STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235532	A. Building B. Wing	02/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ashley Healthcare Center	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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to recognize, assess and respond to an acute change of condition for 1 (R29) resident of 2 residents reviewed for change of condition. Findings include:Review of an admission Record revealed R29 originally admitted to the facility on [DATE] with pertinent diagnoses which included dementia, psychotic disturbance, anxiety, and insomnia. Review of a Minimum Data Set (MDS) (a tool used for assessing a resident's care needs) assessment for R29, with a reference date of [DATE] revealed a Brief Interview for Mental Status (BIMS) (a scale used to determine a resident's cognitive status) score of 13, out of a total possible score of 15, which indicated R29 was cognitively intact. Further documentation revealed was there evidence of an acute change in mental status from the resident's baseline, marked yes. Review of a Resident Code Status dated [DATE] revealed R29 was a Full code (Full resuscitation and life sustaining treatment desired). Review of a Hospice Comprehensive Assessment Plan of Care Update Report dated [DATE], revealed Advance directives - full code. Review of a Care Conference dated [DATE] and [DATE] revealed R29 would continue as a full code. Review of R29's Progress Note dated [DATE] at 12:28 AM revealed .at 1912 called (local) hospice r/t (related to) resident nonresponsive, VS 97.5-54-136/77-92%-15, they are attempting to get ahold of her son regarding her code status, they will continue to work on this, hospice stated if we have to send her to hos (hospital) d/t (due to) coding we can send her. Review of R29's Progress Note dated [DATE] at 9:48 AM revealed .Resident received shower from hospice aide. No new skin issues noted. Resident noted to be very lethargic. Bed linens changed. Review of R29's Progress Note dated [DATE] at 5:41 PM revealed .Resident not eating much during meals. Resident changed to assisted feed, and resident ate greater then 75% for dinner. Hospice notified. Review of R29's Progress Note dated [DATE] at 6:39 PM revealed .Resident has been difficult to arouse, able to arouse enough take medications this morning. Nutritional and fluid intake poor during shift. Resident resting quietly in bed with no s/s (signs and symptoms) of discomfort noted. Turned and repositioned q2hrs and PRN (as needed), check and change, incontinent of bowel and bladder. Review of R29's Progress Note dated [DATE] at 5:09 AM revealed .Resident slept throughout shift, was able to get medications in. however was difficult to arouse. no other oral intake throughout shift. Review of R29's Progress Note dated [DATE] at 12:32 PM revealed .Writer called RP (responsible party), Son and left message to talk with resident regarding code status and declining condition. Await return call. Review of R29's Progress Note dated [DATE] at 6:32 PM revealed .Resident has not been responsive during shift. Very little fluids accepted as resident is not responsive enough to swallow fluid. Tried some thickened liquids also and unable to swallow. Respirations shallow, mouth open, mouth breathing. Resting quietly and comfortably, turned and repositioned Q 2-hr and PRN. Called Hospice to inform them of resident's current condition and code status. Hospice nurse stated she was aware of full code status and understands if resident has to be sent out to go ahead and do so and keep them informed. Information communicated with oncoming (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	nurse. No return call from RP as of this time. Review of R29's Progress Note dated [DATE] at 12:31 AM revealed .at 1900 spoke with her son regarding her decline in her condition and code status, she appeared to be actively dying, unable to hear her B/P (blood pressure), educated him about the CPR that it would entail breaking her ribs and then there is a possibility she will die anyway, he stated to keep her a full code and do CPR on her, explained she would be sent out to the hospital, he stated ok, resident was non responsive, couldn't hear her B/P, and her breathing was 40, called ambulance, (local fire department) came and evaluated her first, then (local ambulance service) came and transported her to (local hospital) at 1945, [NAME] nurse spoke with ER at midnight and she is intubated and being taken to ICU. Review of R29's Vital Sign Record revealed vital signs obtained on [DATE], [DATE], [DATE], [DATE], [DATE], which were noted to be within normal limits. There were no other records that revealed vital signs or assessments in R29's Electronic Medical Record (EMR). Review of R29's hospital Chief Complaint-Reason for Admission dated [DATE] revealed .has been actively dying over the past 2 days with agonal respiration (gasping irregular breaths) and tachycardia (fast heartbeat over 100 beats per minute) on hospice and was brought to the emergency department for altered mental status. ED (Emergency Department) physician contacted the patient's son who resides in (out of state) and the son indicated that he wishes full resuscitation and intubation mechanical ventilation support and the patient was intubated. (R29) was found in respiratory failure and intubated and was found to have right lower lobe pneumonia with thick secretions suctioned and also tested positive for Covid-19 infection. (R29) was found to have severe acidosis (too much acid in body fluids) with hyperkalemia (high potassium levels in the blood) and admitted to intensive care unit with septic shock started on Intravenous fluid and broad-spectrum antibiotic. In an interview and record review on [DATE] at 1:47 PM, the Director of Nursing (DON) stated that R29's condition went back and forth. The DON reviewed progress notes from [DATE] and stated she was unsure why staff would not have sent R29 to the hospital on [DATE] after hospice directed the transfer if R29's condition required it. Upon review of R29's EMR, the DON was unable to locate any documentation of an acute assessment for R29 or acute monitoring for a change of R29's condition. R29 was unresponsive on [DATE] with continued decline until transfer to the hospital on [DATE]. R29's vital signs were taken 5 times within that 14-day period. The DON stated the facility needed to start an SBAR (situation-background-assessment-recommendation) program (used to ensure concise, accurate, and rapid information exchange during critical situations, handoffs, or shifts) and put acute residents with condition changes on a watch list and if the resident needs to be sent to the hospital for treatment the facility should do so. When asked if there should have been acute documentation and a transfer sooner than [DATE] for R29, the DON stated yes. Review of facility policy/procedure Change in a Resident's Condition or Status, revised [DATE] revealed .the nurse supervisor/charge nurse will notify the resident's family or representative when.it is necessary to transfer the resident to a hospital.will promptly notify the resident, his or her attending physician, and representative of changes in the resident's medical condition.