STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235515	A. Building B. Wing	05/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakeview Manor Healthcare Center	408 North Fifth Avenue Tawas City, MI 48763

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure proper storage of respiratory equipment (BiPAP, nebulizer treatment mask and nasal cannula) for 3 residents (#14, #25, and #27) of 3 residents reviewed for respiratory equipment. Findings Include: Resident #25 On 5/11/26 at 11:37 AM, Resident #25 was observed in their room, sitting in a wheelchair. A nebulizer machine was present on the dresser beside the Resident's bed. The administration set of the nebulizer was connected and uncontained with visible fluid present in the medication chamber. An interview was completed at this time. When queried regarding the nebulizer machine and treatments, Resident #25 stated, Do daily in the morning. Record review revealed Resident #25 was admitted to the facility on [DATE] with diagnoses which included Chronic Obstructive Pulmonary Disease (COPD), cerebral infarction (stroke) with resulting right sided hemiplegia and hemiparalysis (one-sided paralysis) and aphasia (difficulty communicating). Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the Resident was cognitively intact and required set up to total assistance to complete Activities of Daily Living (ADLs). Resident #27 On 5/11/26 at 10:42 AM, Resident #27 was observed in their room in bed with their eyes closed. A nebulizer machine was sitting on the dresser next to their bed. The administration set of the nebulizer was connected and uncontained with visible fluid present in the medication chamber. While walking in the hallway on 5/11/26 at 2:55 PM, Resident #27 was heard yelling out that they wanted their nebulizer. From the hallway, Resident #27 was heard yelling, I use it when I need it and they took it away. Registered Nurse (RN) O entered Resident #27's room and told the Resident they could not have it (nebulizer treatment) because they just had it. RN O exited Resident #27's room and walked to the Nurses' station. An interview was completed with RN O and Licensed Practical Nurse (LPN) G at this time. When queried regarding Resident #27's nebulizer treatment, RN O stated, I'm helping out on the floor and (Resident #27) is not happy with me. When asked if they were the Resident's assigned nurse, RN O revealed they were now and LPN G stated, I had (Resident #27) this morning. When asked, LPN G stated, I gave (Resident #27) their breathing treatment. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review revealed Resident #27 was admitted to the facility on [DATE] with diagnoses which included CODP, psychotic disturbance, depression, and anxiety. Review of the MDS assessment dated [DATE] revealed the Resident was cognitively intact and required set up to moderate assistance to complete ADLs. On 5/13/26 at 10:24 AM, Resident #27's nebulizer administration set was observed sitting in a bag on the dresser next to their bed. The nebulizer administration set was connected with visible fluid present in the medication administration chamber. An interview was conducted with the facility Administrator on 5/13/26 at 10:16 AM. When queried regarding facility policy/procedure related to storage of nebulizer administration equipment, the Administrator stated, Rinse and leave out to dry. The Administrator was then informed of observations of Resident #25 and Resident #27's nebulizers having visible fluid in the administration chamber. The Administrator reiterated nebulizer administration equipment should be rinsed and left out to dry following each use. No further explanation was provided. Resident #14: Review of the Face Sheet, care plans dated 2/26 through 5/26, and physician orders dated 2/26, revealed Resident #14 was [AGE] years old, alert and his own person, admitted to the facility on [DATE], dependent on staff for Activities of Daily Living/ADl's, and extremely short of breath with any exertion or excess communication. The residents diagnosis included, acute respiratory failure, panic disorder, anxiety, chronic lung disease, respiratory disorders and shortness of breath with a history of respiratory infections. The resident had a BiPAP machine with connected air piece, Respiratory nebulizer treatment mask, and nasal cannula hook up to an E-tank next to his bed. Review of the residents physician orders dated 4/2/26, revealed orders for inhalation treatments, orders for BiPAP and Nasal Cannula oxygen as needed. Observations were made on 5/11/26 (at 11:14 a.m., 12:45 p.m., and 1:15 p.m.), and on 5/12/26 (at 7:00 a.m., 9:00a.m., and 12:00 p.m.), revealed his BiPAP air piece, nebulizer treatment mask, and nasal cannula/NC hook to the E-tank all were noted to not be in a clean bag for cleanliness and to prevent cross-contamination leading to lung infections. During an interview done on 5/12/26 at 3:00 p.m., the Director of Nursing said the residents BiPAP, nebulizer mask and NC should all be in a clean storage bag when not in use and immediately got them all put in a clean storage bag. Review of the facility Use of Oxygen policy dated 2/28/25, stated The O2 cannula or mask (including treatment masks and BiPAP), when not in use, should be stored in a clean bag, bag should be changed weekly.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the accuracy of Minimum Data Set (MDS) submission assessment data for one resident (Resident #8) of one resident reviewed. Findings include:Resident #8:Review of the facility provided CMS-802 form indicated Resident #8 was receiving Hospice Services. Record review revealed Resident #8 was originally admitted to the facility on [DATE] and most recently readmitted on [DATE] with diagnoses which included heart failure, dementia, major depressive disorder, and generalized anxiety disorder. Review of the most recent Minimum Data Set (MDS) assessment completed, dated 4/10/26, designated Resident #8 was not receiving Hospice services. Review of Resident #8's Electronic Medical Record (EMR) revealed a care plan entitled, (Resident #8) is at risk for decline in condition, pain, depression, weight loss and other symptoms R/T (related to) terminal prognosis. Receives Hospice services. The care plan was created, initiated, and revised on 10/23/25. An interview was completed with Registered Nurse (RN) O on 5/11/26 at 3:00 PM. When queried regarding Resident #8, RN O stated the Resident had been on Hospice since they were admitted in October of 2025. Review of prior MDS assessments in Resident #8's EMR revealed MDS assessments submitted on 10/27/25 and 1/23/26 both indicated the Resident was receiving Hospice Services. An interview was completed with MDS RN F on 5/12/26 at 2:16 PM. When queried, RN F revealed they recently began employment at the facility. RN F was asked if they had completed Resident #8's most recent MDS assessment and responded they had. When queried if Resident #8 was receiving Hospice Services, RN F confirmed they were. RN F was then asked if Resident #8 had been discharged and readmitted to Hospice and verbalized they had not. When asked why the MDS dated [DATE] detailed the Resident was not receiving Hospice Services, RN F reviewed the Resident's EMR documentation and stated the MDS said no Hospice and should have been on Hospice . RN F verbalized made an error. An interview was completed with the facility Administrator on 5/13/26 at 10:07 AM. The Administrator was informed of Resident #8's MDS assessment specifying the Resident was not receiving Hospice services when they had been receiving Hospice services since October 2025. The Administrator verbalized understanding of the concern and indicated RN F is new the facility and MDS RN role.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure that one resident (Resident #19) of 16 residents reviewed for Activities of Daily Living/ADL care received daily oral care and was shaven as needed. Findings Include:Resident #19: Review of the Face Sheet, care plans dated 4/3/26 through 5/13/26, and nursing notes, dated 4/26 and 5/26, revealed Resident #19 was 62 years-old, alert, admitted to the facility on [DATE], and was totally dependent on staff for all Activities of Daily Living (ADL). The resident's diagnoses included, Cerebral Palsy, other symptoms involving the musculoskeletal system, spastic quadriplegic CP, and required assistance with personal care. Observations made during the survey, revealed Resident #19 had not had any oral care done or had been shaven on the following days and times: Observations made on 5/11/25: -At 9:00 a.m., the resident was in his bed awake and was waiting for his breakfast.-At 12:00 p.m., the resident was in his bed waiting for his noon meal.-At 3:00 p.m., the resident was in his bed wake.Observations made on 5/12/25: -At 7:15 a.m., the resident was awake in his bed.-At 10:00 a.m., the resident was awake in his bed. -At 11:00 a.m., the resident was awake in his bed waiting for his noon meal. During an interview done on 5/11/26 at 9:00 a.m., Family Member #1 M stated They (staff) usually shave him on Sunday's during his shower, but not this Sunday, I don't know why (Family member #1 M was also a resident in the adjoining room and she kept his door open so she could watch Resident #19). During an interview done on 5/12/26 at 11:00 a.m., Family Member M stated They still have not shaven him or brushed his teeth, I am just going to do it so it gets done. Review of the residents Functional Ability Deficit care Plan dated 4/14/26, revealed no documentation that Resident #19's Family Member did his daily oral care and staff needed to check daily to make sure it got done. During an interview done on 5/13/26 at 9:00 a.m., In Service RN, Nurse L stated There has been no in service on oral care since I came back (3 months from survey), they (CNA's still have to do it shave and oral care). During an interview done on 5/13/26 at 9:55 a.m., Nursing Assistant/CNA K who frequently care for the resident stated that she sometimes miss it (doing oral care and shaving if needed). During an interview done on 5/13/26 at 10:40 a.m., MDS Coordinator F reviewed the residents Functional Ability Deficit care plan dated 4/14/26, and stated The CNA's (Nursing Assistant's) still have to do the task (oral care daily, and shaving as needed), they need to check to see if (Family Member M) provided oral care and if not, provide it. Review of the residents Functional Ability Deficit care plan up-dated to 5/13/26, revealed MDS Coordinator F had add the intervention of checking daily to see if oral care had been given and if not, provide it to the resident.Review of the facility Routine Resident Care policy dated 3/12/25, stated Daily personal hygiene minimally includes washing their face and hands, shaving, nail care, combing their hair each morning, and brushing their teeth.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement and operationalize policies and procedures to ensure coordination of care and communication with an external dialysis provider for one resident (Resident #7) of one resident reviewed. Findings include: Resident #7: On 5/11/26 at 3:20 PM, Resident #7 was not in their room. An interview was completed with Registered Nurse (RN) P on 5/11/26 at 3:23 PM. When queried regarding Resident #7's location, RN P responded that Resident #7 had recently returned from dialysis and went straight to the Activities Room when they got back. When asked, RN P revealed they were the Residents assigned nurse. When queried regarding the facility policy/procedure related to communication with the external dialysis provider, RN P responded the facility sends a form with the Resident when they leave, the dialysis nurse completes a portion and sends the form back with the Resident. RN P was asked if they had received a dialysis communication form following the Resident's dialysis treatment today and responded they had. RN P provided a Hemodialysis Communication Form dated 5/11/26. Review of the form section titled, Complete at the Dialysis Unit detailed the Resident weighed 55.6 kilograms (kg) pre-dialysis and 57.6 kg after dialysis. The only other documentation completed by the dialysis facility was vital signs. The forms included sections, Medications During Dialysis. Medication Changes Recommended. Diet Changes Needed. Complications During Dialysis. Pertinent Labs. Condition of Shunt. Addition Comments. were all blank. The bottom of the form included a section titled, Completed by the Facility upon Return which was blank. When queried why Resident #7 gained weight during dialysis (normally fluid is removed and weight decreases during dialysis), RN P stated, I'm not sure. Review of Resident #7's prior dialysis forms dated 5/1/26, 5/4/26, and 5/8/26 all showed the Resident had a weight loss during treatment. Review of the Dialysis Communication Form dated 4/27/26 revealed no documentation of a weight prior to dialysis but did include a post dialysis weight. Not all of the dialysis forms were signed by dialysis staff. The prior forms including consistent lower weight post dialysis were reviewed with RN P. When queried, RN P responded that the dialysis staff may have written the pre and post weights in the wrong area. RN P was asked to contact the dialysis center regarding Resident #7's treatment and post dialysis weight gain. RN P revealed the facility did not have a direct phone number to the local dialysis facility and indicated they would need to call the central number and try to be connected to the local facility. RN P was informed the dialysis center gave (Resident #7) a bolus (fluids) when they arrived for treatment and did not take hardly anything off because their blood pressure was in the 90's (low). RN P stated, They (dialysis center staff) don't fill it out (form) and that is why we think everything is going fine. On 5/11/26 at 3:38 PM, an interview was completed with the Director of Nursing (DON). When queried regarding communication with external dialysis facilities, the DON responded that a communication form is sent with the resident and a section is completed by the dialysis center staff. Resident #7's Dialysis Communication Form for 5/11/26 was reviewed with the DON at this time. When queried regarding Resident #7's post dialysis weight gain and the blank areas on the form, the DON confirmed the form was incomplete and stated they will need to address with the dialysis provider. The DON was then informed RN P was asked to contact the dialysis center and that the dialysis center had informed them that Resident #7 was hypotensive (low blood pressure) and had received fluids. The DON stated the lack of communication was not okay and indicated they would contact the dialysis center manager to address the concerns. An interview was attempted to be completed with Resident #7 on 5/11/26 at 3:58 PM in their room. When asked questions, Resident #7 responded but their speech was very garbled and was unable to be understood. A follow up interview was completed with RN P on 5/11/26. When queried regarding Resident #7's speech being garbled and not being able to understand them, RN P revealed they are a casual status employee and do not work often. RN P stated, (Resident #7) was like that a could days ago but I don't really know them though. An interview was conducted with (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Certified Nursing Assistant (CNA) R and CNA Q on 5/11/26 at 4:00 PM. When queried regarding Resident #7's garbled speech, CNA R stated, Been getting worse the past couple of weeks. CNA Q agreed with CNA R and added, Resident #7 was not like this when they first got here. Record review revealed Resident #7 was originally admitted to the facility on [DATE] with diagnoses which included heart disease, Congestive Heart Failure (CHF), hepatitis C, and End Stage Renal Disease (ESRD) with dialysis dependance. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the Resident was cognitively intact and required set up to moderate assistance to complete Activities of Daily Living (ADLs). On 5/13/26 at 1:00 PM, Resident #7 was not in their room and review of the Electronic Medical Record (EMR) revealed the Resident had been discharged . An interview was completed with the DON on 5/13/26 at 1:21 PM. When queried regarding Resident #7, the DON stated, Went out due to fluid overload. With further inquiry, the DON stated, It was partially because of you. They (dialysis center) gave (Resident #7) 1.5 liters of fluid during the treatment on 5/11/26. When asked, the DON revealed facility staff were monitoring the Resident more closely due to the amount of fluid they had received. The DON disclosed Resident #7 was on dietary fluid restrictions at the facility as instructed by the dialysis center and the fluids they had received when at dialysis sent them into fluid overload. Review of facility policy/procedure entitled, Hemodialysis (Revised: 7/23/25) revealed, Residents receiving hemodialysis will be evaluated pre and post treatment and receive necessary interventions.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. Based on interview and record review, 5 of 17 nursing staff (RN's & LPN's) and 5 Nursing Assistants/CNA's of 34 CNA staff failed to have up-to-date annual competency evaluations, resulting in the protentional for Nursing Assistants to not be able to re-certify certification, and improper nursing techniques and care for the facility's census of 54 residents. Findings Include:During an interview done on 5/13/26 at 11:25 a.m., In Service Nurse Director, RN I revealed she had been at the facility for 2 months, and the Nursing Assistant's/CNA's and Nurse's (Rn and LPN) annual competencies (facility competency check-off's) were not up-to-date, no one had done them for months prior to her. In Service Director I stated Before I came, no one did them; the last In Service Nurse did not keep them up-to-date. On 5/13/26 at 11:30 a.m., the In Service Director I and this surveyor went through all nursing and CNA's annual competencies for 2025 through 5/2026. There was a total of 5 Nurse's ana total of d 5 CNA's that were found to not be up-to-date with their facility annual competencies. Review of the facility Training for the Compliance Program policy dated 11/4/2024, stated The Compliance Program will be incorporated into on-boarding (video education) and annual education (facility annual competency check-off's) programs; the staff development (In Service Director) coordinator or designated staff member will be responsible for educating staff. Review of the State expenditures #483 for nurse aide training and competency evaluation dated 12/5/2016, revealed CNAs are required to have annual skill competency evaluations.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, interviews, and record review, the facility failed to ensure a sanitary environment in the kitchen (Soiled equipment, rust on freezer shelves), water in clean and ready for use dishes, and no use-by dates on open and partly used foods, for a census of 57 residents who eat from the kitchen. Findings include:On 5/11/26 starting at 8:15 a.m., the initial kitchen walkthrough was done with Dietary Manager B on 5/11/26 at 8:15 a.m., and the following concerns were noted: -At 8:17 a.m., observation of x 6 clean and ready for use plastic cups with water inside of all of them were in the dry cup container and ready for use. During an interview done on 5/11/26 at 8:19 a.m., Dietary Manager B stated yes, they (cups) are dry. According to the FDA 2022 Food Code, clean equipment and utensils were to be air dried in a manner in which allows them to circulate air in order to dry; no water should be left inside. -At 8:20 a.m., 1 open and partly used bag of chips (Bangles), 1 open package of hamburger buns, 1 open half loaf of bread, and 1 package of hot dog buns, were all found to not have any use-by or expiration dates on them. During an interview done on 5/11/26 at 8:20 a.m., [NAME] C stated yes, they need an open and use-by date on them. Review of the facility Food Purchasing and Storage policy dated 12/10/2024, revealed all left over foods (including breads) were to be dated. According to the 2022 Food Code, 3-501.17 Ready-to-Eat, Time/Temperature Control for Safety Food, Date Marking, Ready-to-eat, 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 -At 8:25 a.m., the pureed machine (makes pureed foods) was found was clean with a top on it sitting on the shelf. This was found to have water inside with the top on it. -At 8:32 a.m., The Arctic Air Freezer bottom shelf was found to have an excessive amount of food and crumbs on the bottom shelf; all shelves had white paint/coating chipping off and rust exposed (from oxidation). During an interview done on 5/11/26 at 8:33 a.m., Dietary Manager B stated Every shift should clean it (the freezer). Review of the facility Food Purchasing and Storage policy dated 12/10/2024, stated Metal shelves will be stainless or coated (painted) to prevent oxidation (leading to rust build-up).According to the FDA 2022 Food Code, 4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensil's, 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, nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure timely implementation of Transmission Based Precautions (TBP) and ensure appropriate hand hygiene for one resident (Resident #58) of two residents reviewed for Infection Control (IC) resulting in a lack of immediate implementation of TBP for a resident with known positive Clostridioides difficile (C. diff- highly contagious bacterium which effects the colon, can be life threatening, and becomes a spore when outside of the body). Findings include:Resident #58: On 5/11/26 at 10:59 AM, a contact isolation sign was observed on Resident #58's room door. Certified Nursing Assistant (CNA) S was observed approaching Resident #58's room and began donning Personal Protective Equipment (PPE) without performing hand hygiene first. Family Member T approached the room while CNA S was donning PPE and asked CNA S if they needed to wear PPE to go into the room. CNA S told Family Member T they were unsure and would need to ask other staff. CNA S left the area, and an interview was completed with Family Member T. When queried if this was the first time they visited Resident #58 at the facility, Family Member T responded it was not. Family Member T revealed the Resident had been in a local hospital prior to being transferred to the facility on Saturday (5/9/26). When asked why Resident #58 was in the hospital, Family Member T disclosed Resident #58 was having severe back pain and found out they had c-diff while in the hospital. Family Member T stated, I came yesterday (5/10/26) and they told them (facility staff) that Resident #58 was positive for C-diff. Family Member T stated revealed the staff at the facility were unaware. CNA S returned at this time and informed Family Member T that they did need to wear PPE to visit the Resident. CNA S entered the room wearing a gown and gloves at this time. Family Member T proceeded to don PPE including a gown and gloves without performing hand hygiene prior to donning PPE. Family Member T opened the Resident's room door while holding their coat and a purse. Staff were present in the room and Family Member T asked if they could bring their items (coat and purse) into the room. The staff in the room were overheard saying yes and Family Member T took the items in the room and shut the door. On 5/11/26 at 11:08 AM, CNA S was observed exiting Resident #58's room. CNA S walked directly into a different resident room (Resident #10) across the hallway from Resident #58 without performing hand hygiene prior to entering Resident #10's room. CNA S was asked what they were doing and stated, You can come in, I'm just going to do oral care. CNA S was asked to step into the hallway and an interview was completed. When queried where they removed their PPE in Resident #58's room, CNA S stated, Right inside the door. CNA S was then asked where they performed hand hygiene after removing their PPE and replied, Well there really isn't anywhere in (Resident #58's room) because the sink is too far. CNA S proceeded to explain the sink was on the opposite side of the room from the door and they would need to walk through the entire room after removing PPE in order to wash their hands and there was not a hand sanitizer dispenser in the room. When asked if they were going to provide oral care to another resident (Resident #10) without performing hand hygiene, CNA S responded that they should have washed their hands before entering (Resident #10's) room and then proceeded to use hand sanitizer. When queried if hand sanitizer was effective against C-diff, CNA S indicated they did not know. Record review revealed Resident #58 was admitted to the facility on [DATE] with diagnoses which included C-diff infection and diabetes mellitus.An interview was completed with IC Registered Nurse (RN) O on 5/12/26 at 11:39 AM. RN O was asked when Resident #58 was placed on TBP due to C-diff infection and replied, I came in on Monday and reviewed the antibiotic listing and seen (Resident #58) was on antibiotics. RN O revealed the Resident was receiving oral Vancomycin (strong antibiotic commonly used to treat C-diff infection) for a Urinary Tract Infection (UTI) and stated, I knew that is not normal for I UTI so I went to look and see if there was a urine culture in the chart and saw the C-diff results. RN O stated, (Resident #58) wasn't on TBP so I put (the Resident) on right away. RN O was asked to clarify if they were saying the Resident was (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235515	A. Building B. Wing	05/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakeview Manor Healthcare Center	408 North Fifth Avenue Tawas City, MI 48763

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	admitted on [DATE] with a positive C-diff culture and not placed in TBP until 5/11/26, RN O confirmed. When queried regarding facility policy/procedure related to implementation of TBP, RN O revealed the admitting nurse is able to implement TBP when appropriate. When queried if they spoke to the nurse who had admitted Resident #58, RN O responded that they had not. When asked if TBP are ordered as a order in the Electronic Medical Record (EMR), RN O stated, Yes. RN O was asked why Resident #58 did not have an order for TBP. RN O reviewed the Resident's EMR and confirmed there was not an order in place for TBP. RN O stated, I missed that. When asked what staff are supposed to tell Resident #58's visitors to do with their personal items, RN O did not provide an explanation. RN O was informed of observation of Family Member T taking their personal items into the Resident's room and stated, I have to find that out still. RN O then stated, The Resident is continent and is using the bathroom. When asked if C-diff is a spore, RN O confirmed it is. RN O was then asked where staff are supposed to wash their hands after providing care and removing PPE and stated, They can use the hand sanitizer to get out the room. They can use hand sanitizer and then go wash their hands. With further inquiry regarding hand sanitizer use following care of Resident #58, RN O stated, Can use hand sanitizer if your hands are not visibly soiled. When asked if hand sanitizer is effective with C-diff, RN O stated, No. RN O was informed of observation and interview with CNA S related to lack of hand hygiene after caring for Resident #58. RN O verbalized hand hygiene needs to be completed but did not provide further explanation. An interview was completed with the facility Administrator on 5/13/26 at 10:07 AM. The Administrator was informed Resident #58 was admitted to the facility with a positive culture for C-diff on 5/9/26 and was not placed on TBP until 5/11/26 as well as observation and interview pertaining to lack of hand hygiene. The Administrator verbalized understanding of concern and indicated the nurse who had admitted the Resident was an agency nurse and would no longer be coming to the facility. Review of facility policy/procedure entitled, Multi Route Transmission Based Precautions (Revised: 11/22/22) revealed, Policy: Transmission-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. This can include. C difficile. Use PPE appropriately, including gloves and gown for all interactions that may involve contact with the resident or the residents environment. Donning PPE prior to entering the room and Doffing and properly discarding before exiting the room.