STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235352	A. Building B. Wing	11/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cass County Medical Care Facility	23770 Hospital St Cassopolis, MI 49031

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to Intake #2641076Based on interview and record review the facility failed to revise a person-centered care plan timely for 1 (Resident #101) of 3 residents reviewed for care plan revisions, resulting in the potential for unmet care needs. Findings include:Resident #101Review of an admission Record revealed Resident #101 was a female who originally admitted to the facility on [DATE] and had pertinent diagnoses which included: Cerebral infarction due to thrombosis of the right posterior cerebral artery (stroke on the right side of the brain due to a blood clot resulting in left side weakness).Review of Order Summary for Resident #101 revealed Name Omitted Hospice service to eval and tx (evaluate and treat) with a start date of 10/15/25.Review of Health Status Note for Resident #101 dated 10/15/25 revealed .seen by hospice nurse this shift.Review of Care Plan for Resident #101 revealed .Focus/goal/interventions.I wish for hospice services.intervention: coordinate care with hospice staff including changes in care needs. Initiated on 10/21/25.In an interview on 10/21/25 at 11:45 AM, Registered Nurse/Unit Manager (RN/UM) T reported Resident #101's hospice care plan was added today and when queried, RN/UM T reported care plans should be entered within the next business day or as soon as possible. RN/UM T reported that Director of Social Services (DSS) X was responsible for care plans related to hospice services. In an interview on 10/21/25 at 12:32 PM, DSS X reported she will initiate hospice care plans related to the coordination of services, she would not create clinical interventions for hospice care. DSS X reported Resident #101 readmitted to the facility with hospice services in place, she did not coordinate the service, and she would not create the care plan unless she coordinated the hospice services.In an interview on 10/21/25 at 12:46 PM, Minimum Data Set/Registered Nurse (MDS/RN) O reported she created Resident #101's hospice care plan today when she reviewed her record, noted the order for hospice services and realized there was not a care plan for hospice services in place. MDS/RN O reported that DSS X was the one that should create hospice care plans.In an interview on 10/21/25 at 12:01 PM, Director of Nursing (DON) B reported her expectations were that specific care plans, such as hospice services, were created sooner rather than later in the resident's care plan.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to Intake #2641076Based on observation, interview, and record review the facility failed to maintain adequate supervision to ensure the safety of 1 (Resident #100) of 3 residents reviewed for safety, resulting in Resident #100 experiencing a fall that resulted in a left side pubic rami fracture (a fracture of the pelvis bone). Findings include:Resident #100Review of an admission Record revealed Resident #100 was a male who originally admitted to the facility on [DATE] and had pertinent diagnoses which included: Repeated falls, dizziness, and weakness.Review of a Minimum Data Set (MDS) assessment for Resident #100, with a reference date of 10/14/25 revealed a Brief Interview for Mental Status (BIMS) score of 10/15 which indicated Resident #10 was moderately cognitively impaired. (BIMS score 8-11 indicates moderate cognitive impairment).Review of Care Plan for Resident #100 revealed Focus: I am at high risk for falls and injury.cognitive loss, general weakness, poor needs/safety awareness, self-initiation of care tasks without assistance.Interventions: Educate/encourage call light use, encourage activities that promote exercise, physical activity for strengthening and improve mobility, ensure proper, well maintained-footwear, therapy referral all initiated on 7/25/25.Review of Morse Fall Scale-2 dated 7/25/25 for Resident #100 revealed .high risk for falling. due to: history of falling, multiple diagnoses, impaired gait (walking ability), and overestimates or forgets limits.Review of facility investigation revealed Registered Nurse (RN) L observed Resident #100 ambulating in his room with his walker in the process of losing his balance and falling backward.RN L witnessed Resident #104 land on his bottom on the floor.Resident #100 was transferred to the local emergency department for evaluation and treatment on 10/10/2025.In a telephone interview on 10/20/25 at 12:16 PM, RN L reported she observed Resident #100 ambulating in his room with his walker, and while she was observing him, the front wheels of his walker came off the floor, he was falling backward, and she watched him hit his head on the footboard of the other bed in the room and land on his bottom on the floor. RN L reported Resident #100 was never moved from the floor and was sent to the hospital for evaluation. RN L reported Resident #100 was diagnosed with a fracture of his pelvis bone while at the hospital. RN L reported that Resident #100 ambulated independently numerous times when he was in his room, he would also self-transfer from his wheelchair to his recliner chair. RN L stated I don't think there was any intervention I could have done because I thought he was independent in his room with his walker.In an interview on 10/20/25 at 10:20 AM, CNA Q reported Resident #100 was impulsive and would self-transfer from his wheelchair into his recliner chair. CNA Q reported Resident #100 would occasionally use his call light but when he pushed it, he was already on his way out of the chair and to the bathroom. CNA Q reported Resident #100 was a one person assist with transfers for safety and balance, but he does not need physical assistance to get up or down. CNA Q reported Resident #100 was toileted before and after meals and the standard was every 2 hours. CNA Q stated we know he will self-transfer, so we follow him to his room after meals to assist with transfers.On 10/20/25 at 12:01 PM, Resident #100 was observed transferring himself from his wheelchair into his recliner chair in his room. Resident #100 stood from his wheelchair in a crouched position, pivoted to his left, and flopped into the recliner chair. At 12:03 PM CNA Q entered Resident #100's room and stated to this surveyor He did it himself didn't he?In an interview on 10/20/25 at 1:08 PM, CNA P reported Resident #100 did not use his call light much before he fell, he would just get up on his own and he would be taking off to the bathroom without us, and we would have to run to catch up with him. CNA P reported that Family Member (FM) DD would remind Resident #100 to wait for the girls to help him.In an interview on 10/20/25 at 1:16 PM, FM DD reported that Resident #100 would go when he needed to go and he would occasionally use his call light, but not all the time.Review of Kardex (a documentation system used to organize and reference key patient information) dated 10/10/25 for Resident #100 (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	revealed ADLS (activities of daily living).toilet transfer I require the assistance of 1 staff member, toileting program: toileting per standard protocol.Safety/Monitoring.Educate/encourage use of call light, ensure proper, well-maintained footwear.In an interview on 10/20/25 at 1:35 PM, CNA W reported offering to assist a resident to the bathroom every 2 hours was standards of care and what should be done for all residents. On 10/20/25 at 3:16 PM, Resident #100's room call light was activated; CNA K and CNA M were both present in the hallway. CNA M walked past this surveyor, the mobile phone from her pocket was heard announcing Room Number (Resident #100's room number) calling . CNA M continued past Resident #100's room and entered another room with CNA K. At 3:27 PM, Resident #100's room call light was still active, CNA K and CNA M exited another resident's room into the hallway, and both walked past Resident #100's room and did not answer the activated call light. At 3:29 PM, CNA P answered Resident #100's room call light. Resident #100's room call light was observed active for 13 minutes before it was answered.In an interview on 10/20/25 at 3:40 PM, RN V reported every staff member carried a mobile phone that was linked to the call light system. RN V reported staff members logged into the system with their assigned hall at the start of the shift and every person assigned to the hall would receive all call light activation notifications. RN V reported call light activations were displayed on a monitor at the nurse's station.In an interview on 10/21/25 at 8:50 AM, CNA H reported Resident #100 was independent when he admitted , was impatient, and when he needed something, he needed it right now and would not wait; he would get up and go and many times we would find him already in the bathroom. In an interview on 10/21/25 at 9:10 AM, Director or Therapy (DOT) R reported Resident #100 had been assessed to be stand by assistance (SBA) and supervision for transfers when he was discharged from therapy services on August 7, 2025. DOT R reported SBA means staff needs to be next to the resident and able to physically assist if needed and supervision means direct observation of the resident during the transfer. DOT R reported Resident #100 was not assessed to be independent at any time during his stay.In an interview on 10/21/25 at 9:30 AM, Physical Therapist Assistant (PTA) I reported he had observed Resident #100 ambulating independently in his room with his walker to the bathroom and was unsure if the nursing department had changed Resident #100's status to independent in his room. PTA I reported the therapy department had not assessed Resident #100 to be independent during his stay.In an interview on 10/21/25 at 9:36 AM, Therapy Manager TM CC reported Resident #100 was never assessed as independent, he was SBA and supervision for safety. TM CC reported Resident #100 would do what he wanted and would get up and walk.In an interview on 10/21/25 at 11:45 AM, Registered Nurse/Unit Manager (RN/UM) T reported Resident #100 would self-transfer in his room. RN/UM T reported staff was aware of Resident #100 self-transferring, but it was not well documented in his record. RN/UM T reported there was no documentation of self-transferring in Resident #100's care plan.In an interview on 10/21/25 at 12:01 PM, Director of Nursing (DON) B reported Resident #100 was impulsive and we did not take credit for the things we did to try to mitigate his impulsivity. DON B reported there was no documentation regarding Resident #100's self-transferring and impulsiveness to get up on his own in his record. DON B reported we did not take credit for what we did.Review of Resident #100's record revealed no noted documentation of impulsive behavior nor any noted documentation regarding Resident #100's self-transferring or independent ambulation. Review of facility policy Accidents and Supervision with a reviewed date of 8/2025 revealed .to ensure the resident environment remain as free of accident hazards as possible.Identification of hazards and risks.This information is to be documented and communication across disciplines.examining data to identify specific hazards and risks to develop targeted interventions to reduce potential for accidents.Implementation: using specific interventions to try to reduce a resident's risk from hazards in the environment.