35 PM, CNA Z reported that CNA's would utilize the Resident's Kardex (care report orders) or care plan to find therapy orders. CNA Z reviewed Resident #67's EHR and reported that Resident #67 did not have orders in place for CNA's to place any devices on Resident #67's bilateral hand contractures. During an interview on 7/11/24 at 10:08 AM, Licensed Practical Nurse (LPN) Unit Manager (LPN-UM) O reported that she was unaware of any devices that Resident #67 was supposed to use related to their bilateral hand contractures. LPN-UM O reviewed Resident #67's EHR and confirmed that there were no orders in place related to Resident #67's bilateral hand contractures. LPN-UM O reported that therapy may have communicated this order to her, but it was missed.

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	07/11/2024

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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47659 This citation pertains to intake# MI00145167 Based on interview and record review, the facility failed to ensure that residents received adequate treatment and care for pain management for 1 of 2 residents (Resident #380) reviewed for pain, resulting in increased pain with the potential to affect activities of daily living (ADL). Findings include: Resident #380 Review of an Admission Record revealed Resident #380 was originally admitted to the facility on [DATE] with pertinent diagnoses which included fracture of right femur. Review of Resident #380's Hospital Discharge Instructions dated 6/11/24 revealed, . Discharge medications . Tramadol 50 mg oral tablet 1 tab, PRN (as needed) every 6 hours Review of Resident #380's Orders revealed traMADol HCl (pain medication) Oral Tablet 50 MG. Give 1 tablet by mouth every 6 hours as needed for pain. Start Date: 6/11/2024 at 6:30 PM. During an interview on 7/09/24 at 11:38 AM, Family Member (FM) II reported that Resident #380 did not receive her pain medication (tramadol) on 6/11/24 and 6/12/24. FM II reported that they had discussed their concern of Resident #380 missing medication with Unit Manager Licensed Practical Nurse (UM-LPN) O and was assured that Resident #380 would receive her medications, but Resident #380 still missed getting her pain medication that evening. FM II reported that Resident # 380 reported increased pain due to not taking the tramadol. Review of Resident #380's Medication Administration Record revealed that Resident #380 received the first dose of tramadol on 6/13/24. Review of Resident #380's Pain Assessment revealed that a documented pain level of 9 out of 10 on 6/12/24, indicating severe pain. During an interview on 7/11/24 at 8:26 AM, LPN D reported that she was the nurse that had cared for Resident #380 the night that she was admitted to the facility. LPN D reported that she often felt like she was not able to complete many of her tasks due to the heavy workload and would frequently have to pass off new resident admission tasks to the oncoming shift. LPN D reported that it was very likely that Resident #380's medication orders were missed because she did not have time to enter the orders or contact the pharmacy to request the medications be delivered. (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	07/11/2024

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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/11/24 at 10:32 AM, UM-LPN O reported that she had been made aware of Resident #380 missing medications on 6/12/24 when Resident #380's family informed her. UM-LPN O was not able to report why Resident #380 did not receive her first dose of tramadol until 6/13/24. UM-LPN O reported that the nurse caring for Resident #380 could have contacted the pharmacy and requested the tramadol medication to be drop shipped (send an urgent medication on the same day) so that the pain medication was available for Resident #380 to take the night she was admitted to the facility. UM-LPN O did not know when Resident #380's medications were ordered and delivered by the facility pharmacy. During an interview on 7/11/24 at 10:51 AM, Pharmacy Technician (PT) E reported that the facility did not request that the pharmacy drop ship Resident #380's tramadol so that it was available the date Resident #380 was admitted . PT E confirmed that the pharmacy sent Resident #380's tramadol on 6/13/24.

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	07/11/2024

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 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. 36221 Based on observation, interview, and record review, the facility failed to ensure a mechanically altered diet was provided as ordered to meet individual needs in 1 of 13 residents (Resident #75) reviewed for dining and dietary orders, resulting in the potential for aspiration, choking, and harm. Findings include: Review of an Admission Record revealed Resident #75 was a female, with pertinent diagnoses which included stroke with left sided weakness, muscle weakness, and dysphagia (difficulty swallowing). Review of a Minimum Data Set (MDS) assessment for Resident #75, with a reference date of 3/9/24, revealed a Brief Interview for Mental Status (BIMS) score of 14, out of a total possible score of 15, which indicated she was cognitively intact. In an observation on 7/9/24 at 10:15 AM, Resident #75 was in her room sitting in her wheelchair with a blanket over her shoulders. Observed an orange sign on the wall above Resident #75's bed which stated . Must be up in dining room for chewable foods with line-of-sight of caregivers due to risk of food enterring (sic) airway. If eating in room, must have pureed SOLIDS . Review of an Order Summary Report for Resident #75 revealed the active physician order .NAS (No Added Salt), CCD (Consistent Carbohydrate) diet Level 3 Advanced (Mechanical Soft) texture, Thin consistency, Must have caregiver line-of-sight supervision for all level 6 foods. If resident eats any foods in her room alone, she must have pureed solids due to risk of food entering airway. No exceptions . with a start date of 6/3/24. Review of a current Care Plan for Resident #75 revealed the focus .Resident has the potential for a nutritional/hydration problem r/t (related to) CVA (stroke), dysphagia, HTN (high blood pressure), at risk for malnutrition . revised 6/10/24, with interventions which included .Diet order: NAS, CCD diet with mech (mechanical) soft textures and thin liquids. Must have pureed foods if she chooses to eat in her room . revised 6/28/24, and .Feeding techniques required: small bites and sips, alternate liquids and solids, upright for all meals, slow rate. Must have supervision while eating soft/bite sized foods; if she chooses to eat alone, will need to have pureed foods . revised 6/10/24. In an observation on 7/9/24 at 1:00 PM, Resident #75 was in her wheelchair in her room, preparing to eat lunch. Observed Resident #75's lunch tray on the table in front of her. Noted Resident #75 was served a taco salad along with a piece of chocolate cake. Observed an orange sign on the wall above Resident #75's bed which stated .Must be up in dining room for chewable foods with line-of-sight of caregivers due to risk of food enterring (sic) airway. If eating in room, must have pureed SOLIDS . Noted the food served to Resident #75 was not pureed. No staff present in room or within line-of-sight of Resident #75 at this time. (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	07/11/2024

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 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an observation on 7/10/24 at 9:06 AM, Resident #75 was in her wheelchair in her room, eating breakfast. Observed Resident #75's breakfast tray on the table in front of her. Noted Resident #75 was served scrambled eggs and a piece of toast. Observed an orange sign on the wall above Resident #75's bed which stated .Must be up in dining room for chewable foods with line-of-sight of caregivers due to risk of food enterring (sic) airway. If eating in room, must have pureed SOLIDS . Noted the food served to Resident #75 was not pureed. No staff present in room or within line-of-sight of Resident #75 at this time. In an interview on 7/10/24 at 2:36 PM, Unit Manager O reported Resident #75 has an order for a mechanical soft diet due to difficulty swallowing. Unit Manager O reported if Resident #75 chooses to eat in her room, the food served must be pureed. In an interview on 7/11/24 at 1:30 PM, Speech Therapist QQ reported Resident #75 had issues with swallowing due to a stroke. Speech Therapist QQ reported they are currently working with Resident #75 with the goal to upgrade her diet orders. Speech Therapist QQ stated .(Resident #75) has a pretty significant risk of airway compromise . In an interview on 7/11/24 at 1:50 PM, Registered Dietitian CC reported Resident #75 has current orders for a mechanical soft diet, but must have pureed foods if she chooses to eat in her room. Registered Dietitian CC reported that information is on Resident #75's Kardex and it would be the responsibility of the nursing staff to notify dietary based on where Resident #75 chooses to eat, to ensure the correct meal consistency is provided. Review of a Kardex (a tool utilized by Certified Nursing Assistants (CNA's) to guide resident care) for Resident #75, dated 7/9/24, revealed .Diet order: NAS, CCD diet with mech soft textures and thin liquids. Must have pureed foods if she chooses to eat in her room .

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	07/11/2024

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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 38905 Based on observation and interview the facility failed to maintain general cleanliness and repair of the dry storage room as well as provide proper storage for items in central supply. Findings Include: During a tour of the facility, at 10:00 AM on 7/9/24, it was observed that the floor drain in the dry storage room was being used for draining the ice machine and walk in cooler condensers. The floor in this area was found with black lines between the floor tiles and visible water coming up from the gaps in the tiles when walked on. During a tour of the central supply storage room, with Environmental Services H, at 3:04 PM on 7/9/24, it was observed that some storage shelving being used was made from raw wood with no covering to make it smooth and easily cleanable. Further observation found clean and sanitary items stored on the floor and on the raw wood surface. These items were: Catheter care equipment, ice bags, hair brushes, bottles of saline, re-usable urinals, and personal protective equipment. When asked about the storage, Environmental Services H stated they needed to rework the organization in central supply to make room for the items on the floor.