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	01/07/2026

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

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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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Based on observation, interview, and record review the facility failed to ensure that there was adequate staff available to meets the needs of the residents, resulting in resident verbalizations of waiting long periods of time to answer call lights and receive assistance with activities of daily living (ADL), including toileting and incontinence care, for a Confidential Group of Residents from a census of 78 residents Findings Include: FACILITY Sufficient and Competent Nurse Staffing: During a review of the facility Offsite survey preparation dated 1/1/2026, the document indicated the facility had Low weekend staffing for the 4th Fiscal Year quarter in 2025; this was July 2025- September 2025. A further review of the CMS (Centers for Medicare and Medicaid Services) PBJ Staffing Data Report for Fiscal Year Quarter 4 2025 (July1 - September 30) identified Excessively Low Weekend Staffing. The document also provided, Triggered = Submitted Weekend Staffing data is excessively low. On 1/6/2026 at 11:46 AM, the Director of Nursing and Administrator were interviewed and asked about the PBJ Staffing Data Report indicating the facility had Fiscal Year 4th quarter Excessively low weekend staffing. The Administrator said that was true; the weekend staffing had been low. On 1/6/2026 at 1:12 PM, during an interview with a Confidential Group of Residents, they identified several recent instances when the facility had low staffing. One resident stated, Last night there were only 2 staff on, and it took 3 hours to get help to go to bed. It was 11:30 PM before they got there and I had been asking since about 8:30 PM. Some people (residents) take 2 people (staff) to help them. A lot of people have quit, so there aren't enough. The residents said they would like to have 2 staff on each hall (with 4 halls), but sometimes there were 2 staff (nurse aides) for the whole building. One Confidential Resident said sometimes it was over 2 hours before she would receive help. The residents said they did not always receive their evening snack, because there were not enough staff to pass them, If they are short-handed, we go without something. A review of the posted nurse staffing forms titled, Report of Nursing Staff Directly Responsible for Patient Care and the facility Skilled Nursing and Rehab Nursing Staff Daily Assignment sheets identified several days when the facilities staffing was low, as identified in the following: 12/15/2025 on the day shift there were 2 nurses and 3 aides with another partial shift aide for a census of 84 residents. 12/31/2025 on the midnight shift, 2 nurse aides and 3 nurses worked for a census of 80 residents. 1/1/2026 on the day shift 3 nurse aides were listed and 3 nurses for a census of 80 residents. 1/5/2026 on the Afternoon shift, 4 of 6 nurse aides called in and did not work that shift; One was replaced leaving 3 nurse aides and 3 nurses to assist residents with the evening meal, toileting and activities of daily living/adl's for a census of approximately 80 residents. On the Midnight shift, 4 of 6 nurse aides called in, with 2 replaced for a total of 4 nurse aides to assist approximately 80 residents to bed. On 1/6/2026 on 3:15 PM, the Director of Nursing and Administrator were asked to view the time cards for nursing staff, including nurses and nurse aides for the dates 11/1/2025, 11/21/2025, 11/25/2025, 12/2/2025, 12/7/2025, 21/9/2025, 12/16/2025, 12/17/2025, 12/24/2025, 12/25/2025, 1/1/2026, 1/3/2025, as during a review of the posted nurse staffing sheets titled, Report to Nursing Staff Directly Responsible for Patient Care identified inconsistencies with the Skilled Nursing and Rehab Nursing Staff Daily Assignment documents. In addition, there were many staff crossed off the assignment (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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	sheets and call ins, and some were identified as Quit, it was difficult to determine which staff and how many were working. On 1/7/2025 at 1:25 PM, Nurse H was interviewed about staffing. She said nurses and nurse aides were working mandatory overtime and it was difficult. On January 7th, 2026, at 1:29 PM, the clinical nursing staff assigned to daily patient care timecards were received for review for the days requested for the nurse aides, but not for the nurses. Timecards for one nurse/an RN were received for 3 days: 11/1/2025, 11/9/2025 and 12/17/2025. There were no additional nurses' timecards received for review. On further review of the timecards, it was identified that many of the nurses and nurse aides were working repeated 16-hour shifts. This was identified also, by the Confidential Group of Residents who said the staff began quitting because of this. On 1/7/2026 at 2:35 PM the Director of Nursing/DON was asked about the timecards and schedules. She identified four nurse aides who had recently quit. Reviewed with the DON that the residents were upset about the care they were receiving when there was not enough staff to care for them. She confirmed the nurse aides and nurses were working 16-hour shifts at times, and the facility was trying to hire additional staff. Reviewed the facility had flagged for Excessively low staffing on the 4th quarter 2025 (July-September 2025) PBJ staffing report and the low staffing continued currently, in addition, the daily staff assignment sheets and Report to Nursing Staff Directly Responsible for Patient Care posted staffing, did not match on many days. A review of the facility policy titled, Nursing Staffing dated origination 9/1/2013, last revised 9/14/2023 and effective 11/1/2024 provided, The nursing services department provides 24-hour nursing services. The facility ensures sufficient nursing staff. to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Nursing service is provided by number and type of personnel to ensure that each resident: Receives treatments, medications and diets as prescribed; Receives rehabilitative nursing care as needed; Receives proper care to maintain their highest level of functioning (prevent decline in function or poor clinical outcomes); Is kept clean, comfortable, and well-groomed; Is protected from accidents, injury and infection. The facility will staff to meet the needs of the residents at the facility. Documentation: Maintain time schedules that indicate the number and classification of nursing personnel, including relief personnel, who work on each unit for each tour of duty (shift). A review of the Facility Assessment provided, . II Staffing, Training, Services & Personnel . A. 1. Function - Sufficiency Analysis Summary A. 1. (The facility) considers the specific needs of each resident unit in the facility to adjust as necessary (ie. Number of staff, skill sets) on a daily basis. This includes the staffing needs for each shift, such as day, evening, night and weekends.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to maintain best practices in the food service area, resulting in the potential to spread food-borne illnesses to all residents who consume food from the kitchen. Findings include: On 01/05/2026 at 9:30am-10:05am, during the initial kitchen tour with Certified Dietary Manager (CDM) A and Dietician B, this surveyor observed a bag of pepperoni with a discard date of 12/24/25 inside the walk-in refrigerator. When interviewed, CDM A stated that the pepperoni should have been thrown out and proceeded to throw out the pepperoni. On 01/05/2026 at 9:30am-10:05am this surveyor observed a bag of shredded lettuce with a best by date of 1/2/26 inside the walk-in refrigerator and CDM A proceeded to throw away the bag of shredded lettuce. On 01/05/2026 at 9:30am-10:05am the sanitizer bucket sitting on the counter in the main dining area was tested with Hydrion QT-40 test strips and the result was zero. When interviewed on what range the sanitizer should be in, CDM A stated they keep the solution between 150-400ppm and they change out the bucket when it's visibly soiled or when starting a new task. On 01/05/2026 at 9:30am-10:05am this surveyor observed the microwave visibly soiled on the interior's ceiling and walls, located in the main dining area. When interviewed on how often the microwave is cleaned, CDM A stated it's cleaned after each meal. On 01/05/2026 at 9:30am-10:05am observed crumbs on plates stacked by the steam table located in the main dining area. When interviewed on whether the plates were supposed to be clean, CDM A stated yes, and she removed the dirty plates from the stack. On 01/05/2026 at 9:30am-10:05am observed a takeout pizza box dated 1/4/26 in the fridge, located in the 400-hallway kitchenette. When interviewed on whether this was the received or discard date, CDM A wasn't sure, and the pizza box was removed from the fridge. On 01/05/2026 at 9:30am-10:05am observed a red stain from an unknown liquid on the inside wall of the fridge, located in the 200-hallway kitchenette. When interviewed on how often the fridge is cleaned, CDM A stated it's cleaned when the fridge is restocked. On 01/05/2026 at 9:30am-10:05am observed the drain line to the ice machine sitting directly inside the drain, located in the 900-hallway kitchenette. On 01/05/2026 at 9:30am-10:05am observed a turkey sandwich with a discard date of 1/4/26 in the fridge, located in the 900-hallway kitchenette. On 01/05/2026 at 11:07am-12:15pm during lunch observation, observed plates with crumbs on the surface stacked beside the steam stable, located in the main dining area. On 01/05/2026 at 11:07am-12:15pm observed [NAME] C scoop up the baked ziti with a utensil and batted away a string of extra cheese off the utensil with her bare hand, and the extra cheese fell back into the serving pan. According to the 2022 Food Code, 3-501.18 Ready-to-Eat, Time/Temperature Control for Safety Food, Disposition, Time/temperature control for safety refrigerated foods must be consumed, sold or discarded by the expiration date.According to the 2022 Food Code, 3-304.14 Wiping Cloths, Use Limitation, Cloths in-use for wiping counters and other equipment surfaces shall be .Held between uses in a chemical sanitizer solution at a concentration specified under S 4-501.114 and The sanitizing solution must be changed as needed to minimize the accumulation of organic material and sustain proper concentration. Proper sanitizer concentration should be ensured by checking the solution periodically with an appropriate chemical test kit.According to the U.S. Environmental Protection Agency for Multi Quat Sanitizer with the registration number 1677-198, the designated chemical solution range for food contact sanitizer is 150-400ppm. According to the facility's policy on Food from Outside Sources, All food brought in is to be checked by the Nurse, Dietary Manager, or Dietician. It must be placed in a sealed container and labeled for the content, the guest's/resident's name and date the food was received, and an expiration date of 3 days after food was brought in.According to the 2022 Food Code, 4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils, Equipment food-contact surfaces and utensils shall be clean to sight and touch, the food-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations, (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris.According to the 2022 Food Code, 5-202.13 Backflow Prevention, Air Gap, An air gap between the water supply inlet and the flood level rim of the plumbing fixture, equipment, or nonfood equipment shall be at least twice the diameter of the water supply inlet and may not be less than 25 mm (1 inch).According to the facility's Food Safety policy, Food items will be served onto clean dishes using clean utensils. Bare hand contact will not be permissible with food. According to the 2022 Food Code, 3-301.11 Preventing Contamination from Hands, Except when washing fruits and vegetables . food employees may not contact exposed, ready-to-eat food with their bare hands and shall use suitable utensils such as deli tissue, spatulas, tongs, single-use gloves, or dispensing equipment.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure that residents' needs were met timely and failed to ensure that call lights were not discontinued without residents' needs being met for three residents (R2, R7, R70) of four residents sampled and a confidential group of residents, resulting in feelings of unimportance and incontinence. Findings include:Resident #7: R7 is [AGE] years old and admitted to the facility on [DATE] with diagnoses that include metabolic encephalopathy, altered mental status, muscle wasting and major depressive disorder. On 01/05/2026 at 1:02PM, an interview was conducted with a family member present in the room. The family member of R7 stated that the call light wait time is an average of 20 minutes and sometimes it can be even longer. The family member also stated, I understand they are low on staff, but when you need to use the bathroom, it can be a long time for someone to sit and wait. The family member was asked if R7 was ever incontinent due to not getting the call light answered timely. The family member stated, yes, there have been a few times she has not made it to the bathroom due to the long wait. Resident #2: On 1/05/2026, at 9:43 AM, Resident #2 was sitting in their wheelchair in their room. Resident #2 complained there wasn't enough help. Resident #2 complained that they have wet their pants waiting on help to the bathroom. Resident #2 continued to offer that the cna's are overworked and when you get a good one, they either leave or get fired. Resident #2 further shared that we save our life for this and we should get what we need. On 1/05/2026, at 3:30 PM, a record review of Resident #2's electronic medical record revealed an admission on [DATE] with diagnoses that included Diabetes, Stroke and high cholesterol. Resident #2 had intact cognition and required assistance with Activities of Daily Living. During survey, a confidential resident complained when they use their call light for help staff often cancel it before meeting their needs. Confidential resident further complained staff often say it will be an hour before I get back to you. Confidential resident complained that made them feel unimportant, but they understood as they are often short staffed. Resident #70: On 1/7/2026, at 9:40 AM, Resident #70 was in bed. Their call light was activated with the lighted visual on in the hallway. Resident #70 explained they needed to get up as their daughter was coming at 11 for a visit. On 1/7/2026, at 9:41 AM, Resident #70 remained in bed. Their call light remained on/activated. Certified Nursing Assistant (CNA) D entered the room and asked can I help you. Resident #70 was overhead explaining they needed to get up and ready as their daughter was coming at 11 to visit. CNA D was overheard telling the resident they would go get help as they cancelled the call light. On 1/7/2026, at 9:48 AM, Resident #70 remained in bed. Resident #70 offered they needed to get up (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and ready. On 1/7/2026, at 9:49 AM, CNA D was observed pulling the clean linen cart towards the end of the 500 hall and stopped three rooms passed Resident #70's room. CNA D offered they were going to start checking people. On 1/7/2026, at 9:52 AM, CNA D was observed assisting another resident into the bathroom and making beds. On 1/7/2026, at 10:00 AM, CNA Dwas overheard telling their hall partner they needed to go into room [ROOM NUMBER]. Both CNA's were observed entering room [ROOM NUMBER]. On 1/7/2026, at 10:07 AM, Resident #70 remained in bed and now had placed their call light back on which was quickly answered. On 1/7/2026, at 10:08, Scheduler Answered Resident #70's call light and stopped CNA D in the hallway alerting them (Resident #70) needs to get up their daughter is coming. CNA D stated were going there next. On 1/7/2026, at 10:22 AM, Resident #70 was observed in their wheelchair in their bathroom brushing their teeth with CNA D assistance. On 1/7/2026, at 11:30 AM, a record review of Resident #70's electronic medical record revealed an admission on [DATE] with diagnoses that included debility, heart failure and anemia. Resident #70 had moderately impaired cognition and required assistance with all Activities of Daily Living.

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Post nurse staffing information every day. Based on observation, interview and record review the facility failed to ensure clinical staff posting was accurately completed for several days in December 2025 and January 2026, resulting in the inability for residents and visitors to know which clinical staff were working on those days.Findings Include: On 1/6/2026 at 11:40 AM, a daily posted nurse staffing sheet (a document listing all nurse staff by discipline (RN, LPN or Nurse aide working in the building on each shift- posted per federal guidelines), titled Report of Nursing Staff Directly Responsible for Patient Care, for 1/6/2026 with a Census of 78 residents was observed posted on the wall in the hallway near the front entryway desk. There were no hours for an RN/Registered Nurse working that day. On 1/6/2026 at 11:45 AM, the Director of Nursing was asked about the posted nurse staffing form for that day, as it was incomplete with no RN hours and she said there was a new scheduler and she would have it fixed. On 1/6/2026 at 1:30 PM Staff Scheduler E was interviewed about the postings, when she provided the schedule book containing the daily staff postings and assignment sheets. She said sometimes the assignment sheets were updated when staff called in for their shift and the daily posted staffing sheets were supposed to be updated also. A review of the Daily posted staffing sheets from December 2025-January 7th, 2026, identified several incomplete forms for the following days: 1/5/2026, 1/6/2026, 12/29/2025, 12/17/2025, 12/16/2025, 12/13/2025, 12/12/2025. Some of the forms did not indicate if an RN had worked that day or how many hours the RN worked in a 24-hour day. Some of the forms did not have RN or LPNs listed or their hours. On 1/5/26 at 12:26 PM, an observation was made of required daily posting of nursing staff hours. The posting was on the wall near the front entrance of the facility by the entrance towards the 200-hall unit. The document for the staffing hours was dated 1/5/26. The information on the document revealed the number of Certified Nursing Assistants (CNA) as 5.5 for day shift with total CNA hours worked 44; afternoon shift was documented as 5 CNAs with total CNA hours worked as 40; and night shift as 5 CNAs with total CNA hours worked as 40. There was no documentation for RN (Registered Nurse) coverage or LPN (Licensed Practical Nurse) coverage for any shift for the number of RN and LPN staff and no documentation of hours worked for RN or LPN staff.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observation, interview and record review, the facility failed to ensure nail care was provided to one resident (Resident #6), of one resident reviewed for Activities of Daily Living (ADL) care. Findings Include:Resident #6:On 1/5/26 at 11:21 AM, an observation was made of Resident #6 (R6) lying on her back in bed, dressed in a gown, lights on and R6 was awake. The call light was hanging on a piece of plastic on the wall, in line with the Resident's feet and not in reach for the Resident with the push mechanism hanging below bed frame. The Resident was asked questions, answered them, but did not engage in conversation. The Resident pulled the covers up around her shoulders. An observation was made of long fingernails. The Resident reported she didn't want to answer questions and turned herself facing the wall. The Resident was left alone. On 1/6/26 at 3:45 PM, an observation was made of R6 lying in bed, awake and dressed in a gown. An observation was made of the Resident's fingernails that were long except for one that was irregular and down to the skin on the 5th right digit. The other nails were long with one curling under, and a couple were jagged and uneven. When questioned about the length of her nails, the Resident reported she liked short nails and that they were sharp and she scratched herself. On 1/6/26 at 4:00 PM, Certified Nursing Assistant (CNA) F and CNA G were interviewed regarding R6's nail care. CNA F was asked about bathing and the CNA explained that sometimes she takes a shower and sometimes it's a bed bath depending on her mood. When asked about nail care the CNAs indicated it should be offered during bathing or as needed. They were unsure when the Resident last had nail care done. CNA F reported she had done morning care with the Resident but did not do the nails and reported, they usually look at the nails on shower days to see if it needs to be done. When asked about refusals for care, the CNAs reported they would let the Nurse know and they would go in after that. CNA G reported they would type in what she didn't want us to do and the nurse will come out and try. When asked if she would allow nail care, the CNAs indicated it would depend on her mood. A review of Resident #6's medical record revealed an admission into the facility on 5/8/25 with diagnoses that included dementia, anxiety disorder, diabetes, depressive disorder and excoriation (skin-picking) disorder. A review of Resident #6's Minimum Data Set assessment revealed a Brief Interview of Mental Status of 10/15 that indicated moderately impaired cognition and the Resident needed substantial/maximal assistance with personal hygiene and dependent on helper with shower/bathing. A review of R6's medical record of a progress note dated 1/5/26, .Observed upon skin assessment during Treatments that residents BIL (bilateral) lower legs are almost healed from where resident scratches her legs with her nails. Previously open areas on residents legs are healed over with dry scabs. Residents groin and buttocks also showing improvement, somewhat mildlyred areas where resident is scratching her skin on her buttocks & groin with her nails. Education provided to resident on infection control of spread of redness if she would quit scratching the areas with her nails. Resident became irrational and agitated stating, It's not me, I don't scratch my skin. Resident then provided with assistance cleaning out dried skin and red dry scabs from under her fingernails. Resident continues to deny scratching as this nurse observed her scratching her buttocks with her nails. Further review of the progress notes revealed a note dated 12/10/25, that revealed, Residents legs assessed. Noted to have several small scratch marks with scabs present. No s/s (signs and symptoms) of infection present to area. Tx (treatment) in place. Nails checks and are short and well trimmed. Resident reports I am doing better at not itching.A review of the progress notes revealed a lack of documentation of the resident refusing nail care and interventions attempted from 1/6/26 back to the note on 12/10/25. A review of R6's care plan revealed a focus for risk for impaired skin integrity/pressure injury with an intervention Observe finger and toe nails on shower days to see if they need to be trimmed, date initiated 9/20/25. Further review of R6's care plan revealed a focus for Actual impairment to skin integrity r/t (related to) scratch marks to bilateral lower legs and red/yeasty buttocks, revision on 12/11/25. Interventions included, Instruct resident to avoid scratching and keep hands and body parts from excessive (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	moisture, Keep fingernails short, created on 12/11/25.On 1/7/26 at 12:30 PM, an interview was conducted with the Director of Nursing (DON) regarding R6's nail care. The DON reported that with R6 it was a hit or miss with things indicating personal care and bathing. The DON reported that nail care was with shower care or as needed. When asked about refusals and facility policy on documentation of refusals, the DON reported the Nurses should have a note in if she refused. An observation was made with the DON of Resident 6's nails and reported that the nails should be attended to and the Resident agreed to have nail care completed. The DON indicated that the Resident may not allow the nail care to be completed. When asked if refusals for nail care should be documented, the DON indicated the nurse should be documenting it.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. Based on observation, interview, and record review, the facility failed to ensure that one resident (Resident #25), with a significant weight loss, was weighed as ordered by the practitioner and the weights were documented in the medical record of two residents reviewed for nutritional status. Findings include:Resident #25:On 1/6/26 AM, an observation was made of Resident #25 sitting up in the room and staff were providing care. After care was completed, an interview was conducted with the Resident who could express simple answers to questions but did not converse in conversation. Resident #25 denied issues with the food he received at the facility. The Resident had been sick with Covid and indicated he was feeling better. The Resident was observed to not have any cough or congestion and denied any pain in his throat. The Resident continued under isolation precautions. A review of Resident #25 (R25) medical record revealed an admission into the facility on 1/22/25 with diagnoses that included cerebral ischemia, dementia, depressive disorder, and Covid-19. A review of the Minimum Data Assessment revealed a Brief Interview of Mental Status score of 5/15 that indicated severely impaired cognition and the resident needed set-up or clean-up assistance with eating. A review of R25's medical record of weights revealed the following:8/1/25, 166.5 lbs (pounds).9/1/25, 165 lbs.10/1/25, 163.5 lbs.11/1/25, 172.5 lbs.11/1/25, 172.5 lbs.12/1/25, 161.5 lbs.12/2/25, 160.0 lbs.An order was for weight monitoring for R25 revealed an order dated 12/8/25 for Weekly Weight, Order Summary: Weekly Weight every day shift every Mon (Monday) for 8 weeks. and signed by the Practitioner on 12/8/25. A review of the Medication Administration Record revealed Weekly Weights every day shift every Mon for 8 weeks with a start date 12/15/25, documented with a check as completed on 12/15/25 and 12/22/25 with no documentation of the weight obtained. Documented as a 5 on 12/29/25 with corresponding progress note that indicated weight held at this time r/t (related to) being on isolation precautions. Further review of the medical record of progress notes revealed a lack of documented weights obtained on 12/15/25 and 12/22/25. Progress notes dated 12/28/25 revealed the Resident had tested positive for Covid. Dated 12/29/25 at 1:28 AM, Afebrile. Denies discomfort. Covid precautions in place. Dated 12/29/25 at 9:10 AM, Dietary Note, Resident noted w (with)/Covid-19 infection w/increased est nutritional needs due to the same. He is at risk for appetite and weight changed r/t Covid-19, as well as social disruption r/t isolation per protocol. Supplements already prescribed for increased est needs and will continue to monitor intake, weights, and labs as available. Progress notes for Resident #25 revealed:-Dated12/20/25 at 10:51 AM, Resident afebrile, EBP (enhanced barrier precautions) in place, VS (vital signs) WNL (within normal limits). Resident productive cough noted. Denies pain or discomfort. -Dated 1/1/26 at 1:09 AM, Isolation precautions continues for covid positive. VS WNL. Denies symptoms. Fluids encouraged.-Dated 1/2/26 at 12:56 AM, .No complaints voiced by resident at this time. VS WNL. Afebrile.-Dated 1/2/26 at 1:30 PM, .Resident remains non-symptomatic of Covis S&S (signs and symptoms), BIL (bilateral) lung sounds clear, VS and WNL. Resident pleasantly confused, calm demeanor.-Dated 1/3/26 at 11:07 AM, Continues on isolation, resident feeling much better he states, LS (lung sounds) are CTA (clear), no coughing noted, no Covid symptoms are present. On 1/7/26 at 9:11 AM, an interview was conducted with Dietitian (RD) B regarding Resident #25's weight loss. A review of the December weights of 11 and 11.5 lbs weight loss with approximately 7% weight loss in a month. The RD indicated that 5% or more would be a significant weight loss. The RD reported that it was expected wt loss and that the Resident was expected to return to his baseline. The RD reported their assessment was conducted on 12/5/25 and supplements were increased and the physician was notified. The RD was asked about the order for the weights for 8 weeks. The RD was not aware of the Resident's current weekly weights obtained. Review of the medical record revealed a lack of documentation of the weights obtained for the weekly weights for 12/15 and 12/22. For the weight that was to be obtained on 12/29, the RD indicated we would try not to contribute to more discomfort during illness of Covid until after out of isolation. The RD reported that they could do weights on (continued on next page)

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	01/07/2026

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

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	someone in isolation if it was medically necessary. The RD reported that the weights, if they had been obtained, should be documented in the medical record. The RD left to try to find if the weights had been obtained. The RD returned with the document titled Vital Signs and Intake/Output Record for the date of 12/22/25 and 12/15/25 for the 200 hall. Resident #25's first name only was on the bottom of the page under the area reweights with the wt of 161 for 12/15/25 and 162 for 12/22/25. The RD agreed that the weights should be in the medical record for analysis of the Resident's weight loss and to determine if the Resident continued to lose weight and if further interventions were needed. The last weight obtained that was documented in the medical record was on 12/2/25 at 160 lbs. which was a weight loss of 11.5 lbs from the prior months weight of 172.5 on 11/1/25. The order for weekly weights was not followed while the Resident was under isolation and the RD reported that everyone was assessed on an individual basis and stated, If needed to, if medically necessary, we could weigh them. The RD reported that the shower room was where the scale was located and when asked if he could use PPE (personal protection equipment) to obtain a weight, the RD responded yes. A review of facility policy titled, Weight Management, effective 7/30/25, revealed, .Practice Guidelines. 2. Residents will be weighed upon admission/readmission; weekly x 4, then monthly or as indicated by the physician and/or the medical status of the resident and document the results in the medical record. 5. Residents determined to be at risk or have significant weight changes will be weighed on a weekly basis. Residents at risk are: .f. Residents with insidious weight loss and 5% in one month. H. Residents deemed necessary by the practitioner, Director of Nursing, Registered Dietitian, or interdisciplinary team. Exceptions to weekly weights include residents with a diagnosis or condition that contraindicates weekly weights, e.g., hospice/terminal residents with a physician's order or planned weight changes under a physician's order or treatment plan.