STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235456	A. Building B. Wing	03/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Courtney Manor	1167 E Hopson Street Bad Axe, MI 48413

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This Citation pertains to Intake Number 2739781.Based on interview and record review, the facility failed to ensure that grievances or concerns were addressed per the facility policy for concerns/grievances for one resident (Resident #6), who had concerns voiced during meetings with the State Ombudsman, of three residents reviewed for complaints. Findings include:Resident #6 (R6):A review of R6's medical record revealed an admission into the facility on 1/6/26 and readmission on [DATE] with diagnoses that included encounter for orthopedic aftercare following surgical amputation, depression, anxiety disorder, paranoid personality disorder, and post-traumatic stress disorder. A review of the Resident's Minimum Data Set (MDS) assessment revealed a Brief Interview of Mental Status (BIMS) score of 15/15 that indicated intact cognition and that the Resident needed partial/moderate assistance with dressing, substantial/maximal assistance with bathing and was dependent on a helper with toileting hygiene and chair/bed to chair transfer. On 3/10/26 at 11:22 AM, an interview was conducted with State Ombudsman (SO) F regarding R6's concerns. The Resident had given consent to discuss multiple concerns that the Resident had voiced to the State Ombudsman. The Ombudsman reported that Elder Advocate K had been witness to staff being rude and inappropriate to the resident when answering the Resident's call light, shutting off the call light and saying they were too busy, which took place on February 2, 2026, approximately 1:00 PM. The Ombudsman reported staff rolling eyes, raising their voice, leaving and not returning to assist the resident. It was relayed to the Administrator (NHA) through correspondence by email. The NHA had responded to the email to the SO. The SO reviewed other concerns the Resident had voiced. When asked if all the concerns were addressed and the Resident was content with resolution, the SO reported the Resident felt concerns continued with call light answered but staff shutting it off, saying they were too busy, needs not met and rude and inappropriate staff. The SO reported it as costumer service/dignity issues. On 3/10/26 at 11:40 AM, an interview was conducted with R6 who answered questions and engaged in conversation. An observation was made of R6, well dressed and groomed, sitting in their wheelchair in their room. The Resident had multiple concerns and reported she had talked to the Ombudsman regarding the concerns, and the Ombudsman had been back to talk with her. When asked about resolution to concerns, the Resident indicated nothing had been resolved. The Resident was asked about staff being rude and reported continued issues with multiple staff, staff answering her call light and they tell her, ?We are taking care of other people.' The Resident reported waiting extended time for staff to answer call lights or staff turn it off and say they will be back then don't show back up, told by staff to go in her brief and they will be back, therapy staff not working enough on transfers to the toilet/bedside commode that is over the toilet. The Resident reported she had her own glucometer, and they made her send it back home, telling her she was not allowed to keep it at the facility. When asked if she had discussed concerns with the Administrator, Director of Nursing or Unit Manager, the Resident reported she did not want to talk to them and would prefer to talk to the Ombudsman. When asked if staff had offered to help her write up a concern form, the Resident reported they had not offered to write any concern forms. When asked if she had been given any (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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	concern or grievance forms, the Resident reported she had not received any. When asked if they gave her any concern forms with resolutions to issues brought up to the Ombudsman, the Resident reported she had not gotten any papers regarding her concerns but indicated she knew the Ombudsman had discussed concerns with the Administrator. On 3/10/26 at 3:24 PM, an interview was conducted with Nurse E who reported she had a good rapport with R6. The Nurse reported going to talk to R6, but the Resident had not given her any concerns, and she had not filled out a grievance form. The Nurse reported that her dressing was not done but they were done, I checked the date and the dressing was changed. The Resident had voiced some concerns about not getting therapy, but she had refused, now she is getting up and doing therapy every day. The Nurse also reported concerns with an eye doctor appointment and did not have her dressing change completed. When asked about facility policy for grievances, the Nurse reported that if there was a concern, you write it up if there was an issue. When asked about staff being rude, the Nurse reported the Resident did not voice those concerns. On 3/10/26 at 3:35 PM, Nurse J was interviewed regarding R6 not getting a dressing change to her right stump on the day of her eye appointment. The Nurse reported the dressing had not been completed prior to leaving for the appointment and when she came back, the Resident had some behaviors and was upset and did not want the dressing changed. When asked about complaints from the Resident regarding staff rudeness, the Nurse reported the Resident often had complaints of the staff from one shift the another and stated, She complains of the past shift to the next shift, that is why she is a two person assist all the time. When asked if she had filled out any concern forms, the Nurse stated, It's normal behavior and her personality. CNA I reported she had not had any complaints from the resident of other staff and reported always having two people when going into the room. A review of the email from the Ombudsman to the Administrator that included, .I have some concerns that came through for your facility regarding Resident 6. That need to be looked into and addressed. The concerns were listed and included the Elder Advocate who had visited with the resident and witness to concerns of staff response to the call light and to R6. The NHA had followed up with an email of the listed concerns. On 3/11/26 at 9:50 AM, an interview was conducted with the Administrator (NHA) regarding multiple concerns from the Ombudsman in an email to the administrator. The NHA reported addressing the staffing concerns and the staff had been educated but had not returned to the facility to work. When asked about a grievance or concern policy on handling concerns, the NHA reported they had a Care Program. When asked if any concern forms or grievances had been written up for R6's concerns, the NHA explained the concerns had been taken care of and that they were not ongoing issues. The NHA reported not filling out concern forms for R6 and that the concerns were being taken care of in real time and addressed. On 3/11/26 at 10:32 AM, an interview was conducted with Ombudsman F. The Ombudsman was asked if the facility had offered to write out a complaint form or a Visitor Assistance Form. The Ombudsman reported they had not offered to have her write it out and was not aware they had written any out or gave it as an option to write them out. The Ombudsman reported that the Resident did not feel comfortable going to the NHA directly but felt comfortable going to the Ombudsman. The Resident has the right to go through an advocate with her concerns, and the concerns should be addressed to the Residents' satisfaction. When asked if they felt the concerns were addressed to the resident's satisfaction, the Ombudsman reported the resident continues to call with concerns and stated, (Resident's name) is frustrated that things have not changed. A review of the facility policy titled, Care Program, last revised 7/8/25, revealed, Purpose: To ensure that the facility actively resolves any concerns/grievances submitted orally or in writing to the Administrator, Director of Nursing, or any other member of the facility's staff. Information: Any resident, his or her representative, family member, employee, or appointed advocate may file a concern/grievance without fear of threat or reprisal. All concerns/grievances are investigated, resolved, and documented.C=Concern: 1. If a resident, a resident's representative, or another interested person has a concern (including missing items), a staff member should encourage and assist the resident, or person acting on the resident's behalf to file a written concern/grievance with the facility. The (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	concern/grievance can be documented using the Resident, Family, Employee, and Visitor Assistance Form. 2. If the Facility receives a concern/grievance orally, staff should document the concern using the Resident, Family, Employee and Visitor Assistance Form.A=Action: 1. Staff receiving the concern/grievance should acknowledge receipt of concern and immediately address the concern if possible and document the resolution. 2. All concerns shall be discussed with the Department Managers during the morning Interdisciplinary Team (IDT) meeting. the team will determine who will investigate the concern. The investigation and report should be completed using a Resident, Family, Employee and Visitor Assistance Form and forwarded to Administrator. 4. If a resident, family member or visitor feels that their concern/grievance has not been addressed to their satisfaction with the Administrator or the individual wants to directly convey their concerns to the Corporate Compliance Officer .R=Response: . The Administrator will send all concerns to ERMA so they may be logged on the facility Concern QA&A log. The report will be used internally for tracking and trending as part of the Facility's Quality Assessment Performance Improvement Program.E=Evaluation: . The Administrator/designee will follow-up with the individual filing the concern again within 7 days after the initial follow-up to assure that the concern is addressed to their satisfaction. The resident's concerns, when the policy was not followed, lead to a lack of: documentation of the concerns on the facility forms that may not lead to facilitate action of investigation and IDT discussion, response with tracking and trending for quality assurance, and evaluation to address satisfaction.

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F 0689 Level of Harm - 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 Number 2724891. Based on observation, interview and record review, the facility failed to ensure that interventions were implemented to ensure a safe environment for one resident (Resident #2) of three residents reviewed for falls, resulting in Resident #2 being transferred without an electronic lift which was required by the plan of care, resulting in Resident #2 sustaining several lacerations and a transfer to the hospital. Findings Include: Resident #2:A record review of the Face sheet and Minimum Data Set/MDS assessment indicated Resident #2 was admitted to the facility on [DATE] with diagnoses: Heart failure, history of falls, chronic kidney disease, history of a stroke, hypertension, hypothyroidism, atrial fibrillation, left leg pain, arthritis and asthma. The MDS assessment, dated 11/26/2025, indicated the resident had full cognitive abilities with a Brief Interview for Mental Status/BIMS score of 15/15 and the resident needed assistance with all care and was dependent with transfers.A record review of an incident report completed by Nurse C, dated 11/11/2025 at 1:00 PM, identified the following: Resident was being transferred from beauty salon chair to w/c (wheelchair) by OT B (Occupation Therapist) and CNA A (Certified Nursing Assistant). This RN thought resident was care planned as a 2-assist lift prn (as needed) but res (resident) is a lift at all times. Resident hit left foot pedal and made 3 big skin tears on left leg. Leg kept bleeding. Pressure applied to stop the bleeding and res (resident) transferred over to (the Hospital Emergency Room) for treatment. Injury Type: Laceration; Injury location: Left thigh- front; Notes 11/12/2025: Area assessed immediately after the incident occurred. A review of the Care Plan for Resident #2 revealed the following: (Resident #2) has a functional ability deficit and requires assistance with self-care/mobility r/t (related to): weakness, impaired mobility, pain. And poor endurance, date initiated and created 8/29/2024 and revised 1/11/2024 with Interventions including: Transfer: Resident is a two assist Invacare lift (electronic lift) with large size Invacare sling, date initiated 9/3/2024 and revised 6/23/2025. (Resident #2) has actual impairment to skin integrity r/t MASD (moisture associated dermatitis) to bilateral buttocks, lacerations/skin tears to RLE and LLE (right lower extremity and left lower extremity), date created 8/29/2024 and revised 1/10/2026, with Interventions including, Treatment to skin impairment to bilateral buttocks/left and right lower legs per order, date initiated 9/3/2024 and revised 1/10/2026; and Use caution during transfers and bed mobility to prevent striking arms, legs, and hands against any sharp or hard surfaces, date initiated 6/6/2025.A record review of the progress notes for Resident #2 identified the following: 11/11/2025 at 1:35 PM, a Skin/Wound Progress Note, Noted to have skin tear to left lateral upper leg with skin flap not approximated. Area approx. 8 cm (to visual eye r/t (related to) amount of bleeding). Skin flap slowly maneuvered to cover wound bed and approximated well with steri strips. Distal to this area is approx. 10 cm open injury which was unable to slow bleeding enough to assess. Pressure applied to area and pressure dressing applied to area. Resident is on Eliquis (a blood thinner) and ASA (aspirin). Resident was transferred with two-assist into w/c (wheelchair) from beauty shop chair. Leg hit w/c where pedal attaches to w/c. CN (Charge Nurse) notified to have resident sent to ER for evaluation. Resident c/o (complains of) burning pain to area.A review of the Hospital Emergency Department discharge report, dated 11/11/2025 at 2:08 PM, identified the following: . Reason for Visit: Leg laceration. Final Diagnosis: 1. ISTAP (International Skin Tear Advisory Panel) type 3 skin tear (a skin tear with a total flap loss, where the entire wound bed is exposed due to the loss of the skin flap) of left lower leg; 2: Skin tear of left lower leg without complication; 3: Hematoma of left lower leg; 4: current use of long term anticoagulation. Keep your area clean and dry and keep compression over the area so the hematoma does not get larger elevate when non-ambulatory. Follow-up with wound care nurse to ensure proper healing of the wound keep area clean and dry.A review of a Medication Administration note dated 12/7/2025 for Resident #2 identified, Cleanse left leg laceration with NS (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	(normal saline) and pat dry. Apply Vaseline gauze to wound, cover with nonadherent dressing and apply kerlix., every shift for laceration to left leg.A review of the Treatment Administration Record (TAR, dated November 2025 for Resident #2, identified a wound treatment to her left leg dated 11/11/2025 to 2/12/2026.A review of the November 2025 Medication Administration Record (MAR) for Resident #2 indicated that the resident had an order for narcotic pain medication Hydrocodone-Acetaminophen Oral tablet 5-325 mg, Give 1 tablet every 8 hours as needed for pain, start date 5/11/2025. The resident had not received any doses of the pain medication from November 1, 2025, to November 10, 2025. After she sustained the leg injury on November 11, 2025, she received 11 doses of the pain medication for the month. On 3/10/2026 at 11:20 AM, the Director of Nursing/DON was interviewed about the incident with Resident #2 and said there was an incident involving the resident during a transfer in the Beauty shop. She said two staff members were transferring the resident to her wheelchair from the Beauty shop chair, and the resident obtained an injury on the foot pedal of the wheelchair during the transfer. She said the two staff were also supposed to use an electronic lift during the transfer, per the resident's plan of care.During an interview with Resident #2 on 3/10/2026 at 3:20 PM, she showed her lower legs with long scars on each. She said she had started to fall during a transfer in the Beauty shop and injured her legs. She said it was healed now but took a long time to heal and had been very painful.During an interview with the Director of Nursing and Administrator on 3/10/2026 at 4:00 PM, the transfer and injury to Resident #2's left leg was reviewed. The Administrator said Nurse C assigned to the resident had told CNA A that the resident could be transferred with a 2-person assist and not use the Invacare lift, so the CNA had someone else help him with the transfer (OT B) and the resident was injured. The DON and Administrator both said CNA A and Nurse C no longer worked at the facility.A review of the Facility Policy titled, Fall Management, dated origination 5/1/2020 and revised 7/8/2025 provided, Policy: The facility will identify hazards and resident risk factors and implement interventions to minimize falls and risk of injury related to falls. Each resident is assisted in attaining/maintaining his or her highest practical level of function by providing the resident adequate supervision, assistive devices, and/or functional programs as appropriate to minimize the risk of falls. A plan of care is developed and implemented based on this evaluation.