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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235551	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/03/2026
NAME OF PROVIDER OR SUPPLIER Greentree of Hubbell Rehabilitation and Health		STREET ADDRESS, CITY, STATE, ZIP CODE 52225 B Avenue Hubbell, MI 49934	

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to Intake# 2631101 Based on observation, interview and record review, the facility failed to protect the resident's right to be free from misappropriation of property, by a staff member for one Resident (Resident #51) of three residents reviewed for misappropriation of property, resulting in 120 narcotic medication pills missing, increased potential for undetected controlled drug diversion and the potential for uncontrolled pain and discomfort with medication delivery delays from refill too soon notices flagged by the pharmacy provider.Findings include:Review of the Food and Drug Administration current labeling information https://www.fda.gov/drugsatfda read in part: NORCO. Abuse.NORCO contains hydrocodone, a substance with a high potential for abuse similar to other opioids including fentanyl, hydrocodone, hydromorphone, methadone, morphine, oxycodone, oxymorphone, and tapentadol, can be abused and is subject to misuse, addiction, and criminal diversion .Resident #51 (R51)Review of an admission Record revealed R51 was originally admitted to the facility on [DATE] with pertinent diagnoses which included: colon cancer. Review of a Minimum Data Set (MDS) assessment for R51 with a reference date of 10/24/2025 revealed a Brief Interview for Mental Status (BIMS) score of 99/15 which indicated R51 was cognitively severely impaired.Review of a Physician's Order Summary read in part: (R51) Hydrocodone-Acetaminophen Oral Tablet 10-325MG (Hydrocodone-Acetaminophen) give 1 tablet three times daily.Review of a Facility Reported Incident (FRI) investigation presented to the State Agency (SA) read in part: Date/Time Incident Discovered: 9/19/2025 10:10AM Incident Summary: On the morning of September 19, 2025, during the routine medication pass, it was discovered that a narcotic was missing. The attending nurse contacted Pharmacy to inquire about retrieving the medication from our StatSafe (securely locked medication storage safe), as it was scheduled to be administered. The pharmacy advised that our facility should already have an adequate supply of the medication on hand. Physician notified and Investigation initiated. Investigation Summary/Actions Taken: Facility Reported Incident Investigation Incident Information Date of Incident: September 19, 2025, Resident Involved: (R51) Medication Involved: Hydrocodone 10-325mg (scheduled narcotic pain medication) Investigating Staff: (Previous) Registered Nurse (RN)/Director of Nursing (DON). Summary of Incident. On September 19, 2025, (Previous staff) notified the DON, she had contacted the pharmacy to refill (R51's) Hydrocodone 10-325mg. The pharmacy indicated the resident should have 120 tablets at the facility. The DON initiated a search for the medication, reviewed proof-of-use sheets and reviewed shift counts. It was determined the medication was not administered, destroyed, or documented as wasted, and was unaccounted for. Chain of custody was reviewed for the medication in question, and a nurse was identified as potentially being involved in the missing medication. This nurse is no longer employed at the facility as of September 14, 2025. Notifications-Law enforcement was notified on September 19, with reports made to the State Police and subsequently to the County Sheriff's Office. The attending physician and residents responsible party were notified. Physician provided orders and replacement medications were obtained. Investigation Findings: Thirty-four residents were interviewed with no concerns identified related to medication management. All licensed nurses were interviewed and demonstrated understanding of narcotic control procedures. No concerns were raised regarding other (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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	nurses or medication management practices. Medication carts were reviewed, and excess or unnecessary narcotics were secured under double lock. Further audits were conducted to identify any other missing medications from residents, and no additional concerns were identified. Corrective Action- Education on narcotic control procedures has been reinforced. Ongoing audits of controlled substances have been implemented. Excess narcotics for hospitalized residents are secured under double lock. Continued monitoring for compliance with facility policy. Conclusion While the investigation did not definitively identify the individual responsible for diversion, the primary staff member of concern has separated employment.With the corrective action plan implemented and the separation of the staff members in question, residents are not at risk for further misappropriation.In an interview on 3/2/2026 at 4:29 PM, at the time (R51's) narcotic medication (Norco 10mg-quanity 120 tablets) went missing, RN B indicated the medication was most likely taken from a staff member when it was delivered. RN B revealed the nurse identified was not signing for the pharmacy medication box when it was delivered and the box was mixed in with other boxes or packages that had been delivered. RN B stated if I remember correctly when the investigation was being completed it was noticed the entire inventory list that has all the medications in the box was missing, along with 4-narcotic count sheets totaling 120 pills and the 4 packages containing 30 pills each In an interview on 3/3/2026 at 8:42 AM., RN C reported at the time R51's narcotic medication went missing it would have been very easy for anyone including staff or a delivery personnel to have tampered with and/or opened the pharmacy medication box. RN C stated, I think it was probably a previous nurse, because most people would not know to take the entire inventory sheet, along with the narcotic count sheets with the narcotic medications that were missing. the box was not locked and was in a regular cardboard box, which was taped with packaging tape RN C reported at times the pharmacy box was still in front office amongst other delivered packages/boxes. RN C stated the fact the box could easily be opened and retaped, especially the bottom of the box because I don't know if or who is required to inspect for tampering. In an observation/interview on 3/03/2026 at 10:54 AM, a UPS delivery staff (DS) entered the facility with approximately 4-6 packages including small and medium cardboard boxes and delivered them to the front office. This surveyor inspected the box which was cardboard, taped with packaging tape, and a pharmacy label. The box did not appear to be locked or tamper proof. DON reported she was not employed at the facility during R51's FRI and Assistant Director of Nursing ADON A would know a little more if this surveyor had any further questions.In an interview on 3/3/26 at 3:50 PM., ADON A reported she was not employed at the facility at the time of R51's FRI investigation, but did start working shortly afterwards and worked on the follow up and auditing, as well as putting new measures in place for the policy and procedures of Medication/Pharmacy services, storage of narcotics to ensure compliance. ADON A reported it was her understanding from the previous DON and Nursing Home Administrator (NHA) working at the time that (R51's) medications along with the inventory list, and narcotic count sheets were taken out of the pharmacy medication box once delivered by a former staff member who previously had issues with substance abuse.Review of a facility Abuse, Neglect and Exploitation policy referenced by the State Operations Manual (SOM)- revision 2025, Appendix PP-F600/F607 read in part: Policy: It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property. Further review of this policy did not address or reference the SOM or protocol for misappropriation (F602).

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Based on interview and record review, the facility failed to ensure adequate staffing to promote the highest practicable level of physical, mental and psychosocial well-being with the potential to affect all 44 residents that reside in the facility.Findings include:Review of Centers for Medicare and Medicaid Services (CMS) Payroll Based Journal (PBJ) Staffing Data Report (quarterly submissions to CMS by nursing homes to report direct care staffing) for FY [fiscal year] Quarter 4 2025 (July 1 - September 30), read in part . [name of facility] triggered for excessively low weekend staffing.During an interview and record review on 3/3/26 at 1:15 p.m., Chief Operating Officer (COO) G reviewed the weekend schedules and payroll information which revealed low weekend staffing for Certified Nurse Aides (CNA) on the following dates and shifts:Saturday, August 2, 2025 3 CNAs day shift 3 CNAs afternoon shiftSaturday, August 9, 2025 3.5 CNAs day shift 3.5 CNAs afternoon shiftSaturday, September 6, 2025 3 CNAs day shiftCOO G acknowledged the facility had low weekend staffing on the above dates and shifts according to the Facility Assessment [(FA) An annual, documented, facility wide evaluation ensuring resources, staffing, and safety measures meet resident needs].Review of CMS final rule, effective August 8, 2024, mandates that nursing home facility assessments must directly inform and determine staffing requirements.Review of document titled Facility Assessment last updated 2/1/25, read in part .Certified Nurse Aides.minimum of 4-5 CNAs on day shift, Minimum of 4 CNAs on afternoon shift.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. Based on interview and record review, the facility failed to ensure two Certified Nurse Aides (CNA's) [L and N] of five CNA's reviewed for competencies had the required yearly competency trainings, including demonstration in skills and techniques necessary to care for residents.Findings include:A review of facility staff personnel records revealed CNA L was hired 1/15/24. CNA L's personnel record did not demonstrate dated competency skills since the date of hire.A review of facility staff personnel records revealed CNA N was hired 2/24/23. CNA N's personnel record did not demonstrate dated competency skills since the date of hire.During an interview on 3/3/26 at 8:34 a.m., Business Office Manager (BOM) O reported two of the CNA's do not have competency trainings in their personnel files and the staff is supposed to have annual competency training.Review of policy titled Competency Evaluation date reviewed/revised 1/1/25, read in part It is the policy of this facility to evaluate each employee to assure they meet appropriate competencies and skill for performing their job.evaluating competency of staff is accomplished through the facilities training program.initial competency is evaluated during the orientation process.subsequent or annual competency is evaluated.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observe each nurse aide's job performance and give regular training. Based on interview and record review, the facility failed to complete a performance review for five out of five Certified Nurse's Aides (CNA's) at least every 12 months. This deficient practice resulted in the potential for inadequate care and unmet resident care needs for all 44 residents residing in the facility.Review of facility personnel records demonstrated the following:CNA E was hired on 11/10/21with no performance reviewCNA K was hired on 11/10/23 with no performance reviewCNA L was hired on 1/15/24 with no performance reviewCNA M was hired on 7/13/23 with no performance reviewCNA N was hired on 2/24/23 with no performance reviewDuring an interview on 3/3/26 at 8:34 a.m., Business Office Manager (BOM) reported I do not have any evaluations of any of the five staff members they are supposed to be done annually.The staff are supposed to have annual performance reviews.During an interview on 3/3/26 at 8:44 a.m., Director of Nursing (DON) acknowledged annual performance reviews were not completed.A request for a policy regarding performance reviews was not provided by the facility prior to exit from the facility.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. This citation pertains to Intake# 2631101.Based on observation, interview and record review the facility failed to fully implement its policy for delivery and storage of controlled medications for one Resident (#51) of three residents reviewed for medication administration, storage and labeling resulting in the misappropriation of 120 narcotic pain medications for R51, the potential for an increase in drug diversion, misappropriation of medications, residents missing pain medication, and the potential for uncontrolled pain and discomfort.Findings include:Review of the Food and Drug Administration current labeling information https://www.fda.gov/drugsatfda read in part: NORCO contains hydrocodone, a Schedule II controlled substance.NORCO-Storage and Disposal-Because of the risks associated with accidental ingestion, misuse, and abuse, advise patients to store NORCO securely, out of sight and reach of children, and in a location not accessible by others, including visitors to the home [see WARNINGS, DRUG ABUSE AND DEPENDENCE]. Inform patients that leaving NORCO unsecured can pose a deadly risk to others in the home . Resident #51 (R51)Review of the admission Record for R51 revealed an original admission to the facility on 8/6/2024 with pertinent diagnoses which included: colon cancer. Review of a Minimum Data Set (MDS) assessment for R51 dated 10/24/2025 revealed a Brief Interview for Mental Status (BIMS) score of 99/15 indicating R51 was cognitively severely impaired.Review of a Physician's Order Summary read in part: (R51) Hydrocodone-Acetaminophen Oral Tablet 10-325MG (Hydrocodone-Acetaminophen) give 1 tablet three times daily.Review of a Facility Reported Incident (FRI) investigation presented to the State Agency (SA) read in part: Date/Time Incident Discovered: 9/19/2025 10:10AM Incident Summary: On the morning of September 19, 2025, during the routine medication pass, it was discovered that a narcotic was missing. The attending nurse contacted Pharmacy to inquire about retrieving the medication from our StatSafe (securely locked medication storage safe), as it was scheduled to be administered. The pharmacy advised that our facility should already have an adequate supply of the medication on hand. Physician notified and Investigation initiated. Investigation Summary/Actions Taken: Facility Reported Incident Investigation Incident Information Date of Incident: September 19, 2025, Resident Involved: (R51) Medication Involved: Hydrocodone 10-325mg (scheduled narcotic pain medication) Investigating Staff: (Previous) Registered Nurse (RN)/Director of Nursing (DON). Summary of Incident. On September 19, 2025, (Previous staff) notified DON that she had contacted the pharmacy to refill (R51's) Hydrocodone 10-325mg. The pharmacy indicated that the resident should have 120 tablets at the facility. The DON initiated a search for the medication and reviewed proof-of-use sheets and shift counts. It was determined that the medication was not administered, destroyed, or documented as wasted, and was unaccounted for. Chain of custody was reviewed for the medication in question, and a nurse was identified as potentially being involved in the missing medication. This nurse is no longer employed at the facility as of September 14, 2025. Notifications- Law enforcement was notified on September 19, with reports made to the State Police and subsequently to the County Sheriff's Office. The attending physician and residents responsible party were notified. Physician provided orders and replacement medications were obtained. Investigation Findings: Thirty-four residents were interviewed with no concerns identified related to medication management. All licensed nurses were interviewed and demonstrated understanding of narcotic control procedures. No concerns were raised regarding other nurses or medication management practices. Medication carts were reviewed, and excess or unnecessary narcotics were secured under double lock. Further audits were conducted to identify any other missing medications from residents, and no additional concerns were identified. Corrective Action- Education on narcotic control procedures has been reinforced. Ongoing audits of controlled substances have been implemented. Excess narcotics for hospitalized residents are secured under double lock. Continued monitoring for compliance with facility policy . Conclusion While (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	the investigation did not definitively identify the individual responsible for diversion, the primary staff member of concern has separated employment.With the corrective action plan implemented and the separation of the staff members in question, residents are not at risk for further misappropriation.In an interview/observation on 3/02/2026 at 3:30 PM., RN B reported she was employed at the facility during the time (R51's) narcotic medication (Norco 10 mg- quantity 120 tablets) went missing. RN B reported the medication for the facility was delivered via UPS/FedEx. RN B reported resident medications come in a regular cardboard box with packaging tape and could easily be opened. RN B reported 2 nurses must now retrieve the pharmacy box, open it together and check all inventory, place all medications into the appropriate storage areas and then both nurses sign the packaging slip, stapled narcotic medications together and sign off on the narcotic count sheets indicating which nurses signed the medications in once delivered . In an observation/interview/record review on 3/2/2026 at 4:04 PM., with RN B's assistance the facility medication carts, medication storage room, Stat-safe and a pharmacy medication box delivered earlier along with narcotic medication count sheets were reviewed. RN B reported before (R51's) narcotic medications went missing the medication box from the pharmacy was often unattended once delivered and there were times nurses went the front office where packages were delivered and had to look through other boxes belonging to either the facility or residents to locate the box labeled with pharmacy. That nurse would open the box, check the inventory then fill their medication cart with the regular prescription medications. RN B reported when it came time to check in schedule/narcotics the nurse would call over another nurse and both nurses had to sign off on the inventory sheet from the pharmacy which came in the box. When this surveyor observed the pharmacy box in the medication room it was noted to be opened on the top with a pharmacy label, and regular packaging tape on the top portion of the box which was slit open, as well as the bottom of the box which was taped closed. The box contained no paperwork or medications as they had already been checked in for the day.In an interview on 3/3/2026 at 8:42 AM., RN C reported pharmacy medications delivered to the facility arrive via UPS/Fed/Ex. RN C reported a while back the process changed so that a nurse must sign in the pharmacy box as soon as it is delivered and the drivers/delivery person were supposed to wait for a nurse signature to retrieve the box. RN C reported the box was not locked as it was a regular cardboard box, which was taped with packaging tape. RN C reports despite the fact (R51's) narcotic medications went missing, at times the box was still retrieved from the front office amongst other boxes left for either the facility or residents. RN C reported this does not happen often, but it does continue to happen. RN C stated the fact the box could easily be opened and retaped, especially the bottom of the box because I don't know if or who is required to inspect for tampering. RN C reported he believes that most nurses at the facility do their best with the current procedure, it seems that if someone wanted to take medications from the box, it could potentially still be easy to do. RN C reported if that were to happen, it would probably be easier to catch because now 2 nurses not only sign the narcotic medication count sheets, but they are also both must sign the entire inventory sheet which includes all medications the pharmacy put in the box. RN C reported he is unsure why the medications are delivered from the pharmacy were not in a hard case locking tote or something like that with zip ties, or the ties with inventory numbers. RN C stated I think this would be something that would add another measure of safety, I am unsure of how the facility management and pharmacy used would accomplish this because the pharmacy is not local.In an observation/interview on 3/3/2026 at 10:54 AM, a UPS delivery staff (DS) entered the facility with approximately 4-6 packages including small and medium cardboard boxes and delivered them to the front office where the DON was seated. It was noted the UPS/DS had the DON sign a device for the packages. When asked, the UPS/DS stated, for the box with the pharmacy label I am required to ask for a nurse who shows identification then gives their signature when those are delivered UPS/DS reported he was newer to the route and was informed of this requirement when dropping off packages last week. UPS/DS reported there were no special delivery instructions on the pharmacy package from the sender. This surveyor inspected the box (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	which was cardboard, taped with packaging tape, and a pharmacy label. The box did not appear to be locked or tamper proof. DON reported she was not employed at the facility during R51's FRI and Assistant Director of Nursing ADON A would know a little more if this surveyor had any further questions.In an interview on 3/3/26 at 3:50 PM., ADON A reported she was not employed at the facility at the time of R51's FRI investigation, but did start working shortly afterwards and worked on the follow up and auditing, as well as putting new measures in place for the policy and procedures of Medication/Pharmacy services, storage of narcotics to ensure compliance. ADON A reported the policies do not currently address the actual procedure in place or address how the facility currently receives resident medications. ADON A reported she was unsure if there was anything in the facility Policy and Procedures of Pharmacy Services and Medication Storage and Labeling nor is it written anywhere regarding who is responsible for checking in delivered medications and who is responsible for checking the medication box for tampering when it is delivered and signed for.Review of a facility Pharmacy Services Policy with a revision date of 4/1/2025 read in part: Policy- It is the policy of this facility to ensure that pharmaceutical services, whether employed by the facility or under an agreement, are provided to meet the needs of each resident, are consistent with state and federal requirements, and reflect current standards of practice. Definitions: Pharmaceutical Services refers to: The process (including documentation, as applicable) of receiving and interpreting prescriber's orders; acquiring, receiving, storing, controlling, reconciling, compounding, dispensing, packaging, labeling, distributing, administering, monitoring responses to, using and/or disposing of all medications, biologicals, chemicals Compliance Guidelines:1. The facility will provide pharmaceutical services to include procedures that assure the accurateacquiring, receiving, dispensing, and administering of all routine and emergency drugs and biologicals to meet the needs of each resident, are consistent with state and federal requirements, and reflect current standards of practice.2. The facility will employ or obtain the services of a licensed pharmacist (in accordance with state requirements) who:a. Provides consultation on all aspects of the provision of pharmacy services in the facility.b. Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable accurate reconciliation; andc. Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.5. The facility in coordination with the licensed pharmacist will provide for:a. A system of medication records that enables periodic accurate reconciliation and accounting for all controlled medications .b. Prompt identification of loss of or potential diversion of controlled medications; andc. Determination of the extent of loss or potential diversion of controlled medications.Further review of this policy revealed no new update or revision after R51's narcotic medications went missing to indicate any new practice, nor does it show the current procedure of pharmacy delivery methods including current pharmacy couriers.Review of a facility Medication Storage Policy with a revision date of 1/17/2025 read in part: Policy- It is the policy of this facility to ensure all medications housed on our premises will be stored in the medication room or medication carts according to the manufacturer's recommendations and sufficient to ensure proper sanitation, temperature, light, ventilation, moisture control, segregation, and security. Policy Explanation and Compliance Guidelines.2. Narcotics and Controlled Substances: a. Schedule II drugs and back-up stock of Schedule III, IV and V medications are stored under double-lock and key. b. Schedule II controlled medications are to be stored within a separately locked permanently affixed compartment when other medications are stored in the same area, such as in refrigerator. c. Any discrepancies which cannot be resolved must be reported immediately as follows: i. Notify the DON, charge nurse, or designee and the pharmacy; ii. Complete an incident report detailing the discrepancy, steps taken to resolve it, and the names of all licensed staff working when the discrepancy was noted; iii. The DON, charge nurse, or designee must also report any loss of controlled substances where theft is suspected to the appropriate authorities such as local law enforcement, Drug Enforcement Agency, State Board of Nursing, State Board of Pharmacy, and possibly the State Licensure Board for Nursing Home Administrators. d. Staff may not leave the (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide a homelike environment free from foul odors and soiled environmental surfaces for all residents residing in the facility.Findings include:During initial entrance tour on 3/1/26 at 1:15 PM., it was noted there was a strong odor of urine when entering the facility. A foul smell of urine was noted on both the A & B units, the hallway to the units and throughout the nursing station areas.In an observation on 3/1/26 at 1:53 PM, room [ROOM NUMBER] both privacy curtains were noted to be heavily soiled with brown smudge marks in multiple areas. In an interview on 3/1/26 at 2:00 PM., Houskeeper (Hsk) I indicated the floors in resident rooms and bathrooms are not mopped daily. Hsk I indicated the strong smell of urine was most likely a combination of the floors not being mopped, soiled linen and soiled briefs that have not been taken out of the facility to the garbage and laundry building. Hsk I reported the laundry facility was in the building next door, and on the weekends sometimes the facility is short staffed, so the linens and garbage are not removed promptly. In an observation on 3/1/26 at 2:11 PM., the bathroom for room [ROOM NUMBER] was soiled with a dried build up urine around the toilet seat and the seat fasteners. Dried feces was smeared on the toilet tank, the rim of the toilet seat, and underneath the toilet seat on the tank bowl. The bathroom had a strong odor of urine.In an observation on 3/01/2026 3:48 PM., strong smell of urine noted on the back unit rooms 1-20 and near nurse's station. In an observation on 3/1/26 at 3:52 PM, room [ROOM NUMBER] both privacy curtains were noted to be heavily soiled. room [ROOM NUMBER] had a strong odor of urine when this surveyor toured the room. In an observation on 3/01/2026 3:50 PM., strong smell of urine noted on while this surveyor toured the unit with rooms 21-31. In an observation on 3/01/2026 3:52 PM., it was noted the bathroom for room [ROOM NUMBER] was soiled with a dried build up urine around the base, feces noted dried and smeared on the toilet tank, rim of the toilet seat, and underneath the toilet seat on the tank bowl. The bathroom had a strong odor of urine.In an observation on 3/02/2026 8:30 AM., strong urine smell on both A & B units upon observation of units for resident initial pool continuation.In an observation on 3/02/2026 2:31 PM it was noted on both A & B units a strong smell of urine while conducting environmental inspection. In an observation on 3/03/2026 at 10:00 AM., the bathroom door of room [ROOM NUMBER]-1 was noted to have a large (greater than 12 inch) circle of paint chipped. Review of the State Operations Manual revealed: Environment refers to any environment in the facility that is frequented by residents, including (but not limited to) the residents' rooms, bathrooms, hallways, dining areas, lobby, outdoor patios, therapy areas and activity areas.A homelike environment is not achieved simply through enhancements to the physical environment. It concerns striving for person-centered care that emphasizes individualization, relationships and a psychosocial environment that welcomes each resident and makes her/him comfortable. It is the responsibility of all facility staff to create a homelike environment and promptly address any cleaning needs.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235551	A. Building B. Wing	03/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greentree of Hubbell Rehabilitation and Health	52225 B Avenue Hubbell, MI 49934

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. Based on interview and record review, the facility failed to ensure Certified Nurse Aide (CNA) training of no less than 12 hours per year was completed for five of five CNAs reviewed for nurse aide training hours. Findings include:During an interview on 3/3/26 at 8:00a.m., Business Office Manager (BOM) revealed the annual 12-hour CNA training is based on the CNA hire date. Review of facility document provided by the BOM revealed the following: CNA E hire date 11/10/21 with 0 hours of training since 5/28/24. CNA K hire date of 11/10/23 with 0 hours of training since 11/10/23. CNA L hire date 1/15/24 with 0 hours of training since hire date. CNA M dire date 7/13/23 with 0 hours of training since hire date. CNA N hire date 2/24/23 with 0 hours of training since 11/15/23. During an interview on 3/3/26 at 8:44 a.m., Director of Nursing (DON) acknowledged five staff did not have 12 hours of annual training. Review of policy titled Nurse Aide Training Program date reviewed/revised 6/11/24, read in part .Each nurse aide shall be provided at least 12 hours of in-service training annually, based on his/her employment date.