| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 235264 | A. Building<br>B. Wing | 11/21/2025 |

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| Ely Manor | 1200 Ely St<br>Allegan, MI 49010 |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>Based on observation, interview and record review the facility failed to maintain best practices in accordance with professional standards of food service safety. The deficient practice has the potential to result in food borne illness among all residents that consume food from the kitchen.Findings include: On 9/22/25 at 9:05 AM, Observation of the walk-in cooler found an open container of sour cream with a best by date of 8/25/25.On 9/22/25 at 9:10 AM, Observation of the three door True cooler found an open box of nutritional juices, mighty shakes, and reduced sugar mighty shakes, containing dozens of cartons intermingled. When asked how many days the items are good for, Certified Dietary Manager (CDM) T stated, I think they are good for 30 days. A review of the manufacturer's directions for use found that the items are only good 14 days from thaw. When asked how they track how long the items have been in the fridge, CDM T stated that normally the box gets dated, but the only date found on the box was the receive by date of 7/11. When asked if she knew when this box was pulled from the freezer, CDM T was unsure. On 9/22/25 at 9:52 AM, Observation of the Memory Care Unit (MCU) pantry fridge found two open containers of Vanilla Med Pass 2.0 with no date to indicate discard of the items. A review of the manufacturers' directions for use found that the item should be consumed within 4 days under refrigeration.On 9/22/25 at 10:00 AM, Observation of the A-side pantry found a carton of milk with the best by date of 9/14/25. According to the 2022 FDA Food Code section 3-501.17 Ready-to-Eat, Time/Temperature Control for Safety Food, Date Marking. (A) Except when PACKAGING FOOD using a REDUCED OXYGEN PACKAGING method as specified under S 3-502.12, and except as specified in (E) and (F) of this section, refrigerated, READY-TOEAT, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD prepared and held in a FOOD ESTABLISHMENT for more than 24 hours shall be clearly marked to indicate the date or day by which the FOOD shall be consumed on the PREMISES, sold, or discarded when held at a temperature of 5 C (41 F) or less for a maximum of 7 days. The day of preparation shall be counted as Day 1. (B) Except as specified in (E) -(G) of this section, refrigerated, READY-TO-EAT TIME/TEMPERATURE CONTROL FOR SAFETY FOOD prepared and PACKAGED by a FOOD PROCESSING PLANT shall be clearly marked, at the time the original container is opened in a FOOD ESTABLISHMENT and if the FOOD is held for more than 24 hours, to indicate the date or day by which the FOOD shall be consumed on the PREMISES, sold, or discarded, based on the temperature and time combinations specified in (A) of this section and: (1) The day the original container is opened in the FOOD ESTABLISHMENT shall be counted as Day 1; and (2) The day or date marked by the FOOD ESTABLISHMENT may not exceed a manufacturer's use-by date if the manufacturer determined the use-by date based on FOOD safety .According to the 2022 FDA Food Code section 3-501.18 Ready-to-Eat, Time/Temperature Control for Safety Food, Disposition. (A) A FOOD specified in 3-501.17(A) or (B) shall be discarded if it: (1) Exceeds the temperature and time combination specified in 3-501.17(A), except time that the product is frozen; (2) Is in a container or PACKAGE that does not bear a date or day; or (3) Is inappropriately marked with a date or day that exceeds a temperature and time combination as specified in 3501.17(A) .On 9/22/25 at 9:18 AM, An interview with CDM T found that clean pots and pans are stored on an open wire rack in the corner of the kitchen. A review of this area found two 1/2 pans stacked and stored wet.On<br>(continued on next page) |

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | 9/22/25 at 3:49 PM, A follow up tour of the kitchen found two 1/4 pans and one 1/2 pan stacked and stored wet. According to the 2022 FDA Food Code section 4-901.11 Equipment and Utensils, Air-Drying Required. After cleaning and SANITIZING, EQUIPMENT and UTENSILS: (A) Shall be air-dried or used after adequate draining as specified in the first paragraph of 40 CFR 180.940 Tolerance exemptions for active and inert ingredients for use in antimicrobial formulations (food-contact surface SANITIZING solutions), before contact with FOOD.On 9/22/25 at 9:22 AM, Observation of the steam table found it had a container catching water as it dripped from the corner of the steam table onto the floor. An interview with CDM T found that one of the wells of the steam table had a small pinhole, so staff have to refill the well a few times throughout the day. When asked how long the leak had been going on, CDM T stated it's been going on since she started a couple months ago. On 9/22/25 at 9:38 AM, Observation of the hot water line under the dish machine found that it was leaking a steady stream onto the floor and into a nearby floor drain.According to the 2022 FDA Food Code section 5-205.15 System Maintained in Good Repair. A PLUMBING SYSTEM shall be: (A) Repaired according to LAW; and (B) Maintained in good repair.On 9/22/25 at 9:33 AM, Observation of the clean utensil drawers found two drawers containing mechanical scoops and serving spoons with an accumulation of crumb debris in the floor and back of the drawers. An interview with CDM T found that staff should be cleaning these out daily. According to the 2022 FDA Food Code section 4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils. (A) EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be clean to sight and touch. (B) The FOOD-CONTACT SURFACES of cooking EQUIPMENT and pans shall be kept free of encrusted grease deposits and other soil accumulations. (C) NonFOOD-CONTACT SURFACES of EQUIPMENT shall be kept free of an accumulation of dust, dirt, FOOD residue, and other debris.On 9/22/25 at 9:54 AM, Observation of the MCU pantry found an ice chest used for hydration pass. An interview with CDM T found that with the ice machine being down right now, staff have to fill up the coolers with bags of ice and stick them in the pantry to be used for resident hydration pass. When asked whose responsibility it is to take care of the ice coolers, CDM T stated that kitchen staff are responsible for filling them, cleaning the coolers/scoops, and stocking them with ice. At this time, the bottom of the cooler had roughly an inch of water in the bottom with a layer of ice floating on top of the water and no way to self-drain or allow the separation of the water and ice. According to the 2022 FDA Food Code section 3-303.12 Storage or Display of Food in Contact with Water or Ice.(B) Except as specified in (C) and (D) of this section, unPACKAGED FOOD may not be stored in direct contact with undrained ice. On 9/22/25 at 9:36 AM, Observation of the dish machine found that it did not hit the required minimum temperatures for the hot water sanitizing rinse. Running the unit three times found contact temperatures ranging between 153F-158F, while requiring a contact of 160F or higher. A record review of the document entitled, Dish Machine High Temperature Log, dated September 2025, found that the Rinse Temp: Minimum 180F (for hot water before it enters the dish machine). A review of the log, listing wash and rinse temperatures for breakfast, lunch, and dinner, found that 41 logged sanitizing rinse temperatures were below the minimum requirement of 180F. According to the 2022 FDA Food Code section 4-501.112 Mechanical Warewashing Equipment, Hot Water Sanitization Temperatures. (A) Except as specified in (B) of this section, in a mechanical operation, the temperature of the fresh hot water SANITIZING rinse as it enters the manifold may not be more than 90C (194F), or less than:.(2) For all other machines, 82C (180F).On 9/22/25 at 9:48 AM, observation of the dry storage room found boxes of food items stored on the floor near storage racks. When asked about the food items stored on the floor, CDM T stated that the delivery had come in on Friday (9/19) and she wasn't here over the weekend to put stock away. According to the 2022 FDA Food Code section 3-305.11 Food Storage. (A) Except as specified in (B) and (C) of this section, FOOD shall be protected from contamination by storing the FOOD: (1) In a clean, dry location; (2) Where it is not exposed to splash, dust, or other contamination; and (3) At least 15 cm (6 inches) above the floor. |

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| F 0841<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Designate a physician to serve as medical director responsible for implementation of resident care policies and coordination of medical care in the facility.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the Medical Director fulfilled their responsibility of implementing Medication Regimen Review (MRR) policies/procedures to include coordination of care between the facility and the consulting pharmacist/pharmacy for 2 (Resident #3 and Resident #51) of 5 residents reviewed for medications. This deficient practice has the potential to affect all residents that reside at the facility. Findings include: Resident #3Review of an admission Record revealed Resident #3 was originally admitted to the facility on [DATE] with pertinent diagnoses which included dementia and anxiety disorder. Review of Resident #3's Medication Regimen Review (MRR) dated 6/11/25 revealed, (Resident #3) is receiving Seroquel (antipsychotic medication). Epidemiological studies suggest an increased risk of hyperglycemia (high blood sugar levels)-related adverse effects during atypical antipsychotic use .Recommendation: Please consider obtaining a fasting lipid panel on the next convenient lab day and then periodically thereafter. Physician/provider response: Agree. Order repeat labs to see trend. This was signed by the Medical Doctor (MD) UU on 9/17/25. Review of Resident #3's MRR dated 7/9/25 revealed, (Resident #3) has received Seroquel (antipsychotic medication) for over one year with the current dose of 75 mg (milligrams) at bedtime. Recommendation: Please consider a gradual dose reduction, perhaps decreasing to Seroquel 50 mg at bedtime while concurrently monitoring for re-emergence of target and/or withdrawal symptoms. If therapy is to continue at current dose, please provide rationale describing why a dose reduction is clinically contraindicated . Physician/provider response: Disagree. Care collaboration with Psych; GDR contraindicated at this time. (MD UU) reviewed via phone. This was signed by Director of Nursing (DON) B. It was noted that there was not a date noted on when this review was completed via phone by MD UU. In an interview in 9/24/2025 at 10:01 AM, DON B reported that she had discovered that the facility had not been receiving resident medication regimen reviews in August 2025. DON B reported that the consulting pharmacist had been sending the reviews to the previous Director of Nursing, and the facility was unaware, so all residents in the facility had not had medication reviews completed for several months. DON B reported that she did not know many months of reviews the facility had missed. When this writer queried about Resident #51's June medication review, DON B confirmed that the facility provider had not reviewed this recommendation from June 2025 until September 2025, so there was a delay of Resident #3 getting the recommended lab order completed. When this writer queried DON B about Resident #3's July 2025 lab order, DON B reported that she could not recall when she had reviewed the July 2025 recommendation with MD UU because she did not note the date on the review. DON B confirmed that this review had not been placed in Resident #3's electronic medical record (EMR) and was not made available until this writer requested it. DON B reported that she should have dated the MRR, and it also should have been signed by MD UU. DON B confirmed that she could not verify that Resident #3's July 2025 recommendation was reviewed timely. Resident #51 Review of an admission Record revealed Resident #51 was originally admitted to the facility on [DATE] with pertinent diagnoses which included Alzheimer's disease and major depressive disorder. Review of Resident #51's MRR dated 5/27/25 revealed, (Resident #51) is noted to be experiencing new onset or worsening of falls as indicated on medication regimen review request. Patient (Resident #51) is receiving Seroquel (antipsychotic) 75 mg in the morning- 50 mg at noon and 75 mg in the evening. Patient's recent lipid panel indicates severe hypertriglyceridemia (too many triglycerides (fats) in your blood) which may be attributable to long term atypical antipsychotic use. Patient has been receiving the same dose for over two years. Patient has continued episodes of delusions. Patient may have symptoms of orthostatic hypotension (a condition where blood pressure drops significantly upon standing up from a sitting or lying position) with recent recorded value of 143/76 while sitting which dropped to 117/61 upon standing.<br>(continued on next page) |

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| F 0841<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Recommendations: Please evaluate current Seroquel dose, perhaps decreasing to 50 mg twice daily and 75 mg in the evening as contributing to this change in status . Physician/provider response: The provider did not respond or sign this form. Review of Resident #51's MRR dated 8/8/25 revealed, (Resident #51) receives Glucophage (Metformin) (oral medication used to treat diabetes) and does not have a serum B-12 level found in the resident medical record . Recommendation: Please consider obtaining a serum B-12 level on the next convenient lab day. Physician/Provider response: Agree. Ok order. This was signed by MD UU on 9/17/25. In an interview in 9/24/2025 at 10:01 AM, DON B reported that she did not know if any provider had reviewed Resident #51's MRR on 5/27/25 as the facility did not have verification of a provider response. DON B confirmed that Resident #51's MRR dated 8/8/25 was not reviewed by a provider in the facility until 9/17/25. DON B reported that the facility was still working through completing medication reviews for residents from the last 3 months for all residents in the facility. DON B reported that MD UU had been completing the medication reviews for all residents. DON B confirmed that MD TT was the facility Medical Director, but he had not been involved in completing the medication reviews for the residents at the facility, and he had not been aware that the facility had not been receiving the medical regimen reviews for all residents at the facility for months. In an interview on 9/24/2025 at 12:46 PM, MD UU reported that he had reviewed multiple outstanding medication reviews for the facility on 9/17/25. MD UU reported that he was not aware of the facility process for completing medication reviews, but that he was helping the facility catch up on the late reviews in the facility. MD UU confirmed that MD TT was the facility Medical Director, so he would be responsible for overseeing the monthly medication reviews for the facility. In an interview on 9/24/2025 at 2:27 PM, Nursing Home Administrator (NHA) A reported that the facility had discovered in August 2025 that the facility had not been reviewing resident medication regimen reviews. NHA A reported that she did not know how long the facility had missed the reviews, but that the facility was currently reviewing the last 3 months of reviews for all residents. NHA A confirmed that MD TT was the Medical Director of the facility, and that he was responsible for overseeing the monthly medication reviews for the facility, and that he had missed that the facility had not been completing the medication regimen reviews for all residents at the facility for several months. This writer attempted to reach MD TT on 9/24/2025 at 1:14 PM. MD TT did not return this writer's phone call by the time of survey exit. Review of the facility's Timeliness of Medication Regimen Review Reports fated 9/7/23 revealed, Policy: The pharmacist will review and report and medication irregularities at least once a month. 1. With new admissions, the consultant pharmacist will complete a MRR and provide a report via secure email within 72 hours to the Director of Nursing/designee. 2. Clinically significant medication issues, identified by the consultant pharmacist during the admission medication regimen review, must be communicated to the prescriber or the designee and resolved by 11:59 P.M. the following day. 3. The consultant will provide monthly MRR reports addressed to the Medical Director, Director of Nursing, and Attending Physician within 3-5 days of completion via secure email or hard copy. 4. The attending physician is expected to review the resident's individual MRR and document and sign that he/she has reviewed the pharmacist's identified recommendations within 14 days of receipt. 5. If the attending Physician does not respond to the resident's MRR report within 14 days, the Director of Nursing will notify the physician of the pending MRR reports. 6. If by the 21st day, the attending physician has not yet responded to the resident's individual MRR report, the Director of Nursing will notify the Medical Director to review and respond to the pending MRR reports. 7. If the Medical Director is also the attending physician, the Director of Nursing will escalate the issue to the facility Administrator. 8. When the consultant pharmacist identifies a recommendation that requires immediate or urgent action, the pharmacist will notify the Director of Nursing and the assigned nurse at the time the recommendation is identified. For further information related to medication concerns, please see F756. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation contains two deficient practice statements, A & B.Deficient Practice Statement (DPS) A Based on observation, interview, and record review, the facility failed to establish and maintain a system for surveillance of employee infections and effectively implement infection control measures related to Enhanced Barrier Precautions (EBP), Transmission-Based Precautions (TBP), catheter care, and cleanliness of resident equipment in 5 of 18 residents (Resident #1, #37, #69, #5, & #73) reviewed for infection control, resulting in the potential for cross-contamination and the development and spread of infection to a vulnerable population. DPS B Based on observation, interview, and record review, the facility failed to have an active and ongoing plan for reducing the risk of Legionella and other opportunistic pathogens of premise plumbing (OPPP). This deficient practice has the increased potential to result in waterborne pathogens to exist and spread in the facility's plumbing system and an increased risk of respiratory infection among any or all the residents in the facility. Findings include:<br><br>DPS A<br><br>In an interview on 9/24/25 at 10:46 AM, Director of Nursing (DON) B reported she was currently responsible for the Infection Preventionist (IP) role at the facility, but Assistant Director of Nursing (ADON) S was in training to take over that position. DON B reported there is a place within the electronic medical record system to track staff illnesses. DON B reported at this time, only four staff have been entered into the electronic medical record staff illness tracking system, with the most recent entry from May of 2025. DON B reported the facility experienced a COVID-19 outbreak in July of 2025 with only a few staff members affected. Noted the staff COVID-19 cases were not entered into the electronic medical record system to track staff illnesses. DON B reported a new system was being implemented to track staff call-ins and signs/symptoms. DON B reported the call-in sheets were given ADON S to determine if there were any trends/patterns identified. DON B reported at this time, there was no current/updated list of staff illnesses identifying start dates and signs/symptoms of infection to assist with infection surveillance.<br><br>In an interview on 9/24/25 at 2:51 PM, ADON S reported the Human Resources Department handles the staff call-ins and keeps the copies of the call-in sheets indicating signs/symptoms. ADON S reported DON B handles the tracking/surveillance of staff illnesses.<br><br>Review of the policy/procedure Infection Prevention Program Overview, dated 2/28/25, revealed .The infection prevention and control program (IPCP) must include, at a minimum, the following elements .The facility establishes a program under which it .Investigates, identifies, prevents, reports and controls infections and communicable diseases for all residents, staff, contractors, consultants, volunteers, visitors and others who provided care and services to the residents on behalf of the facility .The major activities of the program are .Surveillance of infections with implementation of control measures and prevention of infections .There is on-going monitoring to identify possible communicable diseases or infections among residents and staff and subsequent documentation of infections that occur .REPORTING MECHANISMS FOR INFECTION PREVENTION .Employee infections are reported by the employee to his/her supervisor, then to the IP (Infection Preventionist). The IP enters the employee infection data into PCC (electronic medical record system) .<br><br>Resident #37<br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Review of an admission Record revealed Resident # 37 was originally admitted to the facility on [DATE] with pertinent diagnoses which included personal history of traumatic brain injury and neuromuscular dysfunction of the bladder (a condition where the nerves and muscles that control bladder function are impaired).<br><br>Review of Resident #37's Orders revealed, Enhanced Barrier Precautions while performing high contact care activities. Start date: 9/22/25.<br><br>In an observation on 9/22/2025 at 9:06 AM, Resident #37 was lying in his bed. It was noted that his catheter bag was sitting directly on the floor of his room, surrounded by pieces of food. The floor was also noted to be sticky and soiled.<br><br>In an observation on 9/23/2025 at 10:23 AM, Two Certified Nursing Assistants (CNA's) were noted to be assisting Resident #37 with morning care in the resident's room. CNA HH brushed Resident #37's hair and assisted Resident #37 to put on his socks. It was noted that CNA HH was not wearing gloves or a gown when she was assisting Resident #37.<br><br>Resident #1<br><br>Review of an admission Record revealed Resident #1 was originally admitted to the facility on [DATE] with pertinent diagnoses which included chronic kidney disease and legal blindness.<br><br>Review of Resident #1's Orders revealed, Contact and droplet precautions start date: 9/22/25.<br><br>In an observation on 9/23/2025 at 4:12 PM, Activity Aide (AA) BBB entered Resident #1's room to assist him with his television. It was noted that AA BBB did not don (put on) gloves and a gown before entering Resident #1's room, and she did not sanitize her hands after she left Resident #1's room.<br><br>During an observation on 9/23/2025 at 2:33 PM, it was noted that R1 had a sign displayed outside his door STOP! Please see nurse before entering. Contact and droplet precautions. The sign showed the PPE (Personal Protective Equipment) that had to be worn when entering the room which included a gown, gloves, N95 mask and eye protection. There was a cart outside his room with PPE.<br><br>Review of R1's care plan revealed that there wasn't a care plan regarding the contact and droplet precautions.<br><br>During an observation on 9/23/2025 at 2:43 PM, R1 was sitting in his wheelchair next to his bed. R1 yelled out for this surveyor to help him move closer to his bed and needed help changing the channel on his tv. Licensed Practical Nurse (LPN) W was observed walking into R1's room without putting any PPE on. LPN W moved R1's wheelchair so he could be closer to his bed and grabbed the tv remote and helped him find a channel he liked.<br><br>During an interview on 9/23/2025 at 2:53 PM, LPN W stated that she thought R1 was coming off of contact and droplet precautions and said LPN KK would know more since R1 was her resident. When asked if she need to wear PPE when going into a contact and droplet precautions room, LPN W said Yes, but he is coming off of it and stated she would have to check to find off if he should be off contact and droplet precautions.<br><br>During an interview on 9/23/2025 at 2:48 PM, LPN KK stated that R1 and his roommate were both<br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | tested for COVID that morning and they were waiting for the results of the respiratory panel. LPN KK stated that even though they are waiting for the respiratory panel results, R1's room was still under full droplet precautions and anyone going into the room had to wear PPE.<br><br>During an interview on 9/23/2025 at 4:11 PM, Director of Nursing (DON) B stated that when a resident is under contact and droplet precautions, a physician order is put in, a sign is placed on the door, a cart with PPE is placed outside of the door and a care plan is developed. DON B said for contact and droplet precautions a gown, gloves, N95 mask and eye protection needs to be worn before entering the room. DON B said there is a sign on the door that directs anyone on what PPE to wear when entering the room. When discussing R1, DON B' stated that R1 was under contact and droplet precautions because of his roommate. DON B verified there was no care plan for R1 and stated that they were waiting for the respiratory panel to come back and then would determine if a care plan for contact precautions needed to be completed.<br><br>Review of the facility's Enhanced Barrier Policy last revised 3/5/25 revealed, Policy: It is the intent of the facility to use Enhanced Barrier Precautions (EBP) in addition to Standard Precautions for preventing the transmission of the CDC targeted multidrug-resistant organisms (MDROs). Enhanced Barrier Precautions are indicated for residents with any of the following: 1) infection or colonization with a CDC targeted MDRO when contact precautions do not otherwise apply or 2) a wound or indwelling medical device, even if the resident is not known to be infected or colonized with an MDRO and should remain in place for the duration of a resident's stay or until the resolution of the wound or discontinuation of the indwelling medical device that place them at higher risk . Gloves, gowns, and hand hygiene. A. Health care personnel caring for residents on Enhanced Precautions should wear gloves and gowns during high-contact resident care. Examples of high contact resident care activities requiring gown and glove use: Dressing, Bathing/showering, Transferring, providing hygiene (focused on am and pm care), Changing linens, Changing briefs or assisting with toileting, Device care or use; central line, urinary catheter, feeding tube, tracheostomy/ventilator, Wound care: Chronic wounds .<br><br>Review of the facility's Multi Route Transmission Based Precautions policy last revised 11/22/22 revealed, Policy: Transmisson based precautions are the second tier of basic infection control are to be used in addition to standard precautions for residents who may be infected or colonized with certain infectious agents for which additional precautions are needed to prevent infection transmission . Contact Precautions: use contact precautions for residents with known or suspected infections that represent an increased risk for contact transmission Use PPE (Personal Protective Equipment) appropriately, including gloves and gowns for all interactions that may involve contact with the resident or the resident's environment. Donning PPE prior to entering the room and doffing (removing) and properly discarding before exiting the room . Droplet precautions: Use droplet precautions for residents with known or suspected to be infected with pathogens transmitted by respiratory droplets that are generated by a resident who is coughing, sneezing, or talking . Use PPE appropriately, [NAME] mask upon entry into resident's room .<br><br>R69<br><br>According to R69's Minimum Data Set (MDS) dated [DATE], the resident was independent performing her ADLs (activities of daily living). The resident's BIMS (Brief Interview Mental Status) had not been completed however, in conversations with the resident, she was able to recall long and short-term memories and hold an intellectual conversation.<br><br>Review of R69's Diagnoses List included chronic obstructive pulmonary disease (COPD), chronic<br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | respiratory failure with hypoxia, and emphysema.<br><br>Review of R69's Order Summary dated 2/21/25, indicated the resident could use oxygen via nasal cannula (NC) at 2 lpm (liters per minute) to oxygen saturation greater than 88% every shift for the diagnoses of COPD.<br><br>Observed R69's oxygen concentrator (device that concentrates the oxygen from a gas supply (typically ambient air) by selectively removing nitrogen to supply an oxygen-enriched product gas stream) to have dust, lint, and debris covering the top and vents of the machine on<br><br>-9/22/25 at 10:00 AM<br><br>-9/23/25 at 9:22 AM<br><br>-9/23/25 at 1:55 PM<br><br>-9/24/25 at 8:55 AM<br><br>R5<br><br>According to the MDS dated [DATE], R5's BIMS (Brief Interview Mental Status) score of 6/15 indicated she was cognitively impaired, and her diagnoses included stroke.<br><br>Observed on 9/22/25 at 9:40 AM, R5's oxygen concentrator at bedside to have buildup of dust, lint, and food crumbs on the top of it in the vent in the back of it.<br><br>R73<br><br>According to the MDS dated [DATE], R73's BIMS score of 15 /15 indicated she was cognitively intact. Her diagnoses included cancer.<br><br>During an observation and interview on 9/22/25 at 11:14 AM, R73 reported she had lung cancer, and her oxygen concentrator should be running at 3 lpm. Observed the resident wearing oxygen via NC with tubing connected to a concentrator. There was no bubbler/humidifier. The top and back vent of the concentrator has a buildup of dust, lint, and debris.<br><br>DPS B<br><br>On 9/22/25 at 2:01 PM, An interview with Plant and Maintenance (PM) U found that the Maintenance Director is on vacation and not onsite this week. When asked if he knew much about if the facility did regular flushing or sampling of the water supply in regard to the Water Management Plan (WMP), PM U stated that he was unaware of aspects of the WMP and, to his knowledge, didn't carry out any responsibilities associated with it.<br><br>On 9/22/25 at 2:30 PM, Observation of the Memory Care Unit (MCU) Soiled Linen room, with Housekeeping Manager (HM) JJ, found that the hopper had been removed, but water lines were still in place. When asked if she knew if this area was flushed or had the water shut off, HM JJ was unsure. When asked if there was any regular flushing schedule the facility uses for minimal use or unused water fixtures, HM JJ was unsure.<br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | On 9/22/25 at 2:35 PM, Observation of the MCU janitors closet found that the mop sink faucet was connected to a chemical pre-dispense system and was only hooked up to the cold-water supply. The hot water supply did not have a handle for staff to use. When asked about flushing this line, HM JJ was unsure, indicating a stagnant water line in need of regular flushing.<br><br>On 9/22/25 at 2:39 PM, Observation of the Rehab tub room found dust and debris in the bottom of the spa tub. When asked if the tub gets used often, HM JJ stated that its not used, indicating a stagnant water line in need of regular flushing.<br><br>On 9/22/25 at 2:43 PM, Observation of the Biohazard room near the Front Nurses station, found plumbing connections where a hopper used to be. When asked if the water to the hopper was disconnected and capped off or regularly flushed, HM JJ was usure.<br><br>On 9/22/25 at 2:47 PM, Observation of the Front Nurses station janitors closet found a set up that did not use the hot water of the mop sink faucet, and the handle of the faucet was taken off. Upon turning the mount where a handle would go, brown and discolored water ran out of the faucet before slowly turning clear over a 10 second period.<br><br>On 9/22/25 at 3:16 PM, An interview with NHA A found that there should be a book or binder of the water management plan in the Maintenance Directors office.<br><br>On 9/22/25 at 3:20 PM, The surveyor and Nurse Consultant PP were unable to find a binder or book for the facilities WMP. Surveyor was unable to review any policies or procedures of the plan, find documentation of a completed risk assessment of the facility, ensure a Water Management Team was in place to carry out the plan, or ensure proper control measures were being followed to reduce the risk of Legionella or other opportunistic pathogens of premises plumbing. No further documentation was received by the end of survey exit. |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to develop and/or implement a comprehensive resident-specific treatment plan for five (R43, R31, R4, R11, and R71) of 18 residents reviewed for care planning, resulting in the potential for unmet medical, physical, mental, and psychosocial needs.Findings include: R43<br><br>According to R43's admission Record, diagnoses included COPD (chronic obstructive pulmonary disease) and chronic respiratory failure with hypoxia.<br><br>Review of R43's Order Summary indicated the resident had 1-PRN (as needed) Albuterol inhaler dated 11/16/24. Further review of R43's Order Summary indicated the resident could keep an inhaler at bedside per hospice as of 9/16/25. It was noted hospice services were ordered for the resident on 9/15/25.<br><br>Review of R43's Care Plan indicated the resident preferred to keep her inhaler within reach but was not implemented until 9/23/25, 7-days after the physician's order was written and 1-day after the facility's recertification survey had started.<br><br>R31<br><br>According to R31's Minimum Data Set (MDS) dated [DATE], indicated the resident was cognitively intact with a score of 15/15 on his BIMS (Brief Interview Mental Status) and was independent with eating and dressing himself that indicated he had mobility in his arms and hands. His active diagnoses included cardiorespiratory conditions.<br><br>Review of R31's Self-Administration of Medication Evaluation was dated 8/15/2023, indicating the resident was able to self-administer his medications. It was noted the report Evaluation History Self-Administration of Medication Assessment presented by Nursing Home Administrator (NHA) A, identified R31's evaluation to have been completed on 3/11/2025.<br><br>Review of R31's Care Plan indicated there was no resident-specific treatment plan for self-administering medications.<br><br>Review of facility policy, Medication Administration revised 10/17/2023, revealed, Self-administration of medication will be reflected in the resident care plan along with any special considerations.<br><br>Resident #4<br><br>Review of an admission Record revealed Resident #4 was a female, with pertinent diagnoses which included stroke, dementia, and bipolar disorder (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs).<br><br>Review of a Minimum Data Set (MDS) assessment for Resident #4, with a reference date of 7/31/25, revealed a Brief Interview for Mental Status (BIMS) score of 0, out of a total score of 15, indicating severe cognitive impairment. Further review of this assessment for Resident #4 revealed Section I - Active Diagnoses had a check next to bipolar disorder, and Section N - Medications indicated Resident (continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | #4 took antipsychotic medications on a routine basis.<br><br>Review of an Order Summary Report for Resident #4 revealed the physician order .QUEtiapine Fumarate (an antipsychotic medication) Oral Tablet 25 MG (Quetiapine Fumarate) Give 1 tablet via G-Tube (gastrostomy tube) two times a day for Bipolar disorder . with a start date of 7/25/25 and a status of discontinued. Further review revealed the physician order .QUEtiapine Fumarate Oral Tablet 25 MG (Quetiapine Fumarate) Give 25 mg via G-Tube two times a day for mood disorder . with a start date of 7/29/25 and a status of discontinued. Lastly, the active physician order .QUEtiapine Fumarate Oral Tablet 25 MG (Quetiapine Fumarate) Give 25 mg via G-Tube two times a day for Bipolar disorder . was noted for Resident #4 with a start date of 9/11/25.<br><br>Review of the Care Area Assessment (CAA) for Psychotropic Drug Use for Resident #4, contained within the 7/31/25 MDS assessment, revealed .Triggering Conditions .High-Risk Drug (Is Taking): Antipsychotic .Checked (Yes) .(Resident #4) is taking Seroquel-antipsychotic medication to (manage) mood and behavior r/t (related to) Bipolar disorder. (She) is referred for psych services to (manage) behavior and (for) medication adjustment. (She) was noted with (an) episode of agitation, stripping (her) clothes and pulling (her) G-tube, (relieved) after taking scheduled medications .Care Plan Considerations .Will Psychotropic Drug Use be addressed in the care plan? Yes .Will proceed to care plan to manage mood and behavior and monitor potential adverse (effects) of medication that may impact quality of life .<br><br>Review of a Care Plan Report for Resident #4 revealed no focus/goal/interventions related to her diagnosis of bipolar disorder, mood/behavior concerns, and routine use of antipsychotic medications.<br><br>In an interview on 9/23/25 at 2:44 PM, Social Service Director (SSD) FF reported care plans are created for residents based on the information in the medical record, information from residents/family members, social service assessments, MDS assessments and CAAs. SSD FF reported when completing a CAA during the MDS process, a decision is made whether to proceed to the care plan when specific items/areas are triggered. SSD FF reviewed Resident #4's Care Plan and acknowledged there was no focus/goal or interventions related to Resident #4's diagnosis of bipolar disorder, mood/behavior concerns, and routine use of antipsychotic medications.<br><br>Resident #11 (R11) Review of the admission Record and Minimum Data Set (MDS) dated [DATE] revealed R11's initial admission date to the facility was on 5/31/2024 with pertinent diagnoses including dementia (decline in mental abilities such as memory, thinking and reasoning that is severe enough to interfere with daily life), tremors, anxiety and depression. Brief Interview for Mental Status (BIMS) reflected a score of 3 out of 15 which indicated R11 was severely cognitively impaired (00 to 07 is severe cognitive impairment).<br><br>During an interview and observation on 9/22/2025 at 12:11 PM, R11 was lying in bed and was confused and stated she couldn't remember if she had fallen at the facility. Review of R11's fall report dated 7/16/2025 revealed .Resident was found sitting with her back at the bed facing the bedroom door. Resident states that she slid off her bed.Intervention: Nonskid tape applied to the floor in front of the bed.<br><br>Review of R11's functional status care plan revealed . (R11) requires supervision assistance with transfers and ambulation. Interventions.provide safety devices as ordered.bed against wall.<br><br>Review of R11's fall care plan revealed (R11) is at risk for fall related injury and falls r/t (related to) (continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | impaired cognition d/t (due to) dementia, history of falls, incontinence of bladder . interventions.7/16/25 non-skid tape to be applied in front of bed. Date initiated 7/16/2025.<br><br>On 9/24/2025 at 11:50 AM, it was observed that R11 did not have non-skid tape on the floor and her bed was not against the wall.<br><br>During an interview on 9/24/2025 at 11:56 AM, Certified Nursing Assistant (CNA) J stated that R11 had times of confusion but communicates well and had fallen a few times since R11 thinks she can do things herself which she can, but she needs stand by staff assistance. CNA J verified that there wasn't non-skid tape in front or around her bed and that the bed wasn't against the wall.<br><br>During an interview on 9/24/2025 at 12:17 PM, Director of Nursing (DON) B stated that after every fall a new intervention was put into place and IDT (interdisciplinary team) discusses whether the interventions are effective and if changes need to be made and it is put on the care plan. When discussing that R11's bed was not against the wall and non-skid tape was not in front of bed per her care plan, DON B said We will get that fixed.<br><br>Resident #71<br><br>Review of an admission Record revealed Resident #71 was originally admitted to the facility on [DATE] with pertinent diagnoses which included: depression (persistent sad mood that impacts daily life), and chronic respiratory failure with hypoxia (chronic condition in which the lungs cannot adequately provide oxygen to the body over an extended period, leading to low oxygen levels in the blood).<br><br>Review of a Minimum Data Set (MDS) assessment for Resident #71 with a reference date of 9/9/25, revealed the resident refused to complete a Brief Interview for Mental Status (BIMS) assessment. Resident # 71's short-term memory was not assessed. Review of section D revealed Resident # 71 was not assessed for feelings of depression or thoughts of being better off dead/hurting self.<br><br>Review of a Care Plan for Resident # 71 revealed there were no goals or interventions to address Resident 71's safety issues related to smoking/hiding of smoking paraphernalia, or his suspected history of smoking in his room while unsupervised.<br><br>In an interview on 9/22/25, at 2:01pm, Resident #71 reported he had a lighter and cigarettes in his room until a few days ago when a police officer came and confiscated them. Resident #71 reported staff allowed him to go outside and smoke and to keep his smoking materials in his possession. When further queried, Resident #71 reported he had a little paranoia, felt his phoneline was tapped and felt the need to hide his smoking materials.<br><br>In an interview on 9/23/25 at 10:34am, Registered Nurse (RN) X reported on 9/20/25 at approximately 5:00pm a staff member came to her and told her she suspected Resident #71 had been smoking in his room. RN X reported upon investigating she found Resident #71's room appeared smoky and smelled of cigarette smoke. RN X reported she had cared for Resident #71 and did not know he was a smoker until that day. RN X reported she felt Resident #71's care plan should reflect that he smoked, was noncompliant with relinquishing his smoking paraphernalia, and had an incident of smoking in his room.<br><br>In an interview on 9/24/25 at 1:55pm, Nursing Home Administrator (NHA) A confirmed the facility had (continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | not developed a care plan to address Resident #71's preference to smoke cigarettes, his noncompliance with the facility's smoking policy, or his safety needs related to the incident in which he likely smoked a cigarette in his room. NHA A reported although Resident #71 did not get visitors, he had the potential to acquire smoking paraphernalia from other facility visitors and/or other residents. |

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| F 0554<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Allow residents to self-administer drugs if determined clinically appropriate.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure 1.) 2 residents (R43 and R69) of 3 residents reviewed for self-administration of medications was assessed to determine if self-administration of medication was clinically appropriate, and 2.) orders were written for 2 residents (R69 and R31) of 3 residents reviewed to be able to self-administer medications, resulting in unsupervised administration of medications (R43 and R69) and the potential for mismanagement of medication and potential for adverse side effects.Findings include: Review of the facility list of residents that had the Evaluation History Self-Administration of Medication Assessment received 9/23/2025, revealed two residents had been evaluated for self-administrating medications. The residents were R43 on 9/23/25 and R31 on 3/11/25. R43According to R43's admission Record, diagnoses included COPD (chronic obstructive pulmonary disease) and chronic respiratory failure with hypoxia.Review of R43's Order Summary indicated the resident had 1-PRN (as needed) inhaler. Further review of R43's Order Summary indicated the resident could keep an inhaler at bedside per hospice as of 9/16/25.Review of R43's Care Plan indicated the resident preferred to keep her inhaler within reach but was not implemented until 9/23/25, 7-days after the physician's order was written and 1-day after the facility's recertification survey had started. Review of R43's Self-Administration of Medication Assessment was documented as being completed on 9/23/25 which was after the resident began using the medication at bedside on 9/16/25 and further noted to have been done after a list of residents who self-administer medications at bedside was request from the facility's Administrator on 9/23/25. During an interview on 9/24/2025 at 1:53 PM, R43 stated her inhaler had stayed at her bedside since it was ordered for her and she used it every day. This morning, a nurse took it to clean it and did not bring it back. The conversation with R43 revealed the resident was able to recall short- and long-term memories and hold an intellectual conversation.R69According to R69's Minimum Data Set (MDS) dated [DATE], the resident was independent performing her ADLs (activities of daily living). The resident's BIMS had not been completed however, in conversations with the resident, she was able to recall long and short memories and hold an intellectual conversation. Review of R69's Diagnoses List included chronic obstructive pulmonary disease (COPD), chronic respiratory failure with hypoxia, and emphysema. Review of R69's Order Summary, dated 2/25/25, revealed, Saline Nasal Solution 0.65 % (Saline) 1 spray in each nostril every 1 hour as needed for dry nose. Further review of R69's Order Summary indicated there was no order stating the resident could self-administer any medication including Saline spray. Review of R69's Care Plan indicated there was no resident-specific treatment plan for self-administering medications. Observation and interview on 9/22/25 at 10:00 AM, revealed R69 was sitting in her room in a recliner next to a bedside table. On the bedside table was a bottle of Normal Saline nasal spray with the resident's name and dated 2/25/25. R69 stated, Staff left this bottle of nose spray for me to use because my nose gets dry and has little sores in it from the oxygen I wear. Observed on 9/23/5 at 9:22 AM, R69 sitting in her room in a recliner next to a bedside table. On the bedside table was a bottle of Normal Saline nasal spray with the resident's name and dated 2/25/25. Observed on 9/23/25 at 1:55 PM, on R69's bedside table was a bottle of Normal Saline nasal spray with the resident's name and dated 2/25/25. On 9/23/25 at 3:43 PM, email request sent to Nursing Home Administrator (NHA) A for a list of residents that were evaluated to self-administer medications. During an observation and interview on 9/24/25 at 8:55 AM, R69 was awake in her recliner. There was no saline nasal spray visible. R69 stated, The nurse came yesterday (9/23/25) and took my spray away. During an interview on 9/24/25 at 9:10 AM, Director of Nursing (DON) B reported a resident required a self-administer medication evaluation before they could take their medications by themselves. She also stated she did not know if any residents in the facility had had one and was self-administering their medications. She did know that R69 did not have an evaluation. R31According<br>(continued on next page) |

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| F 0554<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | to R31's MDS dated [DATE], indicated the resident was cognitively intact with a score of 15/15 on his BIMS (Brief Interview Mental Status) and was independent with eating and dressing himself that indicated he had mobility in his arms and hands. His active diagnoses included cardiorespiratory conditions.Review of R31's Order Summary did not have an order independently or connected to any medication(s) to self-administer.Review of R31's Care Plan indicated there was no resident-specific treatment plan for self-administering medications. Review of R31's Self-Administration of Medication Evaluation was dated 8/15/2023, indicating the resident was able to self-administer his medications. It was noted the report Evaluation History Self-Administration of Medication Assessment presented by NHA A, identified R31's evaluation to have been completed on 3/11/2025. Review of facility policy, Medication Administration revised 10/17/2023, revealed, .Self-Administration - residents are allowed to self-administer medications when specifically authorized by the attending physician and in accordance with the guideline for self-administration of medication. A self-administration evaluation will be completed prior to the resident starting the self-administering process. |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to protect the residents' right to be free from physical abuse by a resident in 2 (Resident #49 and Resident #51) of 2 residents reviewed for abuse resulting in Resident #49 being physically assaulted by Resident #51 and the potential for a decline in physical, mental, and psychosocial well-being. Findings include: Resident #49Review of an admission Record revealed Resident #49 was originally admitted to the facility on [DATE] with pertinent diagnoses which included Alzheimer's disease and cognitive communication disease. Review of Resident #49's Progress Notes dated 9/11/25 and documented by Physician Assistant (PA) AAA revealed, RN (Registered Nurse) called and notified me resident (Resident #49) was in an altercation with another resident (Resident #51). Resident (Resident #49) was struck in the face with a book by another resident (Resident #51) Resident #51Review of an admission Record revealed Resident #51 was originally admitted to the facility on [DATE] with pertinent diagnoses which included Alzheimer's disease and major depressive disorder. Review of Resident #51's Care Plan revealed, (Resident #51) has the potential to demonstrate physical and verbal aggression R/T (related to): hitting, kicking, resistive to care, biting, slapping, repetitive movements, yelling, screaming and abusive language r/t dementia, delusional thinking, depression and anxiety. Start date: 1/8/25. Goal: Will not harm self or others through the review date. Date Initiated: 01/08/2025. Interventions: Assess and anticipate resident's needs: food, thirst. toileting needs, comfort level, body positioning, need for sleep, pain etc. as needed. Date Initiated: 01/08/2025. Assess resident's understanding of the situation. Allow time for the resident toexpress self and feelings towards the situation, including antecedents, effective calming strategies etc . Date Initiated: 01/08/2025. COMMUNICATION: provide physical and verbal cues to alleviate anxiety; give positive feedback, assist verbalization of source of agitation, assist to set goals for more pleasant behavior, encourage seeking out of staff member when agitated. Date Initiated: 01/08/2025. Notify nurse/social worker when behaviors occur. Date Initiated: 01/08/2025. Observe key times, places, circumstances, triggers, and what de-escalates behavior. Adjust plan of care to reduce incidents of aggression where possible. Date Initiated: 01/08/2025 . Review of Resident #51's Incident Report dated 9/11/25 and documented by Registered Nurse (RN) G revealed, The author writing this note heard the resident (Resident #51) raising her voice. This author observed (Resident #51) holding onto another resident (Resident #49) walker and yelling at other resident (Resident #49). This author removed (Resident #51) from the day room . In an interview on 9/22/2025 at 12:01 PM, Family Member (FM) NN reported that he had recently been contacted by the facility and informed that Resident #51 had been in a physical altercation with another resident, and that Resident #51 had hit Resident #49 in the face with a book. FM NN reported that Resident #51 had a history of aggressive behavior towards other residents. In an interview on 9/23/2025 at 11:23 AM, RN NN reported that he was the nurse caring for Resident #51 on 9/11/25 when she got into a physical altercation with Resident #49. RN NN reported that he had heard yelling in the day room and when he entered the day room, he saw Activity Aide (AA) D in between Resident #49 and Resident #51. RN NN reported that he did not observe the physical altercation between the two residents because it had been broken up by AA D before he got there. RN NN reported that he assisted Resident #51 out of the day room and back to her room. RN NN reported that Resident #51 had a history of being aggressive with other residents, and that she had been in multiple physical altercations with other residents at the facility. In an interview on 9/23/2025 at 11:53 AM, AA D reported that on 9/11/25 she was assisting a resident to walk down the hall when she noticed that Resident #49 and Resident #51 were sitting next to each other in the day room with Resident #49's walker in between them. AA D reported that she saw Resident #51 trying to move Resident #49's walker and she began screaming at Resident #49 and then grabbed a book and smacked Resident #49 across the face with the book. AA D<br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 235264 | A. Building<br>B. Wing | 11/21/2025 |

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

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|---|---|
| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | reported that Resident #49 grabbed Resident's arm in an attempt to block her from hitting her again, but Resident #51 slapped Resident #49 across the face with her other hand. AA D reported that she was able to safely move the resident she was assisting in the hallway, and then she got in between Resident #49 and Resident #51 to stop the physical altercation. AA DD confirmed that Resident #51 did make full on contact with Resident #49 when she hit her with the book and slapped her, and that when Resident #51 slapped Resident #49, she had fallen back in the chair she was in. In an interview on 9/23/2025 at 12:39 PM, Nursing Home Administrator (NHA) A reported that she was aware of the physical altercation on 9/11/25 between Resident #49 and Resident #51. NHA A reported that she was not sure if the incident was considered abuse because the facility was unable to determine the intent of residents. NHA A reported that she was aware that Resident #51 had struck Resident #49 in the face with a book and then slapped Resident #49 across the face. Review of the facility's Abuse policy last revised 9/9/22 revealed, Policy: Each guest/resident shall be free from abuse . Abuse shall include free from verbal, mental, sexual, physical abuse . To assure guests/residents are free from abuse, neglect, exploitation, or mistreatment, the facility shall monitor guest/resident care and treatments on an on-going basis. It is the responsibility of all staff to provide a safe environment for the guests/residents . Definitions: Abuse means the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain, or mental anguish . Physical abuse includes hitting, slapping, pinching, and kicking . |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.<br><br>Based on interview and record review, the facility failed to implement policies and procedures for ensuring the reporting of a reasonable suspicion of a crime in accordance with section 1150B of the Act for 2 (Resident #49 and Resident #51) of 2 residents reviewed for abuse resulting in an allegation of physical abuse not being thoroughly investigated and the potential for ongoing resident to resident physical abuse to occur. Findings include: Resident #49 Review of Resident #49's Progress Notes dated 9/11/25 and documented by Physician Assistant (PA) AAA revealed, RN (Registered Nurse) called and notified me resident (Resident #49) was in an altercation with another resident (Resident #51). Resident (Resident #49) was struck in the face with a book by another resident (Resident #51) Resident #51 Review of Resident #51's Incident Report dated 9/11/25 and documented by Registered Nurse (RN) G revealed, The author writing this note heard the resident (Resident #51) raising her voice. This author observed (Resident #51) holding onto another resident (Resident #49) walker and yelling at other resident (Resident #49). This author removed (Resident #51) from the day room . In an interview on 9/22/2025 at 12:01 PM, Family Member (FM) NN reported that he had recently been contacted by the facility and informed that Resident #51 had been in a physical altercation with another resident, and that Resident #51 had hit Resident #49 in the face with a book. FM NN reported that Resident #51 had a history of aggressive behavior towards other residents. In an interview on 9/23/2025 at 11:23 AM, RN NN reported that he was the nurse caring for Resident #51 on 9/11/25 when she got into a physical altercation with Resident #49. RN NN reported that he had heard yelling in the day room and when he entered the day room, he saw Activity Aide (AA) D in between Resident #49 and Resident #51. RN NN reported that he did not observe the physical altercation between the two residents because it had been broken up by AA D before he got there. RN NN reported that he assisted Resident #51 out of the day room and back to her room. RN NN reported that Resident #51 had a history of being aggressive with other residents, and that she had been in multiple physical altercations with other residents at the facility. RN NN reported that he had reported the incident immediately after it happened to Nursing Home Administrator (NHA) A, who was the facility's designated abuse coordinator. In an interview on 9/23/2025 at 11:53 AM, AA D reported that on 9/11/25 she was assisting a resident to walk down the hall when she noticed that Resident #49 and Resident #51 were sitting next to each other in the day room with Resident #49's walker in between them. AA D reported that she saw Resident #51 trying to move Resident #49's walker and she began screaming at Resident #49 and then grabbed a book and smacked Resident #49 across the face with the book. AA D reported that Resident #49 grabbed Resident's arm in an attempt to block her from hitting her again, but Resident #51 slapped Resident #49 across the face with her other hand. AA D reported that she was able to safely move the resident she was assisting in the hallway, and then she got in between Resident #49 and Resident #51 to stop the physical altercation. AA DD confirmed that Resident #51 did make full on contact with Resident #49 when she hit her with the book and slapped her, and that when Resident #51 slapped Resident #49, she had fallen back in the chair she was in. AA DD reported that they had reported the incident to NHA A right after the incident occurred. In an interview on 9/23/2025 at 12:39 PM, Nursing Home Administrator (NHA) A reported that she was aware of the physical altercation on 9/11/25 between Resident #49 and Resident #51. NHA A reported that she was aware that Resident #51 had struck Resident #49 in the face with a book and then slapped Resident #49 across the face. NHA A confirmed that she did not report the incident to the State Agency. NHA A reported that she usually would report this type of incident. Review of the facility's Abuse policy last revised 9/9/22 revealed, Policy: Each guest/resident shall be free from abuse . Abuse shall include free from verbal, mental, sexual, physical abuse . To assure guests/residents are free from abuse, neglect, exploitation, or mistreatment, the facility shall monitor guest/resident care and treatments on an on-going basis. It is the responsibility of all staff to provide<br>(continued on next page) |

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| Ely Manor | 1200 Ely St<br>Allegan, MI 49010 |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | a safe environment for the guests/residents . Definitions: Abuse means the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain, or mental anguish . Physical abuse includes hitting, slapping, pinching, and kicking . G. Reporting abuse and the 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 (Director of Nursing) 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 . |

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| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Respond appropriately to all alleged violations.<br><br>Based on interview and record review, the facility failed to thoroughly investigate an allegation of resident-to-resident abuse and protect residents from further abuse for 2 residents (Resident #49 & #51) of 2 residents reviewed for abuse, resulting in the potential for ongoing abuse due to an incomplete investigation of abuse. Findings include: Resident #49 Review of Resident #49's Progress Notes dated 9/11/25 and documented by Physician Assistant (PA) AAA revealed, RN (Registered Nurse) called and notified me resident (Resident #49) was in an altercation with another resident (Resident #51). Resident (Resident #49) was struck in the face with a book by another resident (Resident #51) Resident #51 Review of Resident #51's Incident Report dated 9/11/25 and documented by Registered Nurse (RN) G revealed, The author writing this note heard the resident (Resident #51) raising her voice. This author observed (Resident #51) holding onto another resident (Resident #49) walker and yelling at other resident (Resident #49). This author removed (Resident #51) from the day room . In an interview on 9/23/2025 at 11:23 AM, RN NN reported that he was the nurse caring for Resident #51 on 9/11/25 when she got into a physical altercation with Resident #49. RN NN reported that he had heard yelling in the day room and when he entered the day room, he saw Activity Aide (AA) D in between Resident #49 and Resident #51. RN NN reported that he did not observe the physical altercation between the two residents because it had been broken up by AA D before he got there. RN NN reported that he assisted Resident #51 out of the day room and back to her room. RN NN reported that Resident #51 had a history of being aggressive with other residents, and that she had been in multiple physical altercations with other residents at the facility. RN NN reported that he had reported the incident immediately after it happened to Nursing Home Administrator (NHA) A, who was the facility's designated abuse coordinator. In an interview on 9/23/2025 at 11:53 AM, AA D reported that on 9/11/25 she was assisting a resident to walk down the hall when she noticed that Resident #49 and Resident #51 were sitting next to each other in the day room with Resident #49's walker in between them. AA D reported that she saw Resident #51 trying to move Resident #49's walker and she began screaming at Resident #49 and then grabbed a book and smacked Resident #49 across the face with the book. AA D reported that Resident #49 grabbed Resident's arm in an attempt to block her from hitting her again, but Resident #51 slapped Resident #49 across the face with her other hand. AA D reported that she was able to safely move the resident she was assisting in the hallway, and then she got in between Resident #49 and Resident #51 to stop the physical altercation. AA DD confirmed that Resident #51 did make full on contact with Resident #49 when she hit her with the book and slapped her, and that when Resident #51 slapped Resident #49, she had fallen back in the chair she was in. AA DD reported that they had reported the incident to NHA A right after the incident occurred. AA D reported that she had not been asked to complete a written witness statement of the investigation. In an interview on 9/23/2025 at 12:39 PM, Nursing Home Administrator (NHA) A reported that she was aware of the physical altercation on 9/11/25 between Resident #49 and Resident #51. NHA A reported that she was aware that Resident #51 had struck Resident #49 in the face with a book and then slapped Resident #49 across the face. NHA A reported that she was working on an investigation for the incident, and she would submit it shortly. When this writer queried as to what NHA A had for the investigation, NHA A showed this writer a one-page document with a list of staff names that were working during the incident. NHA A was unable to provide further documentation for this writer to review during this interview. NHA A was unable to report what actions she had taken for the investigation during the interview with this writer. In a follow up interview on 9/24/2025 at 2:37 PM, this writer asked NHA A for the investigation report that she had reported she would submit the day before and NHA A reported she was still working on uploading the report. On 9/24/25 at 3:07 PM, NHA A uploaded the Investigation Report. Review of the Investigation Report revealed a two-page typed document which revealed, Allegation Statement: On September 11, 2025, the ADON (Assistant Director of Nursing) and Activities Aide (AA D) reported to the<br>(continued on next page) |

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| | 235264 | A. Building<br>B. Wing | 11/21/2025 |

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| Ely Manor | 1200 Ely St<br>Allegan, MI 49010 |

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| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | administrator that they walked by the common day room and witnessed an altercation between (Resident #49 and Resident #51). (The document then provided a brief medical summary of Resident #49 and Resident #51) . Action taken: Assessments Completed, Informed Responsible Parties, Guardians, Administrator, Director of Nursing, Provider and Police, Staff and Resident interviews completed, Social Worker Visits initiated, Care Plans reviewed and updated as needed, Abuse Policy Reviewed, (local mental health provider) visit planned. Immediate Intervention: Residents were immediately separated and assessed for injury, none observed. Interviews/Investigation: During interviews and investigation it was determined that just prior to the incident, both residents participated in consuming lunch in the dining room. After lunch the residents were residing in the common day room. Interviews/Investigations: (Name Redacted- AA D) - states she was pushing another resident in their wheelchair down the hallway, she passed the day room and noted (Resident #51) and (Resident #49) appeared to be fighting over (Resident #49's) walker, she explained that both resident's had their hands on the walker and were pulling the walker to them. AA D began to enter the day room to assist the residents when she watched (Resident #51) pick up a magazine that was on the table and hit (Resident #49) in the arm with it. (Resident #51) then dropped the magazine and open handed slapped (Resident #49) across the face before she could get to the two residents to intervene. AA D was assisted by the ADON and reported the incident to the primary nurse, assisting (Resident #51) out to the hallway. AA D then reported the incident to the administrator . (Name Redacted- RN NN) states he was completing his medication pass in the hallway when he overheard (Resident #51) raising her voice. RN NN entered the day room and assisted with the separation; it was reported to him by (AA D) that she observed (Resident #51) hitting (Resident #49). (Resident #51) was unable to recall the incident within 10 minutes of the altercation. The administrator attempted to interview (Resident #51), she was laying in her bed, pleasant and calm. She stated she was doing ok today, just going to lay down for a nap. (Resident #49) was unable to recall the incident within 15 minutes of the altercation. The administrator attempted to interview (Resident #49) she was still in the common day room, sitting at the table, walker within reach and appeared to be reading a book. (Resident #49) smiled at the administrator however did not answer any questions. She appeared to be pleasant and calm, no distress noted. Intervention: The residents were separated after the incident. (local mental health provider) contacted for a visit to assist with management of (Resident #51's) behaviors. Conclusion: After investigation and interview it was determined that no intent could be indicated for abuse as both residents have a low BIMs indicating significant cognitive impairment, no witnesses to explain the begin/reasoning for the altercation and neither resident could recall the incident directly after it occurred. No injuries. All appropriate parties notified. It was noted that the Investigation Report did not include assessments that were reported to have been completed, or evidence to verify that the police had been contacted, copies of witness statements, verification that resident care plans were reviewed and updated, or verification of the scheduled mental health provider visits that were reported to have been planned. It was also noted that the description of the interview with AA D did not reflect the statement that AAD had provided to this writer, as AA D had reported to this writer that Resident #51 had hit Resident #49 in the face with a book, and not her arm. The investigation report did not describe any additional outcomes to Resident #49 and Resident #51 such as physical or mental harm, the date and time the incident was reported to responsible parties, provider and the police. The investigation report did not include summary information from the investigation related to the incident from the resident's clinical record, such as relevant portions of the RAI, the resident's care plan, nurses' notes, social services note, lab reports, physician or other practitioner reports or reports from other disciplines that are related to the incident or any relevant details that may have caused Resident #51's behavior, such as habits, routines, medications, diagnosis. The report did not include the plan for oversight of implementation of corrective action, interventions planned and implemented to assist Resident #49 and Resident #51. Review of the Facility's Abuse Prohibition Policy last revised 9/9/22 revealed, Review of the facility's Abuse policy last revised 9/9/22<br>(continued on next page) |

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| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | revealed, Policy: Each guest/resident shall be free from abuse . Abuse shall include free from verbal, mental, sexual, physical abuse . To assure guests/residents are free from abuse, neglect, exploitation, or mistreatment, the facility shall monitor guest/resident care and treatments on an on-going basis. It is the responsibility of all staff to provide a safe environment for the guests/residents . Definitions: Abuse means the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain, or mental anguish . Physical abuse includes hitting, slapping, pinching, and kicking . E. Investigation: 1. Allegations by anyone who becomes aware od verbal, physical, mental, sexual or abuse or mistreatment, neglect, exploitation, involuntary seclusion or misappropriation of property must immediately report it to his/her Administrator. 2. The Director of Nursing or designee will complete an assessment of guests/residents and document findings in the record 3. An incident Report (and/or grievance forms per state specific requirements) will be completed . 5. A preliminary, on-site investigation will be initiated within twenty-four hours of any report. 6. The Administrator or Director of Nursing/designee shall initiate the Incident and Accident Investigation Form (or other grievance forms per state specific guidelines) and take the following actions to ensure that the investigation is conducted effectively. a.If the incident has resulted in an injury (requiring acute intervention) or was a sexual assault, the guest/resident will be transferred to a hospital emergency room. The physician and family will be notified of the transfer . e. The Administrator or Director of Nursing shall call local police when assault, sexual abuse, homicide, forgery or neglect are suspected or have occurred or per state law . |

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| F 0645<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | PASARR screening for Mental disorders or Intellectual Disabilities<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure 1(Resident #4) of 1 resident reviewed for Pre-admission Screening and Resident Review (PASARR) was referred for a comprehensive level II PASARR evaluation, resulting in the potential for the resident to not receive the appropriate mental health treatment and services. Findings include:Resident #4Review of an admission Record revealed Resident #4 was originally admitted to the facility on [DATE] with pertinent diagnoses which included: bipolar disorder (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs).Review of a Minimum Data Set (MDS) assessment for Resident #4 with a reference date of 7/31/25, revealed a Brief Interview for Mental Status (BIMS) assessment score of 0/15, which indicated the resident was severely cognitively impaired.Review of a PASARR Level I screening form for Resident #4 with a reference date of 7/22/25, section II revealed the resident 1.has a current diagnosis of mental illness, 2.has received treatment for mental illness, .3. routinely received one or more prescribed antipsychotic medications in the last 14 days, 4. There is presenting evidence of mental illness.including significant disturbances in thought, conduct, emotions, or judgement.In an interview on 09/24/2025 at 12:02pm, Social Services Director (SSD) FF reported Resident #4 triggered the need for a level II PASARR screening due to her history of mental illness. SSD FF reported a referral for a level II PASARR screening should have been made to a community mental health agency at the time of her admission, but it had not been done.Review of a facility Pre-admission Screening and Resident Review policy with a reference date of 11/12/21 revealed Policy: The PASRR process was established.to ensure that needs are met to assist the individual in reaching their highest potential. All persons .who are seriously mentally ill.are required to be evaluated to determine if a nursing facility is the appropriate place to receive services.7. For those who screen positively for a mental illness.the facility submits the Level I screen to the local community mental health program for comprehensive screening (Level II) .9. If a comprehensive Level II screening is performed, the recommendations are to be included in the plan of care. |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to review and revise a comprehensive, individualized plan of care for 1 of 18 residents (Resident #51) reviewed for care plans, resulting in further occurrences of resident-to-resident physical aggression and the potential for unmet care needs and impaired physical, mental, and psychosocial well-being. Findings include: Resident #51 Review of an admission Record revealed Resident #51 was originally admitted to the facility on [DATE] with pertinent diagnoses which included Alzheimer's disease and major depressive disorder. Review of Resident #51's Care Plan revealed, (Resident #51) has the potential to demonstrate physical and verbal aggression R/T (related to): hitting, kicking, resistive to care, biting, slapping, repetitive movements, yelling, screaming and abusive language r/t dementia, delusional thinking, depression and anxiety. Start date: 1/8/25. Goal: Will not harm self or others through the review date. Date Initiated: 01/08/2025. Interventions: Assess and anticipate resident's needs: food, thirst. toileting needs, comfort level, body positioning, need for sleep, pain etc. as needed. Date Initiated: 01/08/2025. Assess resident's understanding of the situation. Allow time for the resident to express self and feelings towards the situation, including antecedents, effective calming strategies etc . Date Initiated: 01/08/2025. COMMUNICATION: provide physical and verbal cues to alleviate anxiety; give positive feedback, assist verbalization of source of agitation, assist to set goals for more pleasant behavior, encourage seeking out of staff member when agitated. Date Initiated: 01/08/2025. Notify nurse/social worker when behaviors occur. Date Initiated: 01/08/2025. Observe key times, places, circumstances, triggers, and what de-escalates behavior. Adjust plan of care to reduce incidents of aggression where possible. Date Initiated: 01/08/2025 . It was noted that Resident #51's physical and verbal aggression care plan had not been updated since 1/8/25. Review of Resident #51's Progress Note dated 8/24/25 revealed, During this evening meal in the room dining room, the resident (Resident #51) was reported by Certified Nursing Assistant (CNA) (Name redacted) to have initiated physical aggression towards another resident. Review of Resident #51's Incident Report dated 9/11/25 and documented by Registered Nurse (RN) G revealed, The author writing this note heard the resident (Resident #51) raising her voice. This author observed (Resident #51) holding onto another resident (Resident #49) walker and yelling at other resident (Resident #49). This author removed (Resident #51) from the day room . In an interview on 9/22/2025 at 12:01 PM, Family Member (FM) NN reported that he had recently been contacted by the facility and informed that Resident #51 had been in a physical altercation with another resident, and that Resident #51 had hit Resident #49 in the face with a book. FM NN reported that Resident #51 had a history of aggressive behavior towards other residents and had been in multiple other altercations at the facility with residents. In an interview on 9/23/2025 at 11:23 AM, RN NN reported that he was the nurse caring for Resident #51 on 9/11/25 when she got into a physical altercation with Resident #49. RN NN reported that he had heard yelling in the day room and when he entered the day room, he saw Activity Aide (AA) D in between Resident #49 and Resident #51. RN NN reported that he did not observe the physical altercation between the two residents because it had been broken up by AA D before he got there. RN NN reported that he assisted Resident #51 out of the day room and back to her room. RN NN reported that Resident #51 had a history of being aggressive with other residents, and that she had been in multiple physical altercations with other residents at the facility. RN NN reported that he did not know what interventions were in place to assist Resident #51 when she would get aggressive towards other residents. RN NN reported that the facility had moved Resident #51 to other rooms, but that did not seem to help her. RN NN was not aware of any new interventions that the facility had implemented after the incident on 9/11/25. In an interview on 9/23/2025 at 11:53 AM, AA D reported that on 9/11/25 she was assisting a resident to walk down the hall when she noticed that Resident #49 and<br>(continued on next page) |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Resident #51 were sitting next to each other in the day room with Resident #49's walker in between them. AA D reported that she saw Resident #51 trying to move Resident #49's walker and she (Resident #51) began screaming at Resident #49 and then grabbed a book and smacked Resident #49 across the face with the book. AA D reported that Resident #49 grabbed Resident's arm in an attempt to block her from hitting her again, but Resident #51 slapped Resident #49 across the face with her other hand. AA D reported that she was able to safely move the resident she was assisting in the hallway, and then she got in between Resident #49 and Resident #51 to stop the physical altercation. AA DD confirmed that Resident #51 did make full on contact with Resident #49 when she hit her with the book and slapped her, and that when Resident #51 slapped Resident #49, she had fallen back in the chair she was in. AA DD was not aware of any new interventions that the facility had implemented after this incident to prevent further incidences from occurring. In an interview on 9/24/2025 at 8:47 AM, Social Services Director (SSD) FF reported that she was aware of the recent aggressive incidents that Resident #51 had with other residents in August and September 2025. SSD FF reviewed Resident #51's Care Plan with this writer and confirmed that the facility had not reviewed and revised Resident #51's Care Plan to reduce the likelihood of another resident-to-resident incidents from happening again. SSD FF was unable to report any new interventions that the facility had implemented after the August 2025 or September 2025 resident to resident incidents with Resident #51. In an interview on 9/24/2025 at 10:01 AM, Director of Nursing (DON) B reported that she was aware of the resident-to-resident incidents that Resident #51 was involved in during August 2025 and September 2025. DON B reported that Resident #51 did have a history of physical aggression towards others. DON B reported that the facility had considered moving Resident #51 to another room, but they had not moved Resident #51 yet. DON B confirmed that the facility had not reviewed and revised Resident #51's Care Plan to reduce the likelihood of another resident-to-resident incidents from happening again, and that the facility had not implemented any new interventions to address Resident #51's aggression since the August and September 2025 incidents. |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to implement interventions to reduce hazards and risks for 2 residents (Resident #71 and Resident #24) of 6 residents reviewed for accidents, resulting in: 1. Resident #71 maintaining possession of smoking paraphernalia while unsupervised. This deficient practice has the potential to impact all 80 residents of the facility due to the increased risk of a potential fire. 2. Resident #24 being transported in a wheelchair without foot pedals in place, resulting in the potential for an avoidable injury.Findings include:Resident #71Review of an admission Record revealed Resident #71 was originally admitted to the facility on [DATE] with pertinent diagnoses which included: depression (persistent sad mood that impacts daily life).Review of a Care Plan for Resident # 71 with a reference date of 3/12/25, revealed there was no care plan related to Resident 71's noncompliance with the facility smoking policy, hiding smoking paraphernalia, and smoking in his room.Review of a Nurses Note for Resident #71, with a reference date of 9/16/25 at 11:52pm, revealed declined all evening medications.proceeded to go outside for approximately two hours to smoke.Review of a Nurses Note for Resident #71, with a reference date of 9/20/25 at 5:39pm revealed Resident was found awake in his room with oxygen concentrator in use after staff detected the smell of smoke in the hallway. Upon assessment resident (sic) denied smoking in the room, however, odor of smoke was noticeable.Resident was observed to be verbally hostile toward the nurse.Review of a Nurses Note for Resident #71, with a reference date of 9/20/25 at 7:04pm revealed Deputy (Deputy's name) came to facility to address non-smoking facility violations. He was able to confiscate the resident's lighter from his room.Review of a Leave of Absence Sign Out form for Resident #71 revealed 6 occurrences in which Resident #71 signed himself out of the facility between 8/28-9/16/25. Outside smoke was listed as the destination for each occurrence. No staff signatures were present to indicate the resident returned indoors and relinquished his smoking paraphernalia.In an interview on 9/22/25, at 2:01pm, Resident #71 reported he had a lighter and cigarettes in his room until a few days ago when a police officer came and confiscated them. Resident #71 reported staff allowed him to go outside and smoke and to keep his smoking materials in his possession. When further queried, Resident #71 reported he had a little paranoia, felt his phoneline was tapped and felt the need to hide his smoking materials.In an interview on 9/23/25 at 11:50am, Licensed Practical Nurse (LPN) KK reported it was the expectation that staff maintain Resident #71's smoking materials in a cupboard in the locked medication room on his hall. LPN KK reported the floor nurse was expected to regain possession of Resident #71's smoking materials each time he returned from going outside to smoke and then sign the Leave of Absence form.During an observation on 9/23/25 at 11:55am, no smoking materials for Resident #71 were present in the cupboard in the locked medication room of his hall.In an interview on 9/23/25 at 11:02am, Certified Nursing Assistant (CNA) F reported on the evening of 9/20/25 at approximately 5:00pm, she smelled smoke in the hallway near Resident #71's room. CNA F reported the smell intensified as she approached Resident #71's room and when she entered, a smokey haze was present in the room. CNA F reported Resident #71 was sitting in his bed, his oxygen concentrator was running, but the resident did not have his oxygen cannula in his nostrils. CNA F reported she did not see Resident #71 actively smoking when she entered the room. However, CNA F reported based on the smell and the smoke in the room, she was certain Resident #71 had been smoking in his room, and she reported her concern to Registered Nurse (RN) X.In an interview on 9/23/25 at 10:34am, RN X reported she was in another resident's room on 9/20/25 around 5:00pm, when CNA F came to her and reported smoke coming from Resident #71's room. RN X reported she immediately went to investigate, found the resident's door and windows open, and noticed a haze of smoke in Resident #71's room. Resident #71 sat on his bed, with his oxygen concentrator running nearby. His oxygen cannula was on the floor near his bed. RN X<br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | reported she began searching the resident's room for his cigarettes and lighter, because she was sure the resident had been smoking, but Resident #71 demanded she get out of his room. RN X reported she was told by management to contact the police for assistance. RN X reported she had never seen Resident #71's smoking materials locked up where other resident's smoking materials were kept. RN X reported after she called the police, a deputy came to the facility, met with Resident #71 and removed a working lighter from the resident's possession. RN X reported she locked the lighter in the medication cart. When further queried, RN X reported she tested the lighter and found it was in working condition.Review of a Sheriff's Office Summary with a reference date of 9/20/25 at 5:21pm, revealed I was called to (facility name omitted) to assist staff with a resident who was not following the rules. Staff advised me (Resident #71) was not obeying the rules. Staff advised me that he (Resident #71) was smoking inside, and they were requesting that I collect his lighter and cigarettes. I made contact with (Resident #71) who denied smoking inside but handed over his lighter.In an interview on 9/23/25 at 11:16am, CNA DD reported she had seen Resident #71 smoking just outside the front door of the facility at times despite being told he had to leave the property to smoke. CNA DD reported Resident #71 was supposed to turn in his smoking materials to the nurse as soon as he returned indoors but she did not think the resident did so because he went outside multiple times each night. CNA DD reported the facility was aware of other incidences in which Resident #71 was found with smoking materials in his possession and there was suspicion that the resident hid his supplies somewhere on the facility grounds. CNA DD reported one time she was assigned to go outdoors with the resident while he led her to find his smoking materials. CNA DD reported the resident led her all over the property but never divulged where his smoking materials were hidden.In an interview on 9/24/25 at 1:55pm, Nursing Home Administrator (NHA) A reported the facility was aware Resident #71 had a history of maintaining possession of his smoking materials in his room and it was suspected the resident also hid smoking materials outdoors. NHA A reported at times Resident #71 refused to give his smoking materials to the staff when he returned from smoking outdoors and refused to allow staff to search his room. When further queried, NHA A confirmed although Resident #71 had the right to privacy, the facility was responsible to maintain a safe environment for every resident, which outweighed his right. NHA A reported no further interventions had been put in place to mitigate the risks involved with Resident #71 possessing a lighter in his room because she assumed the resident was no longer interested in smoking due to his physical decline.Resident #24Review of an admission Record revealed Resident #24 was originally admitted to the facility on [DATE] with pertinent diagnoses which included: restlessness and agitation and severe intellectual disability.Review of a Minimum Data Set (MDS) assessment for Resident #24with a reference date of 6/23/25, revealed a Brief Interview for Mental Status (BIMS) score of 3/15 which indicated Resident #24 was-severely cognitively impaired.Review of a Care Plan for Resident #24 with a reference date of 2/23/25, revealed a focus/goal/interventions of: (Resident #24) is at risk for fall related injury and falls R/T (related to): weakness, impaired mobility, severe intellectual disability, seizures.Goal: Will be free from injury related to falls.Interventions: I need dycem (therapeutic material that creates friction between two surfaces) to my wheelchair cushion to help reduce my risk of falls.anticipate needs and meet.During an observation on 9/24/25 at 10:58am, Resident #24 quickly emerged from the dining room into the 300 hall, as an unknown staff member pushed Resident #24's wheelchair. Resident #24 had no footrests on her wheelchair and the staff member walked briskly as she pushed the resident. Resident #24's legs were extended in front of her and hovered above the floor 3-4. Uncoordinated up and down movements were noted in Resident #24's legs as she was pushed >75', down the entire 300 hall, until both she and the staff member disappeared around the far corner.In an interview on 9/24/25 at 1:39pm, Registered Nurse (RN) P reported residents should never be pushed in a wheelchair unless footrests are in place to support the resident's feet. RN P reported footrests are necessary to prevent the resident from dropping their feet down onto the floor while in motion which could then cause them to fall forward out of the wheelchair. RN P also reported that pushing a resident in a wheelchair<br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | without using footrests left the resident at higher risk for sustaining foot injuries because their feet could get caught in the wheels or bump against obstacles.Review of a Nurses Note for Resident #71, with a reference date of 9/12/25 at 9:43pm revealed .This nurse asked if she could check his (Resident #71) oxygen level.the level was 64%. It was noted that he was not wearing his supplemental oxygen. When this nurse brought this to (Resident #71's) attention he stated that he did not need it and then asked(sic) do you want to know why?. He then stated he didn't want to live anymore. This nurse explained that not wearing his oxygen was not a way to die. He then stated he would just smoke a cigaretteIn an interview on 9/24/25 at 1:55pm, NHA A confirmed it was the expectation that staff members place footrests on a resident's wheelchair before assisting them with wheelchair mobility. |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe and appropriate respiratory care for a resident when needed.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to identify the need of a bubbler/humidifier to aid in oxygen therapy for 1 of 1 resident (R69) reviewed for oxygen therapy, resulting in the resident experiencing dryness and sores in her nose resulting in psychosocial and physical distress. Findings include: R69According to R69's Minimum Data Set (MDS) dated [DATE], the resident was independent performing her ADLs (activities of daily living). The resident's BIMS (Brief Interview Mental Status) had not been completed however, in conversations with the resident, she was able to recall long and short-term memories and hold an intellectual conversation. Review of R69's Diagnoses List included chronic obstructive pulmonary disease (COPD), chronic respiratory failure with hypoxia, and emphysema.Review of R69's Order Summary, dated 2/21/25, revealed, Oxygen at 2 L/min (deliver liters per minute) via nasal cannula (NC) to maintain saturation greater than 88% every shift for COPD.Review of R69's Care Plan revised 9/2/25, indicated a focus a potential for difficulty breathing and being at risk for respiratory complications related to COPD, emphysema, asthma, and requiring the use of oxygen. The goal was for R69 to display an optimal breathing pattern daily with no labored breathing using interventions that included administering medication and treatment per orders and monitoring for adverse reactions.Observation and interview on 9/22/25 at 10:00 AM, R69 was sitting in her room in a recliner wearing oxygen set at 2 lpm stating, My nose gets dry and has sores in it from the oxygen I wear. I had a bubbler/humidifier (device to provide moistened oxygen that can be very dry and uncomfortable when inhaled directly) at home before I came here and that helped with the dryness.During an observation and interview on 9/24/25 at 8:55 AM, R69 was awake in her recliner wearing oxygen via NC stating, Oxygen dries out my nose and causes sores and scabs. I had a bubbler at home, and it helped a lot. I've told nurses I'd like one but still have not gotten one.During an observation and interview on 9/24/25 at 9:05 AM, Director of Nursing (DON) B in R69's room observed there was no bubbler/humidifier on the resident's oxygen concentrator. R69 stated she had a bubbler at home that helped keep her nose from drying out and causing sores and scabs on the inside of her nose. R69 also explained to the DON she has told the nurses she would like one and that the saline spray she was ordered does not help her like a bubbler does. The DON stated she was unaware of the resident's need and want of a bubbler. |

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| F 0697<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe, appropriate pain management for a resident who requires such services.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure that residents pain medications as ordered in 1 resident (Resident #7) of 6 residents reviewed for medications, resulting in Resident #7 receiving prescribed opioid (pain reliever) medication at a lower dose than the physician had ordered potentially causing Resident #7 to be at risk for breakthrough pain.Findings include:Resident #7(R7)Review of the admission Record and Minimum Data Set (MDS) dated [DATE] revealed R7 admitted to the facility on [DATE] with pertinent diagnoses including hemiplegia and hemiparesis (paralysis and weakness on one side of the body) following cerebral infarction (stroke), dementia (decline in mental abilities such as memory, thinking and reasoning that is severe enough to interfere with daily life), aphasia (impaired speech and language that can limit ability to communicate) and depression. Brief Interview for Mental Status (BIMS) could not be completed due to R7's cognitive impairment. She was under Hospice care due to her terminal diagnosis. On 9/22/2025 at 10:36 AM, R7 was observed in her gerichair in the common room up front at the facility. She was resting with her eyes closed. Review of R7's progress note dated 8/25/2025 and documented by Assistant Director of Nursing (ADON) S revealed This writer noticed resident was receiving 2.5mg of methadone in error instead of her 5mg order. Family was notified, provider was contacted with no new orders, hospice was notified. Resident is not showing any S/S (sign/symptoms) of increased pain, this writer administered 5mg methadone as order reads.Review of Medical Record Coordination Notes Report dated 8/25/2025 and documented by Hospice Registered Nurse (RN) revealed RN returned call to (ADON S) who wanted to confirm (methadone) medication order. She states that staff had only been giving 2.5 mg when the order is for 5 mg's. (ADON S says she wanted to make sure it wasn't changed and she was not aware. RN confirmed with medication list that the order is 5MG three times daily. Review of R7's Medication Error Report dated 8/25/2025 revealed .Description of Error: Methadone dose change from 2.5 mg to 5 mg on 8/20/25. Current form reads methadone 5 mg, but in smaller lettering indicates they are 2.5 mg because of 1/2 tablets. Outcome to resident and care provided: no noted increase in pain. Physician instructions: Destruction of 2.5 mg tablets. 25, 5 mg tablets received to prevent repeat error. Summary of Error: wrong dose. Misread error. Corrective action taken: med (medication) destruction of 2.5 mg tablets. Person making error: multiple (nurses). Person Correcting Error: (ADON S).Review of R7's physician order history for methadone with a start date of 1/7/2025 and end date of 8/20/2025 revealed Give 2.5 mg (milligrams) by mouth every 8 hours for pain. The order was changed on 8/20/2025 to Give 5 mg by mouth every 8 hours for pain.During an interview on 9/23/2025 at 2:11 PM, ADON S stated that she worked the nurse's cart on 8/25/2025 and noted the methadone order increased to 5 mg on 8/20/2025 and she had 2.5 mg tablets on the cart and that's when she realized the nurses were giving one 2.5 mg of methadone to R7 instead of two 2.5 mg tablets. Review of the August MAR revealed that there were 14 opportunities of administering 5 mg of methadone and there were 14 errors of where 2.5 mg of methadone was given instead. There were 5 different nurses involved with administering these medication errors. During a phone interview on 9/24/2025 at 9:03 AM, Registered Nurse (RN) EE stated she didn't know about a medication error with R7's methadone.During a phone interview on 9/24/2025 at 9:56 AM, RN DDD stated she didn't know about a medication error with R7's methadone.During a phone interview on 9/24/2025 at 1:10 PM, RN CCC stated she didn't know about a medication error with R7's methadone. During an interview on 9/23/2025 at 4:01 PM, LPN W stated she didn't know anything about a medication error with R7's methadone. During an interview on 9/23/2025 at 4:08 PM, Director of Nursing (DON) B stated that ADON S found the medication error while working the cart and the nurses working previously didn't question the order change. DON ?B said she didn't do any education with nurses about the medication error or any 1:1 education with the nurses involved. She was going to discuss it at the monthly nurse's meeting that was scheduled for next week. Review of the Medication Administration Policy<br>(continued on next page) |

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| F 0697<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | with a revision date of 10/17/2023 revealed .Procedure: 2. Verify the medication label against the medication administration record for resident name, time, drug, dose and route. A. The nurse is responsible to read it and follow precautionary instructions and prescription labels. B. If the label and medication sheet are different and the container is not flagged indicating a change in directions or if there is any other reason to question the doses or directions, the physician orders are checked for the correct dosage schedule. C. Report any discrepancies to the pharmacy. Do not administer the medication until the discrepancy is resolved. |

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| F 0745<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide medically-related social services to help each resident achieve the highest possible quality of life.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide medically related social services to attain and maintain the mental and psychosocial health for 3 (Resident #71, Resident #13 and Resident # 4) of 18 residents reviewed for social services resulting in: 1. lack of evaluation of psychosocial needs for Resident #71, 2. expired resident guardianship paperwork for Resident #13, and 3. lack of care planning for Resident #4's psychiatric diagnosis with mood/behavior concerns and the use of psychotropic medication.Findings include:<br><br>Resident #71<br><br>Review of an admission Record revealed Resident #71 was originally admitted to the facility on [DATE] with pertinent diagnoses which included: alcohol abuse, depression (persistent sad mood that impacts daily life) and chronic respiratory failure with hypoxia (a condition in which the lungs cannot adequately provide oxygen to the body, leading to low oxygen levels).<br><br>Review of a Minimum Data Set (MDS) assessment for Resident #71 with a reference date of [DATE], revealed the resident refused to complete a Brief Interview for Mental Status (BIMS) assessment. Section E of the MDS revealed Resident #71 exhibited rejection of care daily.<br><br>Review of a Care Plan for Resident # 71 with a reference date of [DATE], revealed a focus/goal/interventions of: (Resident #71) has the potential for mood difficulties r/t (related to) history of drug use, homeless status, paranoid thoughts related to staff.Goal: Mood will have minimal effects on daily life.Interventions.approach in calm, quiet manner. Maintain appropriate body language during interactions.observe and report to SW (social worker) .changes in mood or behavior.<br><br>During an observation and interview on [DATE], at 1:33pm, Resident #71 reported he experienced feelings of anger and paranoia. Resident #71 pointed to his room phone and stated, You see that phone there, it's tapped. Resident #71 reported he frequently felt anxious and struggled to talk about his situation because doing so caused him increased anxiety. At that point, Resident #71 began taking rapid, shallow breaths, waved his left hand over his chest and looked away. After 30 seconds, Resident #71's breath rate lowered, he turned back toward the surveyor and stated, I know I'm going to die.<br><br>Review of a Nurses Note for Resident #71, with a reference date of [DATE] at 9:43pm revealed .This nurse asked if she could check his (Resident #71's) oxygen level.the level was 64%. It was noted that he was not wearing his supplemental oxygen. When this nurse brought this to (Resident #71's) attention he stated that he did not need it and then asked(sic) do you want to know why?. He then stated he didn't want to live anymore. This nurse explained that not wearing his oxygen was not a way to die. He then stated he would just smoke a cigarette.<br><br>Review of a Patient Health Questionnaire 2 (PHQ 2-9) for Resident #71 with a reference date of [DATE], revealed a score of 5 which indicated he experienced depression.<br><br>Review of a Social Services Re-evaluation with a reference date of [DATE] revealed (Resident #71.is alert and oriented.with demonstration of illogical flow of thoughts and distracted thinking with changes in severity.<br>(continued on next page) |

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| F 0745<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of a Standard Evaluations list for Resident #71 revealed the following overdue evaluations: PHQ 2-9 Evaluation due date [DATE], Social Service Re-evaluation due date [DATE]).<br><br>In an interview on [DATE] at 12:02pm, Social Services Director (SSD) FF reported she had no documented interactions with Resident #71 in the past 3 months. SSD FF confirmed the last documented social services interaction with the resident was on [DATE], approximately 15 weeks prior to [DATE]. SSD FF reported the resident should have had a Social Services Re-evaluation done a few weeks ago but stated she must have missed it. SSD FF reported the areas she would assess during a Social Services Re-evaluation included: changes in mood and behavior and changes in mental or cognitive status. When further queried about behavioral health services offered to Resident #17, SSD FF confirmed services had not been offered to Resident #71 in last 12 months.<br><br>Review of a Social Service Program policy with a reference date of [DATE] revealed Policy.The facility will provide medically related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.The social service department will assist with.ongoing assessment and comprehensive care planning,.making referrals and obtaining needed services.Situations in which the facility should provide social services include lack of.legal representative.<br><br>Resident #13<br><br>Review of an admission Record revealed Resident #13 was originally admitted to the facility on [DATE] with pertinent diagnoses which included vascular dementia and cognitive communication deficit.<br><br>Review of Resident #13's Letter of Co-Guardianship dated [DATE] revealed, In the matter of (Resident #13), a legally incapacitated individual . it is ordered the guardianship is continued without modification. The guardian(s) shall continue to file annual reports. The court shall conduct the next review on [DATE] .<br><br>In an interview on [DATE] at 8:35 AM, Social Services Director (SSD) FF reported that Social Work was responsible for ensuring that all residents with a legal guardian had current guardianship paperwork in their electronic medical record (EMR). SSD F was not able to report how often the facility was reviewing resident guardianship paperwork was not expired. SSD F reviewed Resident #13's Letter of Co-Guardianship with this writer and confirmed that the legal document was expired and could not be used as verification that Resident #13's had an active guardian in place. SSD F was unable to report if Resident #13 still had an active legal guardian. SSD F confirmed that the facility should have identified that Resident #13's guardianship paperwork was expired, and that this was missed.<br><br>Resident #4<br><br>Review of an admission Record revealed Resident #4 was a female, with pertinent diagnoses which included stroke, dementia, and bipolar disorder (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs).<br><br>Review of a Minimum Data Set (MDS) assessment for Resident #4, with a reference date of [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 0, out of a total score of 15, indicating severe cognitive impairment. Further review of this assessment for Resident #4 revealed Section I - (continued on next page) |

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| F 0745<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Active Diagnoses had a check next to bipolar disorder, and Section N - Medications indicated Resident #4 took antipsychotic medications on a routine basis.<br><br>Review of an Order Summary Report for Resident #4 revealed the physician order .QUEtiapine Fumarate (an antipsychotic medication) Oral Tablet 25 MG (Quetiapine Fumarate) Give 1 tablet via G-Tube (gastrostomy tube) two times a day for Bipolar disorder . with a start date of [DATE] and a status of discontinued. Further review revealed the physician order .QUEtiapine Fumarate Oral Tablet 25 MG (Quetiapine Fumarate) Give 25 mg via G-Tube two times a day for mood disorder . with a start date of [DATE] and a status of discontinued. Lastly, the active physician order .QUEtiapine Fumarate Oral Tablet 25 MG (Quetiapine Fumarate) Give 25 mg via G-Tube two times a day for Bipolar disorder . was noted for Resident #4 with a start date of [DATE].<br><br>Review of the Care Area Assessment (CAA) for Psychotropic Drug Use for Resident #4, contained within the [DATE] MDS assessment, revealed .Triggering Conditions .High-Risk Drug (Is Taking): Antipsychotic .Checked (Yes) .(Resident #4) is taking Seroquel-antipsychotic medication to (manage) mood and behavior r/t (related to) Bipolar disorder. (She) is referred for psych services to (manage) behavior and (for) medication adjustment. (She) was noted with (an) episode of agitation, stripping (her) clothes and pulling (her) G-tube, (relieved) after taking scheduled medications .Care Plan Considerations .Will Psychotropic Drug Use be addressed in the care plan? Yes .Will proceed to care plan to manage mood and behavior and monitor potential adverse (effects) of medication that may impact quality of life .<br><br>Review of a Care Plan Report for Resident #4 revealed no focus/goal/interventions related to her diagnosis of bipolar disorder, mood/behavior concerns, and routine use of antipsychotic medications.<br><br>In an interview on [DATE] at 2:44 PM, Social Service Director (SSD) FF reported care plans are created for residents based on the information in the medical record, information from residents/family members, social service assessments, MDS assessments and CAAs. SSD FF reported when completing a CAA during the MDS process, a decision is made whether to proceed to the care plan when specific items/areas are triggered. SSD FF reviewed Resident #4's Care Plan and acknowledged there was no focus/goal or interventions related to Resident #4's diagnosis of bipolar disorder, mood/behavior concerns, and routine use of antipsychotic medications. |

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| F 0756<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure timely follow up with pharmacy recommendations occurred for 2 residents (Resident #3 and Resident# 51) of 5 residents reviewed for medications resulting in the potential for medication side effects and/or unnecessary medications for residents. Findings include: Resident #3Review of an admission Record revealed Resident #3 was originally admitted to the facility on [DATE] with pertinent diagnoses which included dementia and anxiety disorder. Review of Resident #3's Medication Regimen Review (MRR) dated 6/11/25 revealed, (Resident #3) is receiving Seroquel (antipsychotic medication). Epidemiological studies suggest an increased risk of hyperglycemia (high blood sugar levels)-related adverse effects during atypical antipsychotic use. These agents have been associated with extreme case of hyperglycemia, ketoacidosis (complication of diabetes where the body cannot produce enough insulin), hyperosmolar coma (serious complication of diabetes that happens when blood sugar levels are very high for a long period of time), and death. In post-marketing trials, elevations of total cholesterol (primarily LDL-low-density lipoprotein) have been observed. It is advisable to monitor cholesterol and triglyceride levels periodically in patients receiving antipsychotics, particular those with pre-existing hypercholesterolemia (disorder known for an excess of low-density lipoprotein (LDL) in your blood) or hypertriglyceridemia (Hypertriglyceridemia means you have too many triglycerides (fats) in your blood. This raises your risk of atherosclerosis and related heart diseases.). Recommendation: Please consider obtaining a fasting lipid panel on the next convenient lab day and then periodically thereafter. Physician/provider response: Agree. Order repeat labs to see trend. This was signed by the Medical Doctor (MD) UU on 9/17/25. Review of Resident #3's MRR dated 7/9/25 revealed, (Resident #3) has received Seroquel for over one year with the current dose of 75 mg (milligrams) at bedtime. Recommendation: Please consider a gradual dose reduction, perhaps decreasing to Seroquel 50 mg at bedtime while concurrently monitoring for re-emergence of target and/or withdrawal symptoms. If therapy is to continue at current dose, please provide rationale describing why a dose reduction is clinically contraindicated . Physician/provider response: Disagree. Care collaboration with Psych; GDR contraindicated at this time. (MD UU) reviewed via phone. This was signed by Director of Nursing (DON) B. It was noted that there was not a date noted on when this review was completed via phone by MD UU. In an interview on 9/24/2025 at 10:01 AM, DON B reported that she had discovered that the facility had not been receiving resident medication regimen reviews in August 2025. DON B reported that the consulting pharmacist had been sending the reviews to the previous Director of Nursing, and the facility was unaware, so all residents in the facility had not had medication reviews completed for several months. DON B reported that she did not know how many months of reviews the facility had missed. When this writer queried about Resident #51's June medication review, DON B confirmed that the facility provider had not reviewed this recommendation from June 2025 until September 2025, so there was a delay of Resident #3 getting the recommended lab order completed. When this writer queried DON B about Resident #3's July 2025 lab order, DON B reported that she could not recall when she had reviewed the July 2025 recommendation with MD UU because she did not note the date on the review. DON B confirmed that this review had not been placed in Resident #3's electronic medical record (EMR) and was not made available until this writer requested it. DON B reported that she should have dated the MRR, and it also should have been signed by MD UU. DON B confirmed that she could not verify that Resident #3's July 2025 recommendation was reviewed timely. Resident #51 Review of an admission Record revealed Resident #51 was originally admitted to the facility on [DATE] with pertinent diagnoses which included Alzheimer's disease and major depressive disorder. Review of Resident #51's MRR dated 5/27/25 revealed, (Resident #51) is noted to be experiencing new onset or worsening of falls as indicated on medication regimen review request. Patient (Resident (continued on next page) |

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| F 0756<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | #51) is receiving Seroquel 75 mg in the morning- 50 mg at noon and 75 mg in the evening. Patient's recent lipid panel indicates severe hypertriglyceridemia (too many triglycerides (fats) in your blood) which may be attributable to long term atypical antipsychotic use. Patient has been receiving the same dose for over two years. Patient has continued episodes of delusions. Patient may have symptoms of orthostatic hypotension (a condition where blood pressure drops significantly upon standing up from a sitting or lying position) with recent recorded value of 143/76 while sitting which dropped to 117/61 upon standing. Recommendations: Please evaluate current Seroquel dose, perhaps decreasing to 50 mg twice daily and 75 mg in the evening as contributing to this change in status . Physician/provider response: The provider did not respond or sign this form. Review of Resident #51's MRR dated 8/8/25 revealed, (Resident #51) receives Glucophage (Metformin) (oral medication used to treat diabetes) and does not have a serum B-12 level found in the resident medical record. Certain individuals (those with inadequate vitamin B-12, folic acid, or calcium intake or absorption) appears to be predisposed to developing subnormal vitamin B-12 levels. In these patients, routine serum vitamin B-12 measurements at 2-3-year intervals may be useful. Recommendation: Please consider obtaining a serum B-12 level on the next convenient lab day. Physician/Provider response: Agree. Ok order. This was signed by MD UU on 9/17/25. In an interview on 9/24/2025 at 10:01 AM, DON B reported that she did not know if any provider had reviewed Resident #51's MRR on 5/27/25 as the facility did not have verification of a provider response. DON B confirmed that Resident #51's MRR dated 8/8/25 was not reviewed by a provider in the facility until 9/17/25. DON B reported that the facility was still working through completing medication reviews for residents from the last 3 months for all residents in the facility. DON B reported that MD UU had been completing the medication reviews for all residents. In an interview on 9/24/2025 at 12:46 PM, MD UU reported that he had reviewed multiple outstanding medication reviews for the facility on 9/17/25. MD UU reported that he was not aware of the facility process for completing medication reviews, but that he was helping the facility catch up on the late reviews in the facility. In an interview on 9/24/2025 at 2:27 PM, Nursing Home Administrator (NHA) A reported that the facility had discovered in August 2025 that the facility had not been reviewing resident medication regimen reviews. NHA A reported that she did not know how long the facility had missed the reviews, but that the facility was currently reviewing the last 3 months of reviews for all residents. Review of the facility's Timeliness of Medication Regimen Review Reports fated 9/7/23 revealed, Policy: The pharmacist will review and report and medication irregularities at least once a month. 1. With new admissions, the consultant pharmacist will complete a MRR and provide a report via secure email within 72 hours to the Director of Nursing/designee. 2. Clinically significant medication issues, identified by the consultant pharmacist during the admission medication regimen review, must be communicated to the prescriber or the designee and resolved by 11:59 P.M. the following day. 3. The consultant will provide monthly MRR reports addressed to the Medical Director, Director of Nursing, and Attending Physician within 3-5 days of completion via secure email or hard copy. 4. The attending physician is expected to review the resident's individual MRR and document and sign that he/she has reviewed the pharmacist's identified recommendations within 14 days of receipt. 5. If the attending Physician does not respond to the resident's MRR report within 14 days, the Director of Nursing will notify the physician of the pending MRR reports. 6. If by the 21st day, the attending physician has not yet responded to the resident's individual MRR report, the Director of Nursing will notify the Medical Director to review and respond to the pending MRR reports. 7. If the Medical Director is also the attending physician, the Director of Nursing will escalate the issue to the facility Administrator. 8. When the consultant pharmacist identifies a recommendation that requires immediate or urgent action, the pharmacist will notify the Director of Nursing and the assigned nurse at the time the recommendation is identified. |

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| F 0804<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview the facility failed to provide food at a palatable texture for 2 residents (R69 and R73) of 18 residents reviewed for palatable foods and 3 of 14 residents in attendance of a confidential meeting, resulting in the potential for decreased food consumption and the potential for nutritional decline.Findings include:R69<br><br>According to R69's Minimum Data Set (MDS) dated [DATE], the resident was independent performing her ADLs (activities of daily living). The resident's BIMS had not been completed however, in conversations with the resident, she was able to recall long and short memories and hold an intellectual conversation.<br><br>Review of R69's Diagnoses List included chronic obstructive pulmonary disease (COPD), chronic respiratory failure with hypoxia, and emphysema.<br><br>During an interview on 9/22/25 at 10:00 AM, R69 complained of cooked vegetables being too soft.<br><br>R73<br><br>According to the MDS dated [DATE], R73's BIMS score of 15 /15 indicated she was cognitively intact. Her diagnoses included cancer.<br><br>During an interview on 9/22/25 at 11:14 AM, R73 complained she does not like the cooked vegetables because they are runny and are like mush.<br><br>In a confidential meeting on 09/24/2025 at 11:22 AM, 3 of 14 residents in attendance reported they were consistently served vegetables that were overcooked resulting in a mushy texture that made the food unappealing. The residents reported the mushy vegetables oozed moisture that drained into the surrounding foods on their plates, making other foods unappealing as well. 1 resident stated, I can't eat those vegetables, and they make the other food look unappetizing when it gets runny.<br><br>On 9/22/25 at 12:05 PM a regular lunch meal test tray was plated for the Rehab / A side hall and was the first meal plated among the 18 trays loaded on the hall cart. The meal consisted of chicken fettucine alfredo, broccoli, and a roll on a heated base with an insulated cover. The dessert was an upside-down pineapple cake.<br><br>On 9/22/25 at 12:15 PM, The meal cart was loaded and on the hall for Rehab / A side.<br><br>On 9/22/25 at 12:29 PM, All meals from the cart were delivered and the test tray was in the conference room with the following temperatures (taken with a digital rapid read thermometer): Fettucine [NAME] was 123F, and the Broccoli was 125F. Observation and taste of the broccoli found they were overly tender to the point of being mushy. |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to maintain accurate and complete medical records for 1 of 18 residents (Resident #13) reviewed for complete and accurate medical record documentation, resulting in the potential for staff and providers mismanaging care for residents. Findings include: Resident #13Review of an admission Record revealed Resident #13 was originally admitted to the facility on [DATE] with pertinent diagnoses which included vascular dementia and cognitive communication deficit. Review of Resident #13's Letter of Co-Guardianship dated [DATE] revealed, In the matter of (Resident #13), a legally incapacitated individual . it is ordered the guardianship is continued without modification. The guardian(s) shall continue to file annual reports. The court shall conduct the next review on [DATE] .In an interview on [DATE] at 8:35 AM, Social Services Director (SSD) FF reported that Social Work was responsible for ensuring that all residents with a legal guardian had current guardianship paperwork in their electronic medical record (EMR). SSD F was not able to report how often the facility was reviewing resident guardianship paperwork was not expired. SSD F reviewed Resident #13's Letter of Co-Guardianship with this writer and confirmed that the legal document was expired and could not be used as verification that Resident #13's had an active guardian in place. SSD F was unable to report if Resident #13 still had an active legal guardian. SSD F confirmed that the facility should have identified that Resident #13's guardianship paperwork was expired, and that this was missed. Review of the facility's Medical Records Management Policy last revised [DATE] revealed, Policy: The facility must maintain medical records on each guest/resident, in accordance with accepted professional standards and practice state and federal law. Medical records must be complete, accurately documented, readily accessible, systematically organized, and maintained in a safe and secure environment. This includes medical records that are kept in the EMR format . The medical record must contain enough information to show that the facility knows the status of the guest/resident, has adequate plans of care, and provides sufficient evidence of the effects of care provided . |

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| F 0881<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Implement a program that monitors antibiotic use.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement the facility's antibiotic stewardship program protocols for 1 (Resident #51) of 5 residents reviewed for unnecessary medications resulting in resident #51 receiving multiple doses of an unnecessary antibiotic and the potential for adverse effects, and the development of antibiotic-resistant organisms from unnecessary and inappropriate antibiotic use. Findings include:<br><br>Resident #51<br><br>Review of an admission Record revealed Resident #51 was originally admitted to the facility on [DATE] with pertinent diagnoses which included Alzheimer's disease and major depressive disorder.<br><br>Review of Resident #51's Progress Notes dated 8/24/25 revealed, During the evening meal in the dining room, Resident #51 was reported by CNA (Certified Nursing Assistant) (Name redacted) to have initiated physical aggression towards another resident . The provider (name redacted) was notified of the acute change in behavior and orders were received . A urine sample will be obtained and sent to the lab for UTI (urinary tract infection) analysis as a potential cause for abrupt behavioral change .<br><br>Review of Resident #51's Progress Notes dated 8/26/25 revealed, . (Resident #51) started on Bactrim (antibiotic medication) q12 (every 12) hours for three days r/t (related to) UTI on 8/26/25 .<br><br>In an interview on 9/24/2025 at 10:01 AM, Director of Nursing (DON) B reported that Resident #51 had a history of aggressive behavior when she had a UTI, and on 8/24/25 she had an aggressive episode towards another resident, so the facility staff assumed that she might have had a UTI. DON B reported that the nurse caring for Resident #51 had completed a urine dip test (A test which involves dipping a test strip in urine to detect certain conditions such as bacteria in urine that could indicate a potential UTI) and the result was abnormal, so the provider on call ordered a urinalysis test and started Resident #51 on Bactrim. DON B confirmed that Resident #51 was started on Bactrim prior to the facility receiving her urinalysis results. DON B confirmed that once the facility received Resident #51's urinalysis results, the facility discontinued Resident #51's Bactrim course, because she did not have a UTI, and therefore, she did not need to take the antibiotic. DON B reported that the facility followed McGeer Criteria (Guidelines used for infection surveillance in long-term care settings, helping healthcare professionals accurately identify and monitor infections). DON B confirmed that Resident #51 did not have any other symptoms indicated on the McGeer criteria checklist to support initiating antibiotic therapy prior to urinalysis results. DON B confirmed that the facility would not normally start an antibiotic for a resident without receiving urinalysis results, but she thought that Resident #51's aggressive behavior made it prudent to start the antibiotic immediately. DON B confirmed that Resident #51 did not have a UTI, and therefore received an unnecessary antibiotic for three days, which increased her risk for adverse effects and the development of antibiotic-resistant organisms.<br><br>Review of the facility's Infection Control and Antibiotic Stewardship policy last revised 4/17/25 revealed, Antibiotic Stewardship refers to coordinated interventions designed to improve and measure the appropriate use of antimicrobials, by promoting the selection of the optimal antimicrobial drug regimen, dose, duration, and route of administration. Protocols will be developed and followed that promote health and wellness through responsible use of antimicrobials in an effort to prevent unnecessary treatment and resultant antibiotic resistance. Current literature stresses that it is important to treat active infections, not asymptomatic colonization in older adults as the emergences<br>(continued on next page) |

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| F 0881<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | of the drug-resistant infections are rapidly outpacing the development of new antibiotic therapies . Guidelines and recommendations for successful implementation of antibiotic stewardship .1. The program will encourage appropriate prescribing; and reduce adverse effects which often include gastrointestinal problems, C. Difficile diarrhea, yeast infections and antibiotic resistance in aging adults . 3. The infection preventionist will be responsible for promoting and overseeing antibiotic stewardship activities in the facility. Responsibilities include educating employees about the importance of antibiotic stewardship and adhering to programs that prevent the spread of infection and improve antibiotic use . 11. Laboratory and diagnostic testing will be used judiciously. Positive urine tests do not always warrant an additional culture and sensitivity in the absence of clinical signs and symptoms of infection. When a culture is positive, antibiograms and lab results will be utilized to help prescribers select the best antibiotic for each guest/resident based on the guidelines for prescribing protocols .<br><br>In an interview on 9/24/25 at 10:46 AM, Director of Nursing (DON) B reported antibiotics may be started prior to obtaining lab results depending on the signs/symptoms and resident history. DON B reported if antibiotics are started prior to receiving lab/culture results, the physician will write a risk/benefit statement detailing the reasons why the benefits of antibiotic treatment outweigh the risks to justify the use of the medication. DON B reported for Resident #51, the physician was aware of a history of explosive behaviors with previous urinary tract infections, therefore antibiotics were initiated before the urine culture results were received. DON B reported in this instance the provider did not write a risk/benefit statement for Resident #51's antibiotic use. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 235264 | A. Building<br>B. Wing | 11/21/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Ely Manor | 1200 Ely St<br>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.

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| F 0926<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Have policies on smoking.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to implement the facility's non-smoking policy for 1 of 1 resident (Resident #71) reviewed for smoking, resulting in the resident possessing smoking paraphernalia while unsupervised in his room.Findings include: Resident #71Review of an admission Record revealed Resident #71 was originally admitted to the facility on [DATE] with pertinent diagnoses which included: depression (persistent sad mood).Review of a Care Plan for Resident # 71 with a reference date of 3/12/25, revealed there was no care plan related to Resident 71's noncompliance with the facility smoking policy, hiding smoking paraphernalia, and smoking in his room.In an interview on 9/22/25, at 2:01pm, Resident #71 reported he had a lighter and cigarettes in his room until a few days ago when a police officer came and confiscated them. Resident #71 reported staff allowed him to go outside and smoke where the staff smoke and to keep his smoking materials in his possession.In an interview on 9/23/25 at 11:50am, Licensed Practical Nurse (LPN) KK reported it was the expectation that staff maintain Resident #71's smoking materials in a cupboard in the locked medication room on his hall. LPN KK reported the floor nurse was expected to regain possession of Resident #71's smoking materials each time he returned from going outside to smoke and then sign the Leave of Absence form.Review of a Leave of Absence Sign Out form for Resident #71 revealed 6 occurrences in which Resident #71 signed himself out of the facility between 8/28-9/16/25. Outside smoke was listed as the destination for each occurrence. No staff signatures were present to indicate the resident returned indoors and relinquished his smoking paraphernalia.In an interview on 9/23/25 at 11:16am, CNA DD reported she had seen Resident #71 smoking just outside the front door of the facility many times despite being told he had to leave the property to smoke. CNA DD reported Resident #71 was supposed to turn in his smoking materials to the nurse as soon as he returned indoors but she did not think the resident did so because he went outside multiple times each night. CNA DD reported the facility was aware of other incidences in which Resident #71 was found with smoking materials in his possession and there was suspicion that the resident hid his supplies somewhere on the facility grounds.Review of a Nurses Note for Resident #71, with a reference date of 9/20/25 at 5:39pm revealed Resident was found awake in his room with oxygen concentrator in use after staff detected the smell of smoke in the hallway. Upon assessment resident (sic) denied smoking in the room, however, odor of smoke was noticeable.Resident was observed to be verbally hostile toward the nurse.Review of a Nurses Note for Resident #71, with a reference date of 9/20/25 at 7:04pm, revealed Deputy (Deputy's name) came to facility to address non-smoking facility violations. He was able to confiscate the resident's lighter from his room. The resident been (sic) formally warned that any future violations will results (sic) disciplinary action taken against him.In an interview on 9/23/25 at 11:02am, Certified Nursing Assistant (CNA) F reported on the evening of 9/20/25 at approximately 5:00pm, she smelled smoke in the hallway near Resident #71's room. CNA F reported the smell intensified as she approached Resident #71's room and when she entered, a smokey haze was present in the room. CNA F reported Resident #71 was sitting in his bed, his oxygen concentrator was running, but the resident did not have his oxygen cannula in his nostrils. CNA F reported she did not see Resident #71 actively smoking when she entered the room. However, CNA F reported based on the smell and the smoke in the room, she was certain Resident #71 had been smoking in his room, and she reported her concern to Registered Nurse (RN) X.In an interview on 9/23/25 at 10:34am, RN X reported she was in another resident's room on 9/20/25 around 5:00pm, when CNA F came to her and reported smoke coming from Resident #71's room. RN X reported she immediately went to investigate, found the resident's door and windows open, and noticed a haze of smoke in Resident #71's room. Resident #71 sat on his bed, with his oxygen concentrator running nearby. His oxygen cannula was on the floor near his bed. RN X reported she was told by management to contact the police for assistance. RN X reported she had never seen Resident #71's smoking<br>(continued on next page) |

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| F 0926<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | materials locked up where other resident's smoking materials were kept. RN X reported after she called the police, a deputy came to the facility, met with Resident #71 and removed a working lighter from the resident's possession. RN X reported she locked the lighter in the medication cart. When further queried, RN X reported she tested the lighter and found it was in working condition.In an interview on 9/24/25 at 1:55pm, NHA A reported residents were not supposed to be allowed to smoke anywhere on the property. Nursing Home Administrator (NHA) A reported the facility was aware Resident #71 had a history of maintaining possession of his smoking materials in his room. NHA A reported at times Resident #71 refused to give his smoking materials to the staff when he returned from smoking outdoors and refused to allow staff to search his room. NHA A reported no further interventions had been put in place to mitigate the risks involved with Resident #71 possessing a lighter in his room because she assumed the resident was no longer interested in smoking due to his physical decline.Review of a facility Non-Smoking Policy with a reference date of 6/10/25 revealed .6. The first violation of this non-smoking policy by a resident who smokes will result in a warning to the resident and their resident representative and documented in the medical record. All smoking paraphernalia will be given to the facility staff. |

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| F 0628<br><br>Level of Harm - Potential for minimal harm<br><br>Residents Affected - Many | Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies.<br><br>Based on interview, and record review, the facility failed to provide written notification to the resident/representative detailing the reason for a transfer to the hospital in 1 of 2 resident (Resident #83) reviewed for hospitalization, resulting in the potential for the resident/representative to be unaware of the reason for the hospital transfer and their right to appeal.Findings include:Resident #83 Review of an admission Record revealed Resident #83 was a male, with pertinent diagnoses which included diabetes, high blood pressure, obstructive lung disease, and depression. Further review of the admission Record revealed Resident #83 was his own responsible party. Review of a Nurses Note for Resident #83, dated 7/8/25 at 6:21 PM, revealed .resident was sent to (Hospital Name) (at 4:10 PM) due to chest pain, c/o (complaints of) SOB (shortness of breath), (respirations) 28, abnormal lab values, and increased HR (heart rate) 122, all parties notified . Review of Resident #83's electronic medical record revealed no documentation to indicate that a written notification of transfer/discharge was provided to the resident/representative when he was transferred to the hospital on 7/8/25. In an interview on 9/24/25 at 10:29 AM, Assistant Director of Nursing (ADON) S reported Resident #83 was at the facility for only a few days before his hospitalization on 7/8/25. ADON S reported Resident #83 was sent to the hospital on 7/8/25 due to abnormal lab results, abnormal vital signs, and complaints of chest pain. ADON S reported paperwork was given to the EMS (Emergency Medical Services) staff at the time of the transfer, which included a Face Sheet (admission Record), a medication list, and a bed hold policy. ADON S reported she did not provide Resident #83 with a written notification detailing the reason for his transfer to the hospital on 7/8/25. In an interview on 9/24/25 at 10:46 AM, Director of Nursing (DON) B reported a Transfer Form is completed when a resident requires hospitalization. DON B reported the Transfer Form is printed and sent with the packet of paperwork for the hospital staff. DON B reported the Transfer Form is not given specifically to the resident/representative when transferred to the hospital. In an interview on 9/24/25 at 12:49 PM, Licensed Practical Nurse (LPN) E reported when a resident is transferred to the hospital, a packet containing the bed hold policy, face sheet, medication list, code status information, and a transfer form is sent with the resident for the EMS and hospital staff. LPN E reported a written notification detailing the reason for the transfer to the hospital is not necessarily given to the resident/representative. Review of the policy/procedure Transfer and Discharge, dated 4/28/25, revealed .The transfer and discharge process must provide sufficient preparation and orientation of residents to ensure a safe and orderly transfer or discharge from the facility .When a resident is transferred on an emergency basis to an acute care facility, notice of the transfer is provided to the resident and the resident representative as soon as practicable . |