

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  11/13/2025
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)		
F 0600  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.  (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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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> This citation pertains to intake 2621833Based on interview and record review, the facility failed to protect the resident's (Resident #301) right to be free from physical abuse by a resident (Resident #300).Findings:Resident #300 (R300)Review of an admission Record revealed R300 was a [AGE] year-old female, admitted to the facility on [DATE], with pertinent diagnoses which included: major depressive disorder severe along with major neurocognitive disorder due to Alzheimer's disease with behavioral disturbance and Psychotic Mood Disorder including mania and depression with psychotic features (per her psychiatric evaluation note). Review of R300's hospital Discharge Summary Note dated 8/19/25 revealed, .The patient was brought into the ER (emergency room) on 5/6/25 by her sister who reported that the patient has been aggressive and acting out more at home. On day of discharge, the patient was doing fair. There was no hallucinations or suicidal or homicidal ideation or intent. She had no physical agitation or aggression.Review of R300's Electronic Medical Record (EMR) revealed:*08/22/2025 at 2:07 AM, Resident has been physically abusive to staff member and observed calling another resident stupid. Resident educated to not call others names and redirected away from others. R300's Care Plan was updated on 8/22/25 with the problem I exhibit socially inappropriate disruptive behavioral symptoms. I have entitlement behavior and have tendencies of feeling like I am the boss/owner of places that I reside at. I will boss others around; say they are lazy, stupid, or other verbally inappropriate or disrespectful things and the approach to Determine if mood endangers myself or others and intervene; remove other peers if necessary. The Care Plan was not updated with interventions for R300's physically abusive behaviors.*08/27/2025 at 3:11 PM, .Becomes upset with other residents' behaviors.Does not like anyone in her personal space.The facility did not initiate enhanced supervision and R300's Care Plan was not updated with interventions to prevent behavior escalation in regards to other residents' behaviors and protection of her personal space. *On 08/28/2025 at 9:57 AM the physician documented, (R300) was seen due to increased behaviors. She is increasing in threatening behaviors. She is threatening other residents with physical harm. We must adjust medication to manage before she injures another resident, herself or staff. R300's antipsychotic medication (Seroquel) was increased at that time.*On 08/28/2025 at 5:41 PM, R300 was moved from the locked Memory Care Unit to the Main Unit. Staff attempted to place a WanderGuard bracelet on the resident however, when reattempted R300 threatened each time she will knock out the staff or kick them in the F*ck*ng face if they try. R300's Care Plan dated 8/19/25 revealed, I will admit to the MCU (Memory Care Unit) for monitoring of wanderings also preventing me from leaving my area of safety. I may need possible protection devices for safety until further evaluated by nurse/therapy for appropriateness. Created: 08/19/2025. The Care Plan was not updated to reflect that R300 was now on the Main Unit or with interventions for increased supervision/monitoring related to her refusal to wear a WanderGuard.*08/29/2025 at 9:40 AM psychiatric consultant Psychiatry Initial Evaluation note revealed R300 was being seen for depression, agitation, irritability, refusal of care. Staff reports that the patient has been agitated and combative at times, she did recently start yelling at staff.IMPULSE CONTROL- Impulse control is impaired, Patient is agitated and combative at times, Patient has threatened staff and other residents.HOMICIDAL IDEATION- Threatening behavior toward staff and other residents.MOOD- Mood is irritable, Patient easily agitated.*08/29/2025 at 4:46 PM, Resident was going into another resident's room cena (Certified Nursing Assistant) attempted to redirect resident and resident punched cena in the stomach. Aide attempted to redirect resident, but resident was becoming increasingly more agitated. Resident redirected to common area. Resident began threatening staff and threatening to kill others. Physician contacted. New order received for Ativan (antianxiety medication) 1mg po (by mouth) one time dose for aggression/agitation. Confirming R300's behaviors escalated to homicidal threats and entering other resident rooms. Additionally, no long-term medication changes/additions were discussed or initiated at that time. *08/29/2025 at 5:34 PM, R300's Behavior Log revealed, threatening other patients with cutting and catching them on fire.hit staff. The facility did not initiate enhanced supervision and R300's Care Plan was not updated with interventions for physically abusive behaviors, homicidal threats, or increased agitation. *08/30/2025 at 2:25 AM, R300's Behavior Log revealed, res (resident) in others rooms taking things that don't belong to her like food, drinks, clothes, paperwork ect. *On 08/30/2025 a dose of as needed Seroquel 25mg was administered at 9:57 PM for Resident verbally frustrated with other residents.*08/30/2025 at 10:07 PM Statements made by resident: I need scissors to protect myself I wish I had a gun I'm angry as hell</p>		

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F 0607  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft.  (continued on next page)

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> This citation pertains to intake 2621833Based on interview and record review, the facility failed to implement their abuse policy resulting in an allegation of physical abuse to go unreported with no investigation.Findings:Resident #203 (R203)Review of an admission Record revealed R203 was a [AGE] year-old female, admitted to the facility on [DATE].Resident #300 (R300)Review of an admission Record revealed R300 was a [AGE] year-old female, admitted to the facility on [DATE], with pertinent diagnoses which included: major depressive disorder severe along with major neurocognitive disorder due to Alzheimer's disease with behavioral disturbance and Psychotic Mood Disorder including mania and depression with psychotic features (per her psychiatric evaluation note).Review of R300's Progress Note dated 09/03/2025 at 12:47 AM written by Registered Nurse (RN) J revealed, .Writer was called to the East Hallway, stated that this Resident heat (hit [sic]) her room mate (sic) on her L (left) hand, she denies the incident. Indicating an allegation of resident-to-resident abuse with the violence committed by R300. There was no documentation indicating the nurse reported the allegation of abuse to the abuse coordinator.During an interview on 09/24/2025 at 8:00 AM, RN J reported that R300 should have been transferred to the hospital immediately when she started to become physically aggressive and assaulting staff (08/22/2025 was the first documented physical assault against staff members.) RN J reported that R300 was difficult for staff to care for due to her psychiatric symptoms and the level of staff members training. RN J reported that she was not on an adequate amount of medication to manage her behaviors and only one medication change was instituted while she was at the facility. RN J reported that she was physically abusive from day one and her behaviors progressively worsened. RN J reported that R203 reported that R300 had hit her hand but there was no witness to the alleged physical abuse. RN J reported that R300 was physically abusive to staff but had never physically assaulted any residents up to that point. RN J reported that R300 and R203 had a good report and R203 would refer to R300 as grandma so she did not believe the physical assault had occurred but documented it in R300's Progress Note as a reference in case something came of it. Further explaining that she was going to keep an eye on R203's left hand and if she identified an injury over her shifts she would have reported it to the required people. During an interview on 09/24/2025 at 8:26 AM, Nursing Home Administrator (NHA) reported she had not been made aware of the allegation of resident-to-resident abuse between R300 and R203 on 09/03/2025. NHA reported the expectation was for staff to immediately report any allegation of resident abuse. During an interview via email on 0 9/24/2025 at 4:24 PM, NHA provided a follow up Witness Statement related to the allegation of abuse between R300 and R203.Review of Registered Nurse (RN) J's Witness Statement transcribed by RN A and received on 9/24/25 revealed, I contacted (RN J) via phone on to clarify and get information related to Progress note in the chart of (R300) on 09/03/2025 at 12:47 AM. (RN J) stated (R300) frequently doted on (R203) playing with her with her toys, trying to take care of her, helping her, and talking to her. She stated upon arriving at the residents shared room after being notified that the resident hands had come in contact. She states she asked (R300) if she had hit the resident's hand, which the resident denied. (R203) resident then stated She hit my hand and started laughing. (RN J) then assessed resident with no marks, redness, injury noted. (RN J) asked the resident if it hurts and (R203) continued laughing. Resident (R203) will cry if there is a problem. (RN J) stated she felt they were playing and spending time together like they have done in the past. (RN J) stated that (R203) called (R300) grandma and they have a very play (sic) relationship. She did not feel there was any abuse that occurred and encouraged (R300) to go to her side of the room and go to bed as it was middle of night. (RN J) felt this was the 2 residents spending time together and playing. When asked why she did not put this information in the chart (RN J) stated she thought that would be too much information.Review of the facility policy Abuse, Neglect and Exploitation implemented 11/1/22 (no review/revision date) revealed: Physical Abuse includes, but is not limited to hitting, slapping, punching, biting, and kicking. It also includes controlling behavior through corporal punishment. Alleged Violation is a situation or occurrence that is observed or reported by staff, resident, relative, visitor or others but has not yet been investigated and, if verified, could be indication of noncompliance with the Federal requirements related to mistreatment, exploitation, neglect, or abuse, including injuries of unknown source, and misappropriation of resident property.Policy Explanation and Compliance Guidelines: 1. The facility will develop and implement written policies and procedures that: a. Prohibit and prevent abuse b. Establish policies and procedures to investigate any such allegations; and c</p>		