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

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to accurately document the code status for 1 resident (R18) of 1 resident reviewed for advance directives.Findings include:Review of an admission Record revealed R18 admitted to the facility on [DATE] with pertinent diagnoses which included paranoid schizophrenia and dependence on supplemental oxygen. Further review revealed he had a court appointed guardian.Review of R18's Care Conference Report note, dated 1/7/2026, revealed he planned to continue as full code status (full resuscitation and life sustaining treatment).Review of R18's Resident Code Status form, signed by his court appointed guardian 6/27/2025, revealed he wished to be full code.Review of R18's Physician's Orders, active 2/23/2026 revealed an order for R18 to be DNR (Do Not Resuscitate).In an interview on 2/23/2026 at 2:25 PM, Registered Nurse (RN) K stated I think he (R18) is full code. RN K then viewed his Medication Administration Record alert and Physician's Orders and reported he was DNR.In an interview on 2/23/2026 at 2:30 PM, R18 reported he wished his heart to be started if it stopped.In an interview on 2/23/2026 at 2:36 PM, the Director of Nursing (DON) reviewed R18's Physician's Orders and Resident Code Status form and reported the order was probably placed incorrectly as DNR because R18 should be full code. The DON reported the Physician's Order for DNR was placed by Minimum Data Set (MDS) RN D.In an interview on 2/23/2026 at 2:44 PM, MDS RN D reviewed R18's Resident Code Status and stated, I must have placed this incorrectly.Review of facility policy/procedure Communication of Code Status, reviewed 1/7/2026, revealed .this facility will implement procedures to communicate a resident's code status to those individuals who need to know this information.

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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the discharge needs were met for 1 resident (R23) of two residents reviewed for discharge concerns. Findings include:Review of an admission Record revealed R23 admitted to the facility on [DATE] with pertinent diagnoses which included type II diabetes mellitus, major depressive disorder, and hoarding disorder. Review of a Minimum Data Set (MDS) (a tool used for assessing a resident's care needs) assessment for R23, with a reference date of 10/11/2025 revealed a Brief Interview for Mental Status (BIMS) (a scale used to determine a resident's cognitive status) score of 15, out of a total possible score of 15, which indicated R23 was cognitively intact. In an interview on 2/23/26 at 10:00 AM, R23 reported that she did not belong at the facility. R23 stated she was quite a distance from her home, and she had requested multiple times that she would like to move closer to where her family resides, possibly in a senior apartment. R23 reported that she visited with the staff and felt like there were no alike residents to talk to in the facility. R23 reported that in the past she had requested her guardian to be dissolved through the court system and she was appointed a different guardian. R23 stated she had not seen her new guardian face to face since the guardian was appointed (11/11/25). R23 stated my rights are being violated. Review of a Point of Care History documentation revealed that between 1/1/2026 and 1/31/2026 R23 was independent for bed mobility, transfers, ambulation, movement on and off the unit, dressing, eating, toileting, and bathing. In an interview and record review on 2/24/26 at 2:09 PM, the Director of Nursing (DON) stated that there were some concerns for R23 that discharge planning had not been started or discussed at a facility level. R23 had voiced to facility staff her wishes to discharge near her home or a senior living apartment. DON stated that R23 was independent in her room and able to complete daily tasks independently. DON stated that R23 self-administers medications and can manage her diabetic device for blood sugar checks without difficulty. Review of a Care Conference dated 9/10/2025 and 1/7/2026 Social Work Tech (SWT) A documented R23 intends to transfer to a facility closer to home. In an interview and record review on 2/24/26 at 2:51 PM, SWT A responded nothing when asked what had been completed toward the discharge planning for R23 to move closer to her home or to a senior apartment. SWT A stated that they had told her not to start the discharge process for R23. When asked who they were SWT A stated the court or the independent medical examiner that was assisting in R23's case. SWT A could not locate documentation for R23's case and could not locate documentation to show that R23 was not capable of being discharged to a facility closer to her home or to a senior apartment. SWT A stated the process for resident discharge planning started in the facility's morning meeting and the team discusses residents that are ready for discharge. SWT A stated I have not been told to begin discharge planning for this resident. SWT A asked if she should have had follow up notes related to discharge planning for R23, SWT A stated yes. Review of facility Job description Social Work Tech revealed .Job summary.assists team members with discharge planning activities.Core responsibilities. to begin discharge planning for residents on admission and ongoing, working with all aspects of the interdisciplinary team to ensure an appropriate and safe resident discharge. In an Interview and record review on 2/24/26 at 3:04 PM, the Nursing Home Administrator (NHA) stated common sense would indicate that R23 should be reevaluated for the opportunity to live independently. The NHA stated the facility needed to reach out to the guardian and ask if the facility could look at other avenues for R23. The NHA was unable to locate documentation that R23 could not re-locate closer to home or be assessed for a senior living apartment. The NHA attempted to reach out to R23's guardian with no answer and a voicemail box that was already full. The NHA stated that it is the facility's due diligence to reach out to the guardian to express R23's wishes. Review of facility policy/procedure Discharge Planning Process, revealed .Discharge planning is a process that (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	generally begins on admission and involves identifying each resident's discharge goals and needs, developing and implementing interventions to address them, and continuously evaluating them throughout the resident's stay to ensure a successful discharge.if discharge to community is determined to not be feasible, the facility will document in the clinical record who made the determination and why.in cases where the resident wishes to be discharged to a setting that does not appear to meet his or her post-discharge needs, or appears unsafe, the interdisciplinary team will treat this situation similarly to refusal of care: a. Discuss with the resident, (and/or his or her representative, if applicable) and document the implications and/or risks of being discharged to a location that is not equipped to meet his/her needs and attempt to ascertain why the resident is choosing that location. b. Offer other, more suitable options of locations that are equipped to meet the needs of the residents. Document any discussions related to the options presented. c. Document refusals of other options that could meet the resident's needs.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to implement a patient centered care plan for pain and pressure ulcers for 1 Resident (R1) of 13 residents reviewed for care plans.Findings included: Review of R1's undated face sheet, revealed he was a [AGE] year-old male admitted to the facility on [DATE] and had diagnoses that included: osteomyelitis, pressure ulcer of right upper back, urinary tract infection, diabetes mellitus, morbid (severe) obesity, chronic pain, and pressure ulcer of unspecified part of back, unstageable. He was his own responsible party.During an interview with R1 in his room on 1/23/26 at 1:20 PM, R1 complained about staff not getting him placed correctly in bed. R1 said he is 6 feet tall, and staff do not get him high enough into bed. R1 was sitting in a recliner next to his bed during this interview. R1 said when staff put him on the bed his butt is not placed high enough for him to bend properly and it causes more pain to his tailbone. R1 said staff do not listen or assist him to become more comfortable. R1 said he would go back to bed more often if staff would listen and help him the way he wanted to be helped. R1 said he has a pressure ulcer on his back and coccyx.R1 was observed being transferred from his wheelchair to his bed with a full body lift on 2/23/26 at 2:28 PM. R1 required the assistance of 3 people, Certified Occupational Therapist Assistant (COTA) F, Registered Nurse (RN) D and Certified Nurse Aide (CNA) J. R1 yelled in pain with all movement and could not tolerate lying flat in bed or on his left side. R1 again reported he cannot stay in bed due to severe pain. He is only able to be comfortable sitting or on his right side when in bed. He reported transferring is extremely painful. COTA F said she had just started educating staff on how to transfer R1 on 2/20/26. R1 said staff did not transfer him as COTA F had directed staff to on 2/20/26 over the weekend. COTA F denied notifying R1's physician that he could not tolerate lying on his back, left side and unbearable pain with transfers.R1 was observed in bed lying on his right side on 2/26/26 at 8:10 AM. R1 reported he went to bed around 2:00 AM. R1 reported he was frustrated because staff did not get him up for breakfast or change his brief after he was placed in bed at 2:00 AM. R1s' room smelled like urine and his top sheet and bottom sheet were wet in the area around his brief. R1 said he cannot eat in bed because he cannot be on his back in bed.During an interview with Certified Nurse Aide (CNA)H on 2/26/26 at 8:15 AM in the main dining room, CNA H confirmed she was assigned to R1 this morning since 6:00 AM. CNA H reported she was not aware R1 wanted to be out of bed for breakfast. CNA H was asked about R1's care plan related to his preferences and times he wanted to be out of bed. CNA H said R1's care plan did not indicate he wanted to be up. CNA H went to get CNA I and Unit Manager (UM) B to assist her getting R1 out of bed. When they got to his room R1 said he wanted to have his pain medication prior to getting out of bed. R1 said when he moves it feels like 10,000 volts of electricity going from his back to his legs. UM B said R1's nurse was on the locked unit and would need to be notified of R1's request for medicationOn 2/26/26 at approximately 8:45 AM, the DON, CNA H and I transferred R1 from his bed to the recliner in his room with a full body electronic lift. R1 assisted with rolling in bed, by grabbing the bed rails to roll. R1 reported he required the head of his bed to elevate approximately 30 degrees due to intolerable pain when he was flat in bed. During the transfer R1 was observed yelling about pain with all movement.During an interview with the Director of Nursing (DON) on 2/24/26 at 12:29 PM, R1's pain concerns were discussed. The DON said when she reviewed R1's pain medication orders she discovered he was not taking all his prn (as needed) pain medications and confirmed R1 has times of confusion and may not know when he is able to have his next dose of pain medication. The DON confirmed they had not met with R1 and discussed his pain medication schedule needs or made attempts to provide medication related to his mobility needs.Review of R1's care plan revealed there were no specific instructions for transfers, no indication of R1's tolerance or preference for positioning or eating meals in his chair. There was no care plan in place for skin or pressure ulcers (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	until after the survey started. R1 pain control was not addressed in his care plan. R1's preferences for pressure relief and positioning were not addressed in his care plan.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to follow physician orders to treat and monitor health conditions for 1 Resident (R2) of 1 Resident reviewed for medical complaints.Findings included: Review of R2's undated face sheet, revealed he was a [AGE] year-old male admitted to the facility on [DATE] and had diagnoses that included: mild cognitive impairment, atypical facial pain, post-traumatic stress disorder and mild neurocognitive disorder. R2 was not his own responsible party.During an interview with R2 on 2/23/26 at 11:38 AM, R2 complained about his right ear hurting and buzzing. R2 said he has reported it to staff, but nothing is being done about it.During an interview with facility Social Worker (SW) A, SW A said R2 had complained about his ears ringing sometime in the last week. The Surveyor requested information on how the facility followed up with R2's concerns about his right ear.On 2/24/26 at 1:08 PM, Social Worker A provided a note form R2's physician dated 1/14/26, noting R2 had ear pain and ordered for R2's ear to be irrigated.Review of a handwritten note dated, 1/14/26 for R2 revealed, Resident complaint of pain - right ear/right neck after completing ABT/PO (antibiotic orally) and debriding of ear wax in ER/hospital. Requesting re-evaluation of right ear/right neck pain. Under Doctor Recommendation was written, Ear wax present, ok to irrigate ear. Signed by R2's physician on 1/15/26.Review of R2's physician orders revealed, 1/20/26, May irrigate rt (right) ear for s/s (signs and symptoms) of discomfort as needed.During an interview with Unit Manager (UM) B on 2/24/26 at 1:12 PM, UM B reviewed R2's order for his ear to be irrigated dated 1/20/26. UM B could not find any documentation in R2's medical record that staff had followed the physician order to irrigate R2's right ear. UM B said the order was still current and she would have staff address R2's right ear discomfort.On 2/24/26 at 1:12 PM, UM B asked Registered Nurse (RN) G to check R2's ears. RN G initially could not find a functional otoscope on the nursing unit. Once a functional otoscope was secured RN G checked both of R2's ears and they were both full of old wax. RN G reported he would get orders to treat R2's wax build up in both ears and after the wax was softened, he would irrigate his ears.

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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 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 (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to thoroughly assess skin on admission, do ongoing assessments, implement an effective treatment plan, and prevent the worsening of pressure ulcers for 1 resident (R1) of 2 residents reviewed for pressure ulcers, resulting in the worsening of a pressure ulcer.Findings included:A review of R1's face sheet, no date, revealed he was a [AGE] year-old male admitted to the facility on [DATE] and had diagnoses that included osteomyelitis, pressure ulcer of the right upper back, urinary tract infection, diabetes mellitus, morbid (severe) obesity, chronic pain, and pressure ulcer of an unspecified part of the back, unstageable. He was his own responsible party.During an interview with R1 in his room on 1/23/26 at 1:20 PM, R1 complained about staff not getting him placed correctly in bed. R1 said he is 6 feet tall, and they do not get him high enough into bed. R1 was sitting in a recliner next to his bed during this interview. R1 said when staff put him on the bed, his butt is not placed high enough for him to bend properly, and it causes more pain to his tailbone. R1 said staff do not listen to him and assist him to become more comfortable. R1 said he would go back to bed more often if staff would listen to him and help him the way he needs to be helped. R1 said he has a pressure ulcer on his back and coccyx.R1 was observed being transferred from his wheelchair to his bed with a full body lift on 2/23/26 at 2:28 PM. R1 required the assistance of 3 people: Certified Occupational Therapist Assistant (COTA) F, Registered Nurse (RN) D and Certified Nurse Aide (CNA) J. R1 yelled in pain with all movement and could not tolerate lying flat in bed or on his left side. R1 again reported he cannot stay in bed due to severe pain. He is only able to be comfortable sitting or on his right side when in bed. He reported transferring is extremely painful. He expressed frustration because of the way staff transferred him and did not listen to him, which was preventing him from going back to bed more often. COTA F said she had just started educating staff on how to transfer R1 on 2/20/26. R1 said staff did not transfer him as COTA F had directed staff to on 2/20/26 over the weekend. COTA F denied notifying R1's physician that he could not tolerate lying on his back, left side, and unbearable pain with transfers. COTA F had not implemented a care plan for R1's transfer needs.R1 was observed in bed lying on his right side on 2/26/26 at 8:10 AM. R1 said he went to bed around 2:00 AM. R1 was frustrated because staff did not get him up for breakfast or change his brief after he was placed in bed at 2:00 AM. R1's room smelled like urine, and his top sheet and bottom sheet were wet in the area around his brief, and the outer edge of the wet spot was a light brown color. The wet area was greater than 12 inches around. R1 said he cannot eat in bed because he cannot be on his back in bed.During an interview with Certified Nurse Aide (CNA) H on 2/26/26 at 8:15 AM in the main dining room, CNA H confirmed she was assigned to R1 this morning since 6:00 AM. CNA H reported she was not aware R1 wanted to be out of bed for breakfast. CNA H said R1's care plan did not indicate he wanted to be up for breakfast. CNA H went to get CNA I and Unit Manager (UM) B to assist her in getting R1 out of bed. When they got to his room, R1 said he wanted to have his pain medication prior to getting out of bed. R1 said when he moves, it feels like 10,000 volts of electricity are going from his back to his legs. UM B said R1's nurse was on the locked unit and would need to be notified of R1's need for medication. UM B left the room and returned with pain medication after the Director of Nursing (DON) did the dressing change on R1's coccyx.On 2/26/26 at approximately 8:30 AM the Director of Nursing (DON) came in and changed the dressing on R1's coccyx and said the wound measured 2.0 x 0.3 x 0.1 cm. She said she would do the wound on the back of his right shoulder when he was up in his chair.On 2/26/26 at approximately 8:45 AM, the DON, CNA H and I transferred R1 from his bed to the recliner in his room with a full-body electronic lift. R1 assisted with rolling in bed by grabbing the bed rails to roll. He required the head of his bed to elevate approximately 30 degrees when he was on his back due to intolerable pain when he was flat in bed. He yelled out in pain with all movement.On 2/26/26 at 11:00 AM Unit Manager (UM) B came in and changed the dressing on R1's back near his right shoulder. The (continued on next page)

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	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

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	old dressing was not dated. UM B measured the wound and said it was 3.5 cm x 3.0 cm.Review of R1's Observation Detail List Report dated 1/27/26 at 05:15 PM revealed on page 11, Number and describe each pressure ulcer 'injury,' Stage 1 on coccyx x 3 cm. There was no indication of a pressure ulcer on his back. R1's face sheet indicates he had a pressure ulcer on his back on admission.Review of R1's Weekly Skin Assessment, dated 1/28/26 at 10:41 AM, revealed the box No identified concerns was checked.Review of R1's progress note dated 1/31/26 at 3:19 PM revealed, Upon changing the resident this morning, the CNAs (Certified Nurse Aides) noted an open area to the resident's coccyx. The area measures 3.4 cm x 0.8 cm x 0.1 cm. No odor, no drainage, no tunneling, no undermining, Peri skin is intact and pink.A review of R1's progress note dated 2/6/26 at 15:27 (3:27 PM) revealed, Wound NP (Nurse Practitioner) in to see resident and evaluate wounds on rt (right) back/shoulder and coccyx. Rt (right) shoulder wound measuring 5.0 x 5.0 x 0.1 cm. Noted light serous drainage with no presence of odor. New tx (treatment) order to cleanse wound with wound cleanser, pat dry apply Hydro [NAME] Blue to wound bed and cover with boarder foam dressing. X3 weekly and PRN. Wound sacrum measuring 2.0 x 0.7 x 0.1 cm, light amount of serous drainage, peri wound with noted peeling skin. Tx (treatment) order to cleanse area with wound cleanser, pat dry apply Hydro Ferr Blue to wound bed and cover with boarder foam gauze. Resident aware of wounds and is agreeable to treatment orders.A review of R1's progress note dated 2/25/26 at 8:43 AM revealed, Wound observed on coccyx measuring 2.0 x 0.3 x 0.1 cm. Wound bed open, pink in nature, slit to coccyx with no presence of drainage, Peril wound intact, normal in color, with dry flakey skin surrounding. Treatment administered placing hydro [NAME] blue on wound bed, cover with boarder foam dressing.A review of R1's care plan revealed there were no specific instructions for transfers and no indication of R1's tolerance or preference for positioning or eating meals in his chair. There was no care plan in place for skin or pressure ulcers until after the survey started.During an interview with the Director of Nursing (DON) on 2/23/26 at 1:22 PM, the DON said R1's wound on the back of his right shoulder and buttock was present on admission. The DON reviewed R1's Electronic Medical Record (EMR) and could not locate measurements on admission or weekly measurements. When R1 entered the facility, they were using a different EMR's. The DON said they normally have residents reviewed weekly by an outside company providing wound services, and she was aware R1 had refused some treatment. A request for all wound measurements and wound treatment refusals, physician notification of refusals, and education related to refusing wound treatment was made. During an interview with the Nursing Home Administrator (NHA) on 2/25/26 at 1:32 PM, the NHA could not locate any wound measurements for the wound on the back of R1's right shoulder from admission to prior to the start of the survey. The NHA found one measurement of R1's coccyx pressure ulcer done on admission indicating it was stage 1 and measured 3 cm. Upon exit, the NHA also located coccyx wound measurements for 1/31/26 and 2/6/26. NHA could not locate education or refusal documents related to R1's wound care that had been done prior to this survey.Review of the facility, Pressure Injury Prevention and Management policy dated 11/1/2022 revealed, 3. Assessment of Pressure Injury Risk. A. Licensed nurses will conduct a pressure injury risk assessment, using the (fill in blank for designated tool), on all residents upon admission/re-admission, weekly x four weeks, then quarterly or whenever the resident's condition changes significantly. C. Licensed nurses will conduct a full body skin assessment on all residents upon admission/readmission, weekly and after any newly identified pressure injury. Findings will be documented in the medical record. 4. Interventions for Prevention and Promote Healing. A. After completing a thorough assessment/evaluation, the interdisciplinary team shall develop a relevant care plan that includes measurable goals for prevention and management of pressure injuries with appropriate interventions.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review the facility failed to assess, monitor and implement a respiratory care plan for 1 Resident (R1) on Continuous Positive Airway Pressure (CPAP). Findings include: Review of R1's face sheet, no date, revealed he was a [AGE] year-old male admitted to the facility on [DATE] and had diagnoses that included: osteomyelitis, pressure ulcer of the right upper back, urinary tract infection, diabetes mellitus, morbid (severe) obesity, chronic pain, and pressure ulcer of unspecified part of back, unstageable. He was his own responsible party. During an interview conducted on 1/23/26 at 1:20 PM in his room, R1 complained that the facility never cleaned his CPAP machine or provided cleaning equipment or supplies. Review of R1's medical record did not reveal a physician order for the use of the CPAP machine or its care and cleaning. Further review of the medical record did not reveal a respiratory care plan for the use and care of the CPAP machine or ongoing respiratory assessments. Review of the Treatment Administration Record (TAR) section of the medical record did not reveal scheduled care or maintenance of the CPAP machine belonging to R1. During an interview conducted 2/25/26 at 2:20 PM, the Director of Nursing (DON) confirmed R1 should have had physician's orders for his CPAP machine. The DON reported that the facility normally placed cleaning and use orders in the TAR. The DON acknowledged they failed to ensure R1 had physician orders in place of R1's CPAP machine. Review of the facility's CPAP/BiPAP Cleaning policy dated 11/2/2022 revealed, It is the policy of this facility to clean CPAP/BiPAP equipment in accordance with current CDC guidelines and manufacturer recommendations in order to prevent the occurrence or spread of infection. The policy continued with a list of Weekly cleaning activities.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review, the facility failed to adequately treat 1 Resident (R1) for pain of 1 Resident reviewed for pain.Findings included: Review of R1's undated face sheet, revealed he was a [AGE] year-old male admitted to the facility on [DATE] and had diagnoses that included: osteomyelitis, pressure ulcer of right upper back, urinary tract infection, diabetes mellitus, morbid (severe) obesity, chronic pain, and pressure ulcer of unspecified part of back, unstageable. He was his own responsible party.During an interview with R1 in his room on 1/23/26 at 1:20 PM R1 complained about staff not getting him placed correctly in bed. R1 said he is 6 feet tall, and staff do not get him high enough into bed. R1 was sitting in a recliner next to his bed during this interview. R1 said when staff put him on the bed his butt is not placed high enough for him to bend properly and it causes more pain to his tailbone. R1 said staff do not listen or assist him in becoming more comfortable. R1 said he would go back to bed more often if staff would listen to him and help him the way he needs to be helped. R1 said he has a pressure ulcer on his back and his coccyx. R1 said he wanted the physician to address his pain medication.R1 was observed being transferred from his wheelchair to his bed with a full body lift on 2/23/26 at 2:28 PM. R1 required the assistance of 3 people, Certified Occupational Therapist Assistant (COTA) F, Registered Nurse (RN) D, and Certified Nurse Aide (CNA) J. R1 yelled in pain with all movement and could not tolerate lying flat in bed, or on his left side. R1 reiterated he could not stay in bed due to the pain. R1 reported he is only able to be comfortable sitting or on his right side when in bed, and that transfers are extremely painful. COTA F reported she recently initiated staff training on how to transfer R1 but had not informed the physician of the pain R1 experiences with poor bed positioning and transfers. COTA F said she had just started educating staff on how to transfer R1 on 2/20/26. R1 said staff did not transfer him as COTA F had directed staff to on 2/20/26 over the weekend.During an interview with Certified Nurse Aide (CNA)H on 2/26/26 at 8:15 AM in the main dining room, CNA H confirmed she was assigned to R1 this morning since 6:00 AM. CNA H reported she was not aware R1 wanted to be out of bed for breakfast. CNA H said R1's care plan did not indicate he wanted to be up for breakfast. CNA H went to get CNA I and Unit Manager (UM) B to assist her getting R1 out of bed. When they got to his room, R1 requested pain medication prior to getting out of bed. R1 said when he moves it feels like 10,000 volts of electricity going from his back to his legs.On 2/26/26 at approximately 8:45 AM, the DON, CNA H, and I, transferred R1 from his bed to the recliner in his room with a full body electronic lift. R1 assisted with rolling in bed by grabbing the bed rails to roll. R1 reported he required the head of his bed to elevate approximately 30 degrees when he was on his back due to intolerable pain when he was flat in bed. During the transfer, R1 exhibited signs of pain with all movement.R1's care plan did not reflect specific instructions for transfer or preferences for positioning. The care plan did not reflect consideration for the Resident's pain with transfers, bed positioning, or mobility.Review of R1's physician orders revealed, 2/2/2026, Hydrocodone-Acetaminophen Oral Tablet 7.5-325 mg, give 1 tablet by mouth every 6 hours as needed for Chronic Pain, not to exceed 3000 mg of Acetaminophen in 24-hr from all sources.Review of R1's February 2026, Medication Administration Record (MAR) Hydrocodone-Acetaminophen Oral Tablet 7.5-325 mg, give 1 tablet by mouth every 6 hours as needed for Chronic Pain, not to exceed 3000 mg of Acetaminophen in 24-hr from all sources, start date, 02/02/2026. R1 did not receive any Hydrocodone- Acetaminophen on, 2/3/26, 2/5/26, 2/10/26, 2/17/26, 2/18/26, 2/20/26, 2/21/26. R1 only received one dose on 2/2/26, 2/4/26, 2/6/26, 2/8/26. 2/12/26, 2/13/26,2/22/26, 2/23/26. R1 received 2 doses on 2/7/26, 2/9/26, 2/11/26,2/15/26, 2/16/26, 2/19/26. R1 Received 3 doses on 2/14/26. R1 never received the 4 doses of pain medication he was allowed to receive.During an interview with the Director of Nursing (DON) on 2/24/26 at 12:29 PM, R1's pain concerns were discussed. The DON said when she reviewed R1's pain medication orders she discovered he was not taking all his prn (as needed) pain medications and confirmed R1 (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	has times of confusion and may not know when he is able to have his next dose of pain medication. The DON confirmed they had not met with R1 to discuss his pain concerns.

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. Based on interview and record review, the facility failed to provide laboratory services to meet the needs of one resident (R9) of one resident reviewed for laboratory services. Findings include:Review of the Electronic Medical Record (EMR) admission record reflected R9 was admitted to the facility 9/18/2025 with diagnoses that included bipolar disorder.Review of the EMR Progress Notes for R9 reflected an entry dated 2/19/2026 at 9:44 AM. The entry reflected, (Name of Physician) in to evaluate and treat patient for recent increase in behaviors. Gave order to perform urinalysis and collect (comprehensive metabolic panel (CMP) serum blood draw) Orders entered. Will collect urine.Review of the EMR Physician Orders for R9 did not reveal the orders had been entered as indicated by the Progress Note of 2/19/2026 at 9:44 AM.Further review of the EMR did not reveal any further documentation that lab specimens were obtained, lab results, monitoring for lab results, or attempts to determine the root cause of the recent increase in behaviors of R9.On 2/25/2026 at 1:25 PM, an interview was conducted with Registered Nurse (RN) E. RN E reported she entered the Progress Note of 2/19/25 at 9:44 AM and indicated she had placed the Physician's Orders into the EMR, as well. During the interview RN E reviewed the EMR but did not locate the Physician's Order for the lab work for R9. RN E provided a laboratory requisition form dated 2/20/2026 that included the name of R9. The laboratory requisition form reflected CMP was circled and Additional Tests reflected a handwritten entry for a urinalysis with a culture and sensitivity. RN E reported the form was faxed to the lab. RN E was unable to locate any other documentation that the lab had been completed. RN E indicated no mechanism was in place to ensure ordered lab work had been completed other than nurse shift to shift report.On 2/26/2026 at 1:45 PM, Unit Manager (UM) B reported that neither the CMP serum draw or the urine specimen was obtained. UM B reported staff had placed a hat into the commode to collect a urine specimen but R9 did not void. UM B reported RN E told her when lab came to the facility, she observed lab staff walking toward the room of R9 and assumed the CMP serum specimen had been obtained. UM B reported she had contacted the lab and was told the serum specimen for the CMP had not been obtained. UM B reported the facility is in transition to a new EMR system and the former system automatically notified the lab of the order, but the new system does not. UM B added since the new system does not notify the lab of Physician Orders a lab requisition form is now faxed to the lab. UM B could not provide any further information on a process to ensure laboratory services had been provided as ordered.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to maintain an accurate, clear, and concise Electronic Medical Record (EMR) for 2 residents (R18, and R9) of 14 residents reviewed.Findings include:R9 Review of the Electronic Medical Record (EMR) admission record reflected R9 was admitted to the facility 9/18/2025 with diagnoses that included bipolar disorder. Review of the EMR Progress Notes for R9 reflected an entry dated 2/19/2026 at 9:44 AM. The entry reflected, (Name of Physician) in to evaluate and treat patient for recent increase in behaviors. Gave order to perform urinalysis and collect (comprehensive metabolic panel (CMP) serum blood draw) Orders entered. Will collect urine. Review of the EMR Physician Orders for R9 did not reveal the orders had been entered as indicated by the Progress Note of 2/19/2026 at 9:44 AM. Further review of the EMR did not reveal any further documentation that lab specimens were obtained, of lab results, monitoring of the Resident, monitoring for lab results, or attempts to determine the root cause of the recent increase in behaviors of R9. On 2/25/2026 at 1:25 PM, an interview was conducted with Registered Nurse (RN) E. RN E reported she entered the Progress Note of 2/19/25 at 9:44 AM and indicated she had placed the physician's orders into the EMR, as well. During the interview RN E reviewed the EMR but did not locate the Physician's Order for the lab work for R9. RN E was unable to locate any other documentation that the lab had been completed or that the change in behavior of R9 identified on 2/19/2025 had been conveyed to subsequent nursing staff for continuity of care. On 2/26/2026 at 1:45 PM, Unit Manager (UM) B reported that neither the CMP serum draw or the specimen for the urinalysis for R9 was obtained. UM B could not provide any further documentation or information since the Progress Note entry of 2/19/2026 when a change in resident behavior had been identified and a plan for further evaluation had been indicated. R18 Review of an admission Record revealed R18 admitted to the facility on [DATE] with pertinent diagnoses which included paranoid schizophrenia and dependence on supplemental oxygen. Further review revealed he had a court appointed guardian. In an interview on 2/23/2026 at 10:21 AM, R18 reported he wished to be transferred to a facility closer to his family. R18 reported he had discussed this desire with the facility social worker, but nothing had been done to assist him with this transfer request. Review of R18's Social Work Progress Note, dated 8/6/2025 at 4:37 PM, revealed the court instructed the guardian to find placement for R18 closer to his home and family. In an interview on 2/24/2026 at 2:45 PM, Social Worker A reported the court ordered R18's guardian to find placement closer to home for him in August of 2025 and she had discussions with R18 (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	regarding his transfer request. Social Worker A reported she would look for documentation regarding these discussions. In an interview on 2/24/2026 at 3:47 PM, the Nursing Home Administrator (NHA) reviewed a concern form for R18 dated 12/16/2025 in which R18 requested to transfer to a facility closer to home and the facility had sent several referrals to facilities to initiate the transfer process. The NHA reported there were no progress notes in the EMR regarding these transfer discussions or referrals. Social Worker A reported she could find no documentation in the EMR regarding the transfer discussions that had taken place at the facility. In an interview on 2/24/2026 at 4:12 PM, the NHA reported there should be progress notes documented in the EMR and Care Conference documentation regarding the resident's request to transfer and the work the facility had done to facilitate this. Review of facility policy/procedure Documentation in Medical Record, reviewed 2/18/2026, revealed .Each resident's medical record shall contain an accurate representation of the actual experiences of the resident and include enough information to provide a picture of the resident's progress through complete, accurate, and timely documentation.

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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 observations, interview and record review, the facility failed to clean 1 resident's (R1) Continuous Positive Airway Pressure (CPAP) machine of 1 Resident on CPAP.Findings included: Review of R1's undated face sheet, revealed he was a [AGE] year-old male admitted to the facility on [DATE] and had diagnoses that included: osteomyelitis, pressure ulcer of the right upper back, urinary tract infection, diabetes mellitus, morbid (severe) obesity, chronic pain, and pressure ulcer of unspecified part of the back, unstageable. He was his own responsible party.During an interview with R1 in his room on 1/23/26 at 1:20 PM, R1 reported that he cleaned and cared for his Continuous Positive Airway Pressure (CPAP) machine when he was at home, but no one has cleaned it since he was admitted to the facility. No cleaning equipment or supplies were visible in the room, and the machine was sitting on the windowsill with the tube still connected to the machine.During an interview with the Director of Nursing (DON) on 2/25/26 at 2:20 PM, the DON confirmed that R1 should have orders for CPAP cleaning and it would be documented in R1's medical recorded in the Treatment Administration Record (TAR) section if the facility had been cleaning the machine. The DON could not locate any documentation that R1's CPAP had been cleaned since his admission to the facility.Review of R1's medical record revealed no documentation related to the cleaning of R1's CPAP machine.Review of the facility CPAP/BiPAP Cleaning policy dated 11/2/2022 revealed, It is the policy of this facility to clean CPAP/BiPAP equipment in accordance with current CDC guidelines and manufacturer recommendations in order to prevent the occurrence or spread of infection. Definitions: CPAP, or continuous positive airway pressure, is a respiratory therapy intervention used to provide a patent airway during periods of sleep apnea. It uses air pressure generated by a machine, delivered through a tube into a mask that fits over the nose or mouth. 7. Weekly cleaning activities: a. Wash headgear/straps in warm, soapy water and air dry. B. Wash tubing with warm, soapy water and air dry. 8. Following manufacturer instructions for the frequency of cleaning/replacing filters and servicing the machine.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. Based on interview and record review, the facility failed to operationalize the facility infection control policy to provide influenza and pneumococcal vaccines timely for two newly admitted Residents (R1 and R21) of six residents reviewed for immunizations. Findings include:R1Review of the Electronic Medical Record (EMR) admission record reflected R1 was admitted to the facility 1/27/2026 and made their own medical decisions.Review of the EMR for R1 revealed the facility document titled Resident - Vaccine Consent. The document dated 1/28/2026 reflected R1 has signed the consent form to accept the influenza and pneumonia vaccines.Review of the EMR Physicians Orders for R1 reflected an order dated 2/2/2026 May have Pneumococcal and May have annual Influenza Vaccine and to administer vaccines to patients who have not already received it unless contraindicated.Review of the EMR immunization record of R1 reflected documentation of the Mantoux Skin Test but no immunizations for influenza or pneumonia.Review of the Progress Notes for R1 did not reveal documentation the influenza and pneumonia vaccines were contraindicated for the Resident.R21Review of the Electronic Medical Record (EMR) admission record reflected R21 was admitted to the facility 1/23/2026 and was their own responsible party.Review of the EMR for R21 revealed the facility document titled Resident - Vaccine Consent. The document dated 1/28/2026 reflected R21 had completed the consent form to accept the influenza and pneumonia vaccines.Review of the EMR Physicians Orders for R21 reflected an order dated 1/23/2026 that Per CDC guidelines, administer vaccines requested to patients who have not already received it unless contraindicated .The EMR immunization record of R21 was reviewed. This record reflected documentation of the Mantoux Skin Test but no immunizations for influenza or pneumonia were recorded.Review of the Progress Notes for R21 did not reveal documentation the influenza and pneumonia vaccines were contraindicated for the Resident.On 2/24/2026 at 1:14 PM, an interview was conducted with the Director of Nursing (DON) who is also the facility Infection Preventionist (IP). The DON IP was informed that consents and physician orders for immunizations were noted in the EMR but that the record did not reflect these were administered, The DON IP reported that residents must be reviewed in Michigan Care Improvement Registry (MCIR - a State of Michigan system for tracking immunizations administered within the state) to determine what immunizations residents are eligible for. The DON IP reported she had not been in the DON IP position very long and did not have access to MCIR yet to review resident immunization eligibility. The policy provided by the facility titled Infection Prevention and Control Program last reviewed and revised 5/7/2025 was reviewed. The policy reflected, This facility has established and maintains an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections as per accepted national standards and guidelines. The policy reflected Policy Explanation and Compliance Guidelines to include: .7. Influenza and Pneumococcal Immunization:a. Residents will be offered the influenza vaccine each year between October 1 and March 31, unless contraindicated or received the vaccine elsewhere during that time.b. Residents will be offered the pneumococcal vaccines recommended by the CDC upon admission, unless contraindicated or received the vaccines elsewhere.c. Education will be provided to the residents and/or representatives regarding the benefits and potential side effects of the immunizations prior to offering the vaccines.d. Residents will have the opportunity to refuse the immunizations.e. Documentation will reflect the education provided and details regarding whether or not the resident received the immunizations.

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 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. Based on interview and record review the facility failed to operationalize the facility infection control policy to provide Covid-19 vaccine timely for two newly admitted Residents (R1 and R21) of six residents reviewed for immunizations and failed to implement a process to track and monitor staff Covid-19 education and immunization status. Findings include:R1Review of the Electronic Medical Record (EMR) admission record reflected R1 was admitted to the facility 1/27/2026 and made their own medical decisions.Review of the EMR for R1 revealed the facility document titled Resident - Vaccine Consent. The document dated 1/28/2026 reflected R1 had signed the consent form to accept the Covid-19 Series/Vaccine and the Recommended Annual Covid -19 Booster.Review of the EMR Physicians Orders for R1 reflected an order dated 2/2/2026 to administer vaccines requested to patients who have not already received it unless contraindicated.Review of the EMR immunization record of R1 did not reflect the Covid-19 series/vaccine had been initiated.Review of the Progress Notes for R1 did not reveal the Covid-19 vaccination was contraindicated for the Resident.R21Review of the Electronic Medical Record (EMR) admission record reflected for R21 was admitted to the facility 1/23/2026 and was their own responsible party.Review of the EMR for R1 revealed the facility document titled Resident - Vaccine Consent. The document dated 1/28/2026 reflected R21 had completed the consent form to accept the Covid-19 Series/Vaccine and the Recommended Annual Covid -19 Booster.Review of the EMR Physicians Orders for R21 reflected an order dated 1/23/2026 that Per CDC guidelines, administer vaccines requested to patients who have not already received it unless contraindicated .The EMR immunization record of R21 was reviewed. This record did not reflect the Covid-19 vaccine/series had been initiated.Review of the Progress Notes for R21 did not reveal documentation the Covid-19 vaccine was contraindicated for the Resident.On 2/24/2026 at 1:14 PM an interview was conducted with the Director of Nursing (DON) who is also the facility Infection Preventionist (IP). The DON IP was informed that consents and physician orders for immunizations were noted in the EMR but that the record did not reflect these were initiated, The DON IP reported that residents must be reviewed in Michigan Care Improvement Registry (MCIR - a State of Michigan system for tracking immunizations administered within the state) to determine which vaccinations residents were eligible for. The DON IP reported she had not been in the DON IP position very long and did not have access to MICR yet to review resident immunization eligibility. The policy provided by the facility titled Infection Prevention and Control Program last reviewed and revised 5/7/2025 was reviewed. The policy reflected, This facility has established and maintains an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections as per accepted national standards and guidelines. The policy reflected Policy Explanation and Compliance Guidelines to include: 8. COVID-19 Immunization:a. Residents and staff will be offered the COVID-19 vaccine when vaccine supplies are available to the facility.b. Residents and staff will be screened prior to offering the vaccination for prior immunization, medical precautions and contraindications to determine candidacy for the vaccination.c. Education about the vaccine, risks, benefits, and potential side effects will be given to residents or resident representatives and staff prior to offering the vaccine.e. Residents or resident representatives will have the opportunity to accept or refuse a COVID-19 vaccination, and change their decision based on current guidance.g. The resident's medical record includes documentation that indicates, at a minimum, the following:i. That the resident or resident representative was provided education regarding the benefits and potential risks associated with COVID-19 vaccine; andii. Each dose of COVID-19 vaccine administered to the resident, oriii. If the resident did not receive the COVID-19 vaccine due to medication contraindications orrefusal. Facility Employee Covid-19 Tracking During the interview conducted on 2/24/2026 at 1:14 PM with the DON (continued on next page)

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	IP it was reported she did not maintain documentation of Covid-19 screening, education or the Covid-19 vaccination status of facility staff. In a follow-up interview conducted 2/25/2026 at 2:43 PM the DON IP reported that, outside of the new employee orientation packet, new staff do not receive initial additional training on Covid-19. On 2/25/2026 at 2:27 PM the Nursing Home Administrator (NHA) reported she was not aware if the facility had maintained documentation of the Covid-19 immunization status of staff. During an interview conducted 2/25/2026 at 2:33 PM Human Resources Coordinator (HRC) L reported she does not maintain a record of staff Covid-19 offering or immunization status. HRC L reported new staff are offered covid-19 education and vaccination but only read the education if they accept the vaccination. HRC L reported documentation of the vaccination would be placed in their employee file. HRC L reported since she had been in the position no new employee had accepted the information or the vaccination. HRC L reported yearly Covid-19 education is provided along with other topics but reported she did not know what month of the year it is presented. HRC L reported she had never been told she needed to maintain a record of the Covid-19 vaccination status of staff. Review of the Infection Prevention and Control Program cited above reflected: h. The facility will maintain documentation related to staff COVID-19 vaccination that includes at a minimum, the following;i. That staff were provided education regarding the benefits and potential risks associated with COVID-19 vaccine;ii. Staff were offered the COVID-19 vaccine or information on obtaining COVID-19 vaccine; andiii. The COVID-19 vaccine status of staff and related information as indicated by the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN).