

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235532	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/13/2025
NAME OF PROVIDER OR SUPPLIER Ashley Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 103 West Wallace Street Ashley, MI 48806	

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)
<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake #2579353. Based on observation, interview, and record review the facility failed to ensure fall interventions were implemented for 1 resident (R203) of three residents reviewed for falls resulting in R203 falling from her raised bed to the floor and sustaining a fracture of her femur. Findings include: Review of an admission Record revealed R203 admitted to the facility on [DATE] with pertinent diagnoses which included autism, anxiety, and developmental disorder. Review of current fall Care Plan interventions for R203, with a start date of 3/11/2025, directed staff to utilize a fall mat on the left side of bed and keep bed in lowest position when not providing care. Further review revealed another intervention started 3/8/2025 directed staff to keep frequently used items including the call light within reach while in room. Review of MI-FRI #61119 facility investigation report revealed R203 fell from her raised bed to the floor the afternoon of 7/20/2025 when Certified Nursing Assistant (CNA) J walked away from her bed while providing care and R203 rolled off the bed and onto the floor sustaining a fracture of her right femur. Resident #203 was documented as having a history of being able to roll herself out of bed. During an interview on 8/13/2025 at 9:05 AM, the Nursing Home Administrator (NHA) reported CNA J was educated that you cannot leave the bedside of R203 with the bed elevated. The NHA reported R203 had a history of rolling herself out of bed. Review of CNA J's Discipline Record Form, dated 7/29/2025, revealed .Providing care for resident when stepping out to grab hoyer, bed was still at hip level. Resident fell out of bed and ended in a fracture. Review of R203's nursing Progress Note, dated 7/20/2025 at 6:49 PM, revealed .CENA (CNA) was changing resident and getting her up for lunch, she had a sling under her, bed was mid-way up, the CENA left the room to obtain the lift to get up the resident.the CENA heard a thud and observed resident lying on her R (right) side on the floor. In an observation and interview on 8/13/2025 at 9:38 AM in an empty room, CNA J re-acted R203's fall that occurred on 7/20/2025. CNA J raised the bed to hip level and reported she left the bedside with the bed still raised and walked to the doorway. CNA J stated, Before I got to the doorway, I heard a thud and R203 had fallen to the floor. In an observation on 8/13/2025 at 9:16 AM in R203's room, R203 was in her bed and the call light was on the bedside table and out of reach. In an interview on 8/14/2025 at 9:20 AM, CNA E reported R203's call light should be left within reach as she was able to use her call light. Review of facility policy/procedure Fall Prevention Program, reviewed 6/26/24, revealed .Each resident will be assessed for fall risk and will receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls. provide additional interventions as directed by the resident's assessment. interventions will be monitored for effectiveness. the plan of care will be revised as needed.</p>

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 235532
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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to implement Enhanced Barrier Precautions (EBP) for 1 resident (R203) of 7 residents reviewed. Findings include: Review of an admission Record revealed R203 admitted to the facility on [DATE] with pertinent diagnoses which included autism, anxiety, and gastrostomy. Review of current Care Plan interventions for R203, with a start date of 4/10/2025, revealed R203 was on EBP and directed staff to follow Centers for Disease Control guidelines. Review of R203's Physician's Orders revealed an active order for EBP started 4/8/2025. Further review revealed R203 required tube feedings through a gastrostomy. Review of facility policy/procedure Enhance Barrier Precautions, revised 2/26/2025, revealed .an order for enhanced barrier precautions will be obtained for residents with any of the following. feeding tubes. make gown and gloves available immediately near or outside of the resident's room. PPE (Personal Protective Equipment) is only necessary when performing high-contact care activities. high-contact resident care activities include. dressing, bathing, transferring, providing hygiene, changing linens. In an observation in R203's room on 8/12/2025 at 2:35 PM, Certified Nursing Assistant (CNA) E and CNA I provided incontinence care to R203 without wearing a gown. The signage on the door showed R203 required EBP. In an interview on 8/12/2025 at 3:00 PM, CNA E reported she did not normally work that hall and was not aware R203 required EBP. CNA E reported residents with EBP require gown and gloves when providing care related to the reason for the precautions such as tube feeding. CNA E reported CNAs were not required to use EBP while providing incontinence care. In an interview on 8/13/2025 at 9:31 AM, Registered Nurse (RN) K reported R203 was on EBP because of her tube feeding and CNAs were not required to use EBP because they did not do anything with the tube feeding. The definition of high contact resident care activities from facility signage was reviewed with RN K which stated gown and gloves were necessary when performing close contact care such as incontinence care and transfers for residents in EBP.</p>		