

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235519	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/10/2026
NAME OF PROVIDER OR SUPPLIER King Nursing & Rehabilitation Community		STREET ADDRESS, CITY, STATE, ZIP CODE 2280 Tower Hill Road Houghton Lake, MI 48629	
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 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. Based on interview and record review, the facility failed to ensure Certified Nurse Aide (CNA) training of no less than 12 hours per year was completed for three of five CNAs reviewed for nurse aide training hours. Findings include: During an interview on 6/10/26 at 7:37 a.m., the Business Office Manager (BOM) reported, The 12 hours of training in a year is based on the CNAs hire date. The BOM acknowledged the facility used online training. Review of facility documents provided by the Nursing Home Administrator (NHA) revealed the following: CNA H was hired on 1/18/22 with 3.87 hours of training from 1/18/25 - 1/18/26. CNA I was hired on 7/25/19 with 8.75 hours of training from 7/25/24 - 7/25/25. CNA J was hired on 6/29/23 with 3.25 hours of training from 6/29/24 - 6/29/25. During an interview on 6/10/25 at 9:26 a.m., the NHA reported, There were educational issues. we have CNAs that did not receive their 12 hours of training in a year.		

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 the provision of adequate supplies, care and services to meet the personal hygiene needs of 1 Resident (#4) of 12 residents reviewed for Activities of Daily Living. This deficient practice resulted in resident dissatisfaction with the lack of assistance with personal hygiene and showers and has the potential to affect all residents who required staff assistance and clean linens for the completion of personal hygiene. Findings include: Review of R4's Minimum Data Set (MDS) assessment, dated 3/20/26, revealed R4 was re-admitted to the facility on [DATE], with active diagnoses that included the following, in part: renal failure, diabetes mellitus, hyperlipidemia (high cholesterol), anxiety disorder, depression, and psychotic disorder. R4 Scored 15 out of 15 on the Brief Interview for Mental Status (BIMS), reflective of intact cognition. During an interview on 6/8/26 at 6:40 p.m., when asked if R4 received showers as scheduled, R4 speaking loudly and with apparent frustration said that they did not get washed up that day, 6/8/26, because staff said there were no towels or washcloths to wash up all the facility residents. R4 continued to report they were supposed to get a shower the previous Friday, and they didn't. When asked if they had refused the shower, R4 said they had not refused the shower. During an interview and observation on 6/8/26 at approximately 7:00 p.m., two confidential Staff members were asked to view the clean linen room with this Surveyor. Observed, with the count verified by one of the confidential Staff were 15 white, cotton washcloths, 16 white bath towels, 12 fitted sheets, 5 flat sheets, 3 pull sheets, and 17 pillowcases. Staff both confirmed there were not adequate linens to meet the needs of all the residents. One Confidential Staff said they, themselves, routinely did laundry at night so they would have linens for the residents. The same confidential Staff said they had cut up facility towels to have washcloths for residents. When asked when the last time they had cut up the towels, the same confidential Staff said it was that day. When asked if other staff cut up towels, the same confidential Staff stated, We all do (on night shift). The same confidential Staff said they had not seen the blue/grey microfiber cloths in the linen room until the previous day and said they did not know what they were for. Observation of the clean and dirty laundry rooms on 6/8/26 at approximately 7:15 p.m., with Staff T and U, found clean laundry in two large dryers. The dryers were cold, and the laundry was compressed down to fill approximately 1/2 of the dryer bins. The dirty laundry contained one white cotton washcloth, and no other towels/washcloths. All dirty laundry appeared to have been washed and dried and left to sit overnight in the two dryers. Staff U said laundry was only done in the facility by laundry staff from 6:00 a.m. until 2:00 p.m., when laundry staff left for the day. Observation of the clean and dirty laundry rooms with another confidential Staff on 6/9/26 at 6:15 a.m., found the same laundry observed in the dryers the previous evening (6/8/26) was fluffed this morning. The confidential Staff confirmed the facility had been having difficulty maintaining enough washcloths and towels for resident care and acknowledged staff were cutting up facility towels to make washcloths for the residents. The confidential Staff said two days ago (approximately 6/6/26), blue microfiber cloths (resembling a cleaning cloth/dishcloth) were placed in the clean linen room for staff to use and confirmed residents were not always getting their clean ups because there may not have been adequate supplies to do the wash ups. Observation of the clean linen storage, in the presence of Staff Q on 6/9/26 at approximately 6:20 a.m., revealed the following linen counts: Clean linen room: 16 white towels, 0 white hand towels and 0 white (cotton) washcloths. 100 Hall linen cart: 7 white towels and 6 (cotton) washcloths. 200 Hall linen cart: 0 white towels and 0 (cotton) washcloths. 300 Hall linen cart: 5 white towels and 0 (cotton) washcloths. Review of R4's Alteration to ADLs (Activities of Daily (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Living) Care Plan, retained from the Electronic Medical Record (EMR) on 6/9/26 at 3:28 p.m., revealed the following, in part: Approach Date of 5/14/24, Bathing choice is showers in the morning on Fridays only. Review of R4's CNA (Certified Nurse Aide) Shower Sheet(s) listing, retained on 6/9/26 at 10:38 a.m., from within the EMR, did not include a shower sheet for 6/5/26. Review of the Shower Sheets, maintained in a binder at the nurses' station on R4's hall, on 6/10/26 at 12:49 p.m., revealed a shower sheet was not present for a 6/5/26 shower completion. During an interview on 6/9/26 at 7:45 a.m., when asked if they were aware facility towels were being cut up to use as washcloths for facility residents, the Nursing Home Administrator (NHA) said she was not aware. The NHA acknowledged the limited [number] of towels and washcloths had been an issue for the last month. The NHA said washcloths had been disappearing. Review of the Activities of Daily Living (ADLs)/Maintain Abilities policy, reviewed 1/2025, revealed the following, in part: It is the policy of the facility to specify the responsibility to create and sustain an environment that humanizes and individualizes each resident's quality of life by ensuring all staff, across all shifts and departments, understand the principles of quality of life, and honor and support these principles for each resident; and that the care and services provided are person centered, and honor and support each resident's preferences, choices, values and beliefs. 3. The facility will provide care and services for the following activities of daily living: a. Hygiene -bathing, dressing, grooming, and oral care . 4. A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene .		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview and record review the facility failed to ensure the temperature of the medication storage refrigerator was maintained at acceptable temperatures. This deficient practice resulted the exposure of resident medications to temperatures outside of acceptable storage ranges and the potential for reduced efficacy of resident medications. Findings include: During observation of the facility's medication storage room on 6/10/26 at approximately 8:50 a.m., in the presence of Registered Nurse (RN) G, the medication refrigerator was unlocked and the contents observed. No refrigerator medication log was found in the medication room. RN G looked in the medication refrigerator for a thermometer without results. This Surveyor located the thermometer on the second shelf toward the back of the refrigerator, between stored medications. The thermometer was difficult to read but appeared to show a temperature of 34 degrees Fahrenheit (F.), moving higher as held up to 36 degrees. RN G pulled the thermometer out of the refrigerator into the room air, reading a temperature of 38 degrees F. No temperature log for the medication storage refrigerator was found inside the locked medication room. The Refrigerator logs for the past six months were requested. RN G looked through several binders at the nurses' station and asked another nurse where the refrigerator temperature logs were kept in the building. The binder was obtained and only June 2026 refrigerator temperature logs were present in the binder, with temperatures monitored once daily. The medication refrigerator temperature logs for January 2026 through May 2026 were unable to be located prior to survey completion. On 6/10/26 9:22 a.m., RN C provided the [Corporation Name] LTC (Long Term Care) Facility Pharmacy Services and Procedures Manual policy 5.3 Storage and Expiration of Medications, Biologicals, Syringes and Needles, revision Date 1/1/13, which revealed in part: Facility should ensure that medications and biologicals are stored at their appropriate temperatures according to the United States Pharmacopeia guidelines for temperature ranges. Facility staff should monitor the temperature of vaccines twice a day. 11.1 Room Temperature: 59-77 degrees F., Refrigeration 36-46 degrees F. On 6/10/26 at 10:23 a.m., Review of the Maintenance of Medication Storage Areas policy, dated 4/2020, revealed the following, in part: . Refrigerators used for medication storage must have a thermometer monitoring ideal temps 35-46 degrees F. (unless otherwise specified.) Adjust refrigerator setting until thermometer registered is appropriate . Refrigerators with vaccines stored in them require monitoring and recording of temperature 2x a day. On 6/10/26 at 10:44 a.m., Consultant Pharmacist V was asked regarding the [Corporation Name] Medication Storage Policy provided by the facility, dated 2013. Consultant Pharmacist V stated, That is old. Lately we have just been using the CDC (Centers for Disease Control) refrigerator storage policy that says twice a day for refrigerators that contain vaccine. Consultant Pharmacist V was asked to provide a copy of the policy/form regarding appropriate medication storage within the facility, and it was provided via email to this Surveyor. 06/10/2026 11:05 AM Observation of the medication administration room storage fridge with RN G, found the refrigerator to be at a temperature of 32 degrees F. RN G was given the thermometer to read, and agreed the thermometer read 32 degree F. The thermometer was located on the same second shelf of the medication refrigeration as the first detailed observation detailed above. When asked what the concern would be with the medication storage refrigerator at a temperature of 32 degrees F., RN G stated, It is too low. RN G confirmed that when a refrigerator is only checked once a day there is no way to know the time of excursion for medications outside of the recommended medication storage temperature. On 6/10/26 at approximately 11:10 a.m., Assistant (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Director of Nursing (ADON)/RN A entered the medication room and said she was going to turn the refrigerator up. ADON A was asked to provide a list of all medications stored in the refrigerator at this time, following the temperature measured at 32 degrees F. by RN G and this Surveyor. During an interview on 6/10/2026 at 11:15 a.m., the Nursing Home Administrator (NHA) was informed regarding the medication administration room storage refrigerator found with a temperature of 32 degrees F. During an interview on 6/10/26 at 11:40 a.m., ADON A provided a handwritten list of the medications/biologicals/vaccine located within the medication storage refrigerator, which included the following: Three [Consultant Pharmacy] Back-Up Boxes (which included insulins and other medications per ADON A). [Name Brand] intravenous antibiotic. [Name Brand] Nebulizer solution. Pneumococcal [Name Brand] vaccine. Fast-acting and Long-acting insulin. Dulaglutide (diabetic medication) injection. Review of the Instructions for Use for the dulaglutide injection, [Name Brand] long-acting insulin, fast-acting insulin, and pneumococcal vaccine included the following storage instructions, respectively, which included the following, in part: Store your Pen in the refrigerator between 36 F to 46 F (2 C to 8 C). Do not freeze your Pen. If the Pen has been frozen, throw the Pen away and use a new Pen. Store your unused Pen in the refrigerator between 36 F to 46 F (2 C to 8 C). Do not freeze. Do not use if [Name Brand Long-Acting Insulin] has been Frozen. Keep new pens in the refrigerator between 36 F to 46 F (2 C to 8 C). Do not freeze your [Name Brand fast-acting] insulin. Do not use [Name Brand fast-acting insulin] if it has been frozen. Upon receipt, store refrigerated at 2 C to 8 C (36 F to 46 C) ,,, Do not freeze. Discard if the vaccine has been frozen		

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, interview and record review the facility failed to provide palatable food, served at a safe an appetizing temperature, for 8 Confidential Residents of 12 residents reviewed for food palatability. This deficient practice resulted in resident dissatisfaction with being served cold food, and the potential for foodborne illness with potentially hazardous foods served at an unsafe temperature. Findings include: During initial kitchen tour observations on 6/8/26 at approximately 5:25 PM, dietary staff were observed serving food from the steam table. Temperature checks revealed the following: *Hamburgers measured at 119 degrees F (degrees Fahrenheit) on the top of pan and 131 degrees F on the bottom of the pan.*French fries measured 122 degrees F On 6/8/2026 at 6:08 PM, One confidential Resident was observed in her room moving the frenchfries and hamburger around on her plate with a fork. This confidential Resident stated she was moving her food around because it was cold and she didn't want to eat it since it was cold. During a confidential group meeting on 6/9/26 at 2:07 p.m., one of the confidential Residents reported, We need a microwave in our rooms, so we can warm our food up. The food is always cold here. During an observation of dinner in the main dining room on 6/8/26 at 5:20 p.m., one of the confidential Residents was sitting at the same table with this Surveyor and stated, Everything is cold. When asked if their hamburger was cold, they again stated, Everything is cold. The hamburger the French fries, the coffee - they are all cold. The confidential Resident handed this Surveyor a French fry to feel how cold the French fries were. The French fry was cold, greasy and limp to the touch. When the confidential Resident was asked for their meal tray card, they refused and said they didn't want anyone to get in trouble. During an observation in the kitchen on 6/8/26 at approximately 5:35 p.m., Dietary Manager (DM) E was observed removing the tray of French fries from the tray line and placing them in the oven for re-heating. This Surveyor requested the temperature of the French fries placed back in the oven. DM E opened the oven, pulled the French fry tray partially out of the oven and placed the instant read thermometer in the middle of the French fries, The instant read thermometer measured the temperature of the French fries, partially in the oven at 122 degrees Fahrenheit. During interviews in the dining room on 6/8/26 between 5:20 p.m. and 5:31 p.m., four confidential Residents all said their hamburger and french-fries were served to them cold. When two of these confidential Residents were asked about the palatability of their food, both, respectively, said the food was not cold, but it was not hot either. It was room temperature. Review of the Tray and Dining Room Meal Service policy, revised 4/21, revealed the following, in part: POLICY: The Dietary Department will provide accurate, efficient, and consistent meal service . PROCEDURE . 4. Food is to be tasted, and temperatures taken prior to meal service. Any item that does not meet the minimum requirement > (greater than) 135 degrees for hot items, and < (less than) 41 degrees for cold items should be removed and brought to the correct temperature. This may cause (continued on next page)		

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a tray line delay, however, resident safety first and foremost . 6. Food is to be on the steam table no longer than 30 minutes before resident meal service. Cold or frozen foods should remain in the refrigerator/freezer until needed. Milk will be stored in an ice bath during meal service .		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 ensure that hot and cold food items were maintained at safe temperatures during meal service to prevent the risk of foodborne illness for residents. Findings include: During the dinner meal service observation on 6/8/26 at approximately 5:25 PM, dietary staff were observed serving food from the steam table. Temperature checks revealed the following: Hamburgers measured at 119 F (degrees Fahrenheit) on the top of pan and 131 F on the bottom of the pan. French fries measured 122 F Both items were below the required minimum hot holding temperature of 135 F. Additionally, during the same observation, cold food items were noted to be above safe temperature ranges: Pickle spears measured 63.5 F Glass of milk, not stored in ice bath measured 47.2 F Glass of lemonade measured 44.8 F Cup of vanilla pudding measured 50.8 F Cup of strawberries measured 44 F All exceeding the recommended maximum cold holding temperature of 41 F. On 6/8/26 at approximately 5:35 PM, during an interview, Dietary Staff member Q confirmed food temperatures had not been monitored at the steam table. On 6/8/26 as approximately 6:00 PM, Dietary Manager E stated staff are expected to check and document food temperatures before and during meal service to ensure compliance with food safety standards. According to the 2022 FDA Food Code section 3-501.16 Time/Temperature Control for Safety Food, Hot and Cold Holding. (A) Except during preparation, cooking, or cooling, or when time is used as the public health control as specified under S3-501.19, and except as specified under (B) and in (C) of this section, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD shall be maintained: (1) At 57C (135F) or above, except that roasts cooked to a temperature and for a time specified in 3-401.11(B) or reheated as specified in 3-403.11(E) may be held at a temperature of 54C (130F) or above; or (2) At 5C (41F) or less. Review of the facility's policy titled Tray and Dining Room Meal Service indicated. Any item that does not meet the minimum requirement >135 degrees for hot items and <41 degrees for cold items should be removed and brought to correct temperature. Cold or frozen foods should remain in the refrigerator/freezer until needed. Milk will be stored in an ice bath during meal service.		

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. Based on observation and interview, the facility failed to protect the privacy of medical records for one Resident (#21) of one resident reviewed for privacy of medical records. Findings include: Resident #21 (R21) On 6/9/26 at 1:36 p.m., a medication cart was observed near the nurse's station with a facility laptop open. R21's personal health information was observed on the screen with no facility staff present near the medication cart. During a interview on 6/10/26 at 1:50 p.m., Nursing Home Administrator (NHA) reported, I often go around closing laptop screens due to the same issue. it is a problem. Review of policy titled Resident Rights last updated 9/22, read in part Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the residents right to: privacy and confidentiality.		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. 628Based on interview and record review the facility failed to:Provide a bed hold notice for one Resident (#1) of two residents reviewed for hospitalization andSend a copy of the residents written notice of transfer to the Office of the State Long term Care Ombudsman for two Resident's (#1 & #46) of two residents reviewed for hospitalization.Findings include: Resident #46 (R46) During review of R46's EMR, a progress note was documented on 3/28/26 that stated, .Resident was sent out via EMS for slurred speech and change in condition. The Nursing Home Administrator had stated at during an interview on 6/9/26 at 1:12 p.m., that she was unaware of the requirement to notify the Ombudsman of discharges. The NHA was unable to provide an Ombudsman list from March to verify that R46 was on it. Resident #1 (R1) was transferred to the hospital Emergency Department (ED) on 1/5/26. There was no documentation in the Electronic Medical Records (EMR) indicating the resident/responsible party were provided a bed hold notice. There was no documentation in the EMR that the ombudsman was provided with a notice of transfer. Review of an email communication from the Long-Term Care Ombudsman on 6/9/26 at 11:42 a.m., revealed the ombudsman had not received a list of discharges from the facility. During an interview on 6/9/26 at 1:12 p.m., the Nursing Home Administrator (NHA) reported, The facility had not been sending the ombudsman a list of discharges.I didn't know I was supposed to send the ombudsman a list.we do not send a resident or the resident representative a bed hold notice upon transfer to the hospital. During an interview on 6/10/26 at 8:15 a.m., Registered Nurse (RN) G reported, When a resident is sent out to the hospital, we do not give the resident or resident representative a copy of the bed hold notice.they have that information on admission but, we do not provide the bed hold policy or notice upon discharge to the hospital . Review of a policy titled Bed hold last reviewed 1/22, read in part .This policy applies to all residents regardless of payment source and will be provided to the resident or the residents representation at the time of admission and again with any emergency transfer from the community [facility].		

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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** Based on observation, interview, and record review, the facility failed to implement revision to care plans to address necessary care and services provided for two Residents (#4 & #1) of two residents reviewed for care plan revisions. Findings include: Resident #4 (R4) Review of R4's Minimum Data Set (MDS) assessment, dated 3/20/26, revealed R4 was re-admitted to the facility on [DATE], with active diagnoses that included the following, in part: renal failure, diabetes mellitus, and hyperlipidemia (high cholesterol). R4 Scored 15 out of 15 on the Brief Interview for Mental Status (BIMS), reflective of intact cognition. R4 was documented as receiving a therapeutic diet while a resident in the facility. During an interview on 6/8/26 at 6:40 p.m., when asked about their satisfaction with food in the facility, R4 said not enough food was being served, and noted that she received one hamburger patty for dinner that evening, served with a bun and French fries. R4 had a diagnosis of diabetes and said she does not eat bread or fries and only had one hamburger patty that she consumed. Review of R4's Nutritional Care Plan revealed the following, in part: Approach Date (for all interventions listed below) dated 2/9/2021. Diet as ordered. Honor food preferences within acceptable dietary limits for [R4's] quality of life concerns . Medications as ordered. Monitor FAR (Food Acceptance Record) . Observe tolerance to diet, make adjustments PRN (as needed). Offer substitutions if consumes < (less than) 50% (percent) of meal. RD to review PRN. During an interview on 6/10/26 at 12:55 p.m., Dietary Manager (DM) E was asked about R4's prescribed diet. DM E looked at R4's lunch dietary tray card and said R4's diet was a regular diet with extra protein. The tray card was documented with Regular, ExPro. DM E stated, I didn't know [R4] was supposed to get double protein. I will change that right now. DM E acknowledged R4 did not get double protein on her lunch tray which consisted of spaghetti with meat sauce, garlic bread and zucchini, and agreed that because the diet was not documented as Diet Regular/Double Protein/Thin liquids, R4' had not received double protein as ordered for approximately 2 months. (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235519	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/10/2026
NAME OF PROVIDER OR SUPPLIER King Nursing & Rehabilitation Community		STREET ADDRESS, CITY, STATE, ZIP CODE 2280 Tower Hill Road Houghton Lake, MI 48629	
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	Review of R4's Physician Order, dated 3/30/26, revealed the following: Diet regular/double protein, thin liquids. The order was signed by a physician on 4/5/26 and was also found in the Electronic Medical Record (EMR) listing of physician orders. This newly prescribed dietary order (as of 3/30/26) was not added to R4's care plan to provide resident-specific instructions and interventions as appropriate for the resident's care needs. Review of the Tray and Dining Room Meal Service policy, revised 4/21, revealed the following, in part: Policy: The Dietary Department will provide accurate, efficient, and consistent meal service. Trays will be checked for accuracy at each meal. Resident#1 (R1) Review of R1's MDS dated [DATE], revealed admission to the facility on [DATE] with diagnoses that included hip fracture. R1 scored 3 of 15 on the BIMS assessment reflective of severe cognitive impairment. Review of document titled Safety Events&mdash;Fall events revealed, Event Date: 1/5/26. Evaluation Notes: Resident took herself to the bathroom and she was coming back to sit in the wheelchair. she stated that she tripped and fell on her right hip. resident was complaining of severe hip pain and stated I think I broke my hip. the nurse called EMS. hospital called and resident does have a fractured right hip. Review of R1's care plan did not reveal any interventions or revisions from the fall. During an interview on 6/10/26 at 8:58 a.m., RN/MDS C reported, There is no revision or interventions to R1's care plan following the fall that occurred on 1/5/26. During an interview on 6/10/26 at 1:50 p.m., the Nursing Home Administrator (NHA) acknowledged the care plan should be reviewed/revised with interventions following a fall with major injury. Review of policy titled. Resident Incident/Accident Reporting Protocol last reviewed 1/25, read in part. Following an incident/accident event, the charge nurse shall ensure immediate interventions are in place to prevent re-occurrence. during an investigation, the administrator, DON [Director of Nursing], or designee shall review all documentation or materials related to the event, review at the next AM morning meeting with the Interdisciplinary Team (IDT) on a daily basis for review. and further possible interventions to prevent reoccurrence of incidents. The plan of care will be updated to reflect what interventions were put into place to prevent reoccurrence of incidents.		

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NAME OF PROVIDER OR SUPPLIER King Nursing & Rehabilitation Community		STREET ADDRESS, CITY, STATE, ZIP CODE 2280 Tower Hill Road Houghton Lake, MI 48629	
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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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to implement a restorative nursing program to maintain or improve Range of Motion (ROM) for two Residents (#26 and #42) of two residents reviewed for range of motion. Findings include: Resident #26 (R26) Review of R26's Minimum Data Set (MDS) assessment dated [DATE], revealed admission to the facility on 4/21/26. R26 scored 15 of 15 on the Brief Interview for Mental Status (BIMS) assessment reflective of intact cognition. During an interview on 6/8/26 at 6:46 p.m., R26 reported, I am having difficulty using my hand and feeding myself. I am having difficulty moving or using my hand and am losing strength in my hand. there is no one in restorative therapy helping me with range of motion or improving my strength in my hand. Resident #42 (R42) Review of 42's MDS assessment dated [DATE], revealed admission to the facility on 5/1/26. R42 scored a 8 of 15 on the BIMS assessment reflective of moderate cognitive impairment. During an interview on 6/8/26 at approximately 6:30 p.m., R42 reported, I am having problems with losing strength in my hands and my hands feel weak. I do not work with a restorative nursing program at the facility. During an interview on 6/9/26 at 12:02 p.m., Registered Nurse (RN) M reported, The Director of Nursing (DON) is in charge of the restorative therapy program however, there is no formalized program for restorative therapy, there is no charting regarding restorative therapy notes, and there is no restorative aide. During an interview on 6/9/26 at 12:42 p.m., Physical Therapy Assistant (PTA) O reported, I have never met with the DON regarding the restorative therapy program. I am not aware of a restorative therapy program at this facility. During an interview on 6/9/26 at 1:05 p.m., the Nursing Home Administrator (NHA) reported The DON is supposed to be in charge of the restorative nursing program and there is no one implementing the program at this time. Review of policy titled Overview and Philosophy Restorative Nursing read in part, .Restorative nursing is utilizing the skill and expertise of each discipline to plan, implement, and facility all individual pathways for returning the individual to their highest, practicable, physical, mental, and psychological functional level of well-being .reaching an individual's highest possible level can mean maintain a current level and instituting a program to assure an individual will not diminish. restorative nursing is a planned, systematic program that builds on positive goals from impairment deficits. maintaining at a certain level, preventing deterioration. restorative nursing focuses on restoring or compensating for skills lost through disuse or changes in physiology. restorative nursing seeks to maximize and prolong abilities with specific, measurable objectives.		

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NAME OF PROVIDER OR SUPPLIER King Nursing & Rehabilitation Community		STREET ADDRESS, CITY, STATE, ZIP CODE 2280 Tower Hill Road Houghton Lake, MI 48629	
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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to meet the increased protein needs of one Resident (#4) out of one resident reviewed for their daily nutritional needs. Findings include:Review of R4's Minimum Data Set (MDS) assessment, dated 3/20/26, revealed R4 was re-admitted to the facility on [DATE], with active diagnoses that included the following, in part: diabetes mellitus. R4 Scored 15 out of 15 on the Brief Interview for Mental Status (BIMS), reflective of intact cognition. R4 was documented as receiving a therapeutic diet while a resident in the facility.During an interview on 6/8/26 at 6:40 p.m., when asked about their satisfaction with food in the facility, R4 said not enough food was being served, and noted that she received one hamburger patty for dinner that evening, served with a bun and French fries. R4 said she was diabetic, does not eat bread or fries, and was offered only one hamburger patty which she consumed for dinner that evening.Review of R4's Nutritional Care Plan revealed the following, in part: Approach Date, 2/9/21, Diet as Ordered.Review of R4's Physician Order, dated 3/30/26, revealed the following: Diet regular/double protein, thin liquids. The order was signed by a physician on 4/5/26 and was also found in the Electronic Medical Record (EMR) listing of physician orders. Review of the Tray and Dining Room Meal Service policy, revised 4/21, revealed the following, in part: Policy: The Dietary Department will provide accurate, efficient, and consistent meal service.Trays will be check for accuracy at each meal.On 6/10/26 at approximately 12:30 p.m., R4 was observed eating her lunch tray which included spaghetti with meat sauce, garlic bread and zucchini. R3 was only eating the spaghetti meat sauce and said she would not be eating the pasta or the garlic bread. The spaghetti sauce did not appear to be a double serving of protein.During an interview on 6/10/26 at 1255 p.m., Dietary Manager (DM) E was asked about R4's prescribed diet. DM E looked at R4's lunch dietary tray card and said R4's had a regular diet with extra protein. The tray card was documented with Regular, ExPro. DM E stated, I didn't know [R4] was supposed to get double protein. DM E acknowledged R4 did not get double protein on her lunch tray because the diet was not documented as Diet Regular/Double Protein/Thin liquids on the meal tray card, DM E also acknowledged R4 had not received double protein as ordered for approximately 2 months.		

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the resident/resident representative understood the purpose of binding arbitration agreements (an out of court alternate form of dispute resolution) for two Residents (#43 & #22) of three residents reviewed for arbitration. Findings include: Resident #43 (R43) Review of R43's Minimum Data Set (MDS) assessment dated [DATE], revealed admission to the facility on 4/8/26. Section B: [Hearing Speech and Vision] of the MDS revealed R43 understands with clear comprehension and makes herself understood. Review of document titled [name of facility] Agreement to Resolve Legal Disputes Through Arbitration revealed R43 signed the document on 4/9/26. During an interview on 6/10/26 at 6:52 a.m., R43 reported, I know what binding arbitration is and I don't believe in it. I feel right is right and wrong is wrong and a person should be able to hold people accountable. I have not signed any arbitration here, at least I don't remember signing anything. When I was first admitted to the facility they gave me a bunch of paperwork to sign. All the person did was flip pages and tell me to sign here and sign there. they didn't explain anything. I didn't have time to review the paperwork like I would have liked to and normally would. I trusted them. I just had surgery and there was a lot on my mind. I had just come into a new place and I didn't know anyone, I needed rehab so I could go home, and I was in a lot of pain. I really thought they would have explained what I was signing, but I felt rushed and thought I had to sign it all to be at the facility. During an interview on 6/10/26 at 7:35 a.m., Business Office Manager (BOM) B reported, All the residents or their representatives have signed the binding arbitration agreement and not one person has refused to sign. Resident #22 (R22) Review of R22's MDS assessment dated [DATE], revealed admission to the facility on 4/26/26. Section B of the MDS revealed R22 understands with clear comprehension and makes herself understood. Review of document titled [name of facility] Agreement to Resolve Legal Disputes Through Arbitration revealed R22 signed the document on 4/27/26. During an interview on 6/10/26 at 7:50 a.m., R22 reported, I don't remember much when I first came to the facility. I remember signing papers, but I have no idea what I was signing. I just had a heart attack and remembering things at that time was not a priority. I do not recall signing anything regarding arbitration. During an interview on 6/10/26 at 1:50 p.m., the Nursing Home Administrator (NHA) reported, I have asked BOM B to explain the arbitration agreement and ensure the residents understand what they are signing. the residents should not feel pressured to sign and understand what they are agreeing to regarding arbitration . Review of policy titled Binding Arbitration Agreement Policy last reviewed/revised 3/2026, read in part . When explaining the arbitration agreement, the facility shall: a. Explicitly inform the resident or his or her representative of his or her right not to sign the agreement as a condition of admission to, or a requirement to continue to receive care at, this facility. B. explain to the resident and his or her representative in a form and manner that he or she understands.		