

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235554	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/03/2026
NAME OF PROVIDER OR SUPPLIER Eastwood Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 900 Maas Street Negaunee, MI 49866	
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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview and record review, the facility failed to prepare food in accordance with professional standards for food service safety, resulting in the potential to spread food borne illness among all residents that consume food from the kitchen. Findings include: On 6/1/2026 at 11:50 AM observed two large stainless steel bowls laying in the hand sink. Dietary Manager (DM) I was asked why the bowls were in the sink, and they stated that those are normally used to cover the plate warmer, and the employees must have removed them and stored them in there because they are currently dishing food up for lunch from the tray line and using the plates from the plate warmer. According to the 2022 FDA Food Code section 4-903.11 Equipment, Utensils, Linens, and Single-Service and Single-Use Articles. (A) Except as specified in (D) of this section, cleaned EQUIPMENT and UTENSILS, laundered LINENS, and SINGLE-SERVICE and SINGLE-USE ARTICLES shall be stored: (1) In a clean, dry location; (2) Where they are not exposed to splash, dust, or other contamination. According to the 2022 FDA Food Code section 5-205.11 Using a Handwashing Sink. (A) A HANDWASHING SINK shall be maintained so that it is accessible at all times for EMPLOYEE use. (B) A HANDWASHING SINK may not be used for purposes other than handwashing. On 6/1/2026 at 2:49 PM observed two unlabeled spray bottles on a shelf above the dish drain curtain area in the dish machine room. When queried, DM I was able to identify the contents and a dishwashing liquid and a sanitizer solution. According to the 2022 FDA Food Code section 7-102.11 Common Name. Working containers used for storing POISONOUS OR TOXIC MATERIALS such as cleaners and SANITIZERS taken from bulk supplies shall be clearly and individually identified with the common name of the material. P On 6/2/2026 at 11:15 AM observed [NAME] J dropping a bottle of salad dressing on the floor in front of the two-door reach in cooler and reached down with gloved hands and pick the bottle of dressing up off of the floor and place the dressing onto the shelf in the cooler. [NAME] J closed the door to the cooler and walked over to the prep table and began to immediately wrap a sandwich on a plate with plastic wrap, tucking the plastic under the plated sandwich and using the gloved hand to cut the plastic wrap and finish wrapping the sandwich, without changing their gloves or washing their hands. During this observation, DM I was asked about how that situation would normally be handled. DM I stated that any food item that falls on the floor is to be disposed of. When asked about the facilities handwashing policy, DM I stated that employees are trained upon starting, and managers constantly observe food staff and educate them as needed on a daily basis. According to the 2022 FDA Food Code section 3-301.11 Preventing Contamination from Hands. Even though bare hands should never contact exposed, ready-to-eat food, thorough handwashing is important in keeping gloves or other utensils from becoming vehicles for transferring microbes to the food. (A) Personal Cleanliness, i.e., handwashing procedures, including frequency and methodology of handwashing that ensure food employees keep their hands and fingertips clean, and handwashing occurs at the times (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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	specified in section 2-301.14, including after using the toilet and between tasks that may re-contaminate the hands. On 6/1/2026 at 2:55 PM observed a cart rinsing hose at the cart rinsing station across from the dish machine area had an atmospheric vacuum breaker at the faucet outlet. A hose with a spray nozzle was connected to this faucet, leaving the hose and the atmospheric vacuum breaker under constant pressure. This has the potential to cause failure of the atmospheric vacuum breaker. At the time of this observation, DM I confirmed the presence of the spray nozzle on the end of the hose that is attached after the faucet that has the atmospheric vacuum breaker. According to the 2022 FDA Food Code section 5-205.15 System Maintained in Good Repair. A PLUMBING SYSTEM shall be: (A) Repaired according to LAW; and (B) Maintained in good repair.		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on interview and record review the facility failed to provide documentation to the hospital to ensure a safe and effective transition of care for four Residents (#3, #43, #74, and #101) of four residents reviewed for hospitalization. Findings include: Resident #3 (R3) was transferred to the hospital Emergency Department (ED) on 2/6/26. There was no documentation in the Electronic Medical Record (EMR) indicating specific documentation to the hospital regarding contact information of the practitioner responsible for the care of the resident, resident representative information, advanced directive information, comprehensive care plan goals, discharge summary, special instructions for ongoing care, and any other information to ensure a safe and effective transition of care. During an interview on 6/3/26 at 9:37 a.m., the Director of Nursing (DON) reported, We do not document any information that is given to the hospital when a resident is transferred from the facility. Resident #43 (R43) Review of R43's census indicated R43 was sent to the emergency department on 12/26/25. Review of R43's electronic medical record failed to ensure regulatory documentation was communicated to the local hospital where R43 was transferred to. Resident #74 (R74) Review of R74's census indicated R74 was sent to the emergency department on 12/15/25. Review of R74's electronic medical record failed to ensure regulatory documentation was communicated to the local hospital where R74 was transferred to. Resident #101 (R101) Review of R101's census indicated R101 was sent to the emergency department on 5/21/26. Review of R101's electronic medical record failed to ensure regulatory documentation was communicated to the local hospital where R101 was transferred to. Review of policy titled, Transfer and Discharge (including AMA), dated 2/11/25, read in part Policy: It is the policy of this facility to permit each resident to remain in the facility, and not transfer or discharge the resident from the facility, except in limited circumstances. This policy applies to all residents regardless of their payment source. Policy Explanation and Compliance Guidelines.8. For a transfer to another provider, for any reason, the following information must be provided to the receiving provider: a. Contact information of the practitioner who was responsible for the care of the resident; b. Resident representative information, including contact information; c. Advanced directive (continued on next page)		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	information; d. All other information necessary to meet the resident's needs, which includes, but is not limited to: i. Resident status, including baseline and current mental, behavioral, and functional status, reason for transfer, recent vital signs; ii. Diagnoses and allergies; iii. Medications (including when last received); and iv. Most recent relevant labs, other diagnostic tests, and recent immunizations. e. All special instructions and/or precautions for ongoing care, as appropriate such as; i. Treatments and devices.iii. Special risks such as risk for falls.f. The resident's comprehensive care plan goals.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. Based on observation, interview, and record review, the facility failed to secure medications and maintain the security for one medication cart of two medication carts reviewed for medication storage. Findings include: On 6/2/2026 at 7:24 AM, an observation was made of the C-wing medication cart which was discovered unlocked and unattended by a nurse. At 7:28 AM, an interview was conducted with Certified Medication Technician B who was responsible for the medication cart and was asked if she normally leaves her medication cart unlocked and unattended and replied, No. Certified Medication Technician B was asked where she went and what she was doing and replied, I just went to the nourishment room to get a couple of juices. The nourishment room is located behind a closed door, and the medication cart was not in view of Certified Medication Technician B. On 6/2/26 at 7:46 AM, an interview was conducted with the Director of Nursing (DON) who was asked what her expectations were for medication carts and replied, Always lock them when you walk away and never leave unlocked if not directly in sight. Review of policy titled, Medication Storage dated 6/24/24, read in part Policy: It is the policy of this facility to ensure all medications housed on our premises will be stored in the pharmacy and/or medication rooms 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: 1. General Guidelines: a. All drugs and biologicals will be stored in locked compartments.		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on interview and record review, the facility failed to ensure timely staff response to resident call lights for five sampled Residents (#18, #58, #59, #74, #87) and two confidential residents out of of ten residents reviewed for staffing. Findings include: Resident #18 (R18), Resident #58 (R58), Resident #59 (R59), Resident #74 (R74), Resident #87 (R87) Review of R18's, R58's, R59's, R74's, and R87's Call (time response) Statistic report, retrieved by the facility on 6/2/26 at 12:53 p.m., revealed the following call light response times, respectively between 5/1/26 and 5/31/26: R18 - 10 call lights with Target Times of 5:00 Minutes that had Actual Time(s) of staff response between 20 to 34 minutes wait time. R58 - 28 call lights between 21 minutes to 1 hour and 33 minutes wait time. R59 - 13 call lights between 20 minutes to 1 hour and 2 minutes wait time. R74 - 11 call lights between 20 minutes to 31 minutes wait time. R87 - 9 call lights between 21 minutes to 35 minutes wait time. During an interview on 6/3/26 at 8:22 a.m., when asked what time frame staff were expected to respond to resident call lights, Assistant Director of Nursing (ADON) H stated, I believe 10 minutes is the anticipated time for response. When asked if R18's call light response times had been audited in the last month (May 2026), ADON H stated, I don't believe I have ever tracked [R18's] call light response times and then recalled an audit sheet for Call Lights. R18's call lights were reviewed on 5/18/26 with no extended call light response wait times. Review of the Call Statistic report for May 2026, confirmed R18 did not have any extended wait times on that specific day, but had multiple extended call light wait times. ADON H acknowledged they had not pulled the Call Statistic report for May 2026 to identify any concerns related to timely care response for R18. ADON H said she was not aware of any concern related to call light response times expressed by [R18] in the last month. Review of the Resident Rights policy, dated 1/4/23, revealed the following, in part: .4. Respect and Dignity. The resident has a right to be treated with respect and dignity, including . c. The right to resident and receive services in the facility with reasonable accommodation of resident needs and preferences . 8. Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and support for daily living safely. 9. Grievances. The resident has the right to: a. Voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished; and the behavior of staff . and other concerns regarding the LTC (Long Term Care) stay. b. The resident has the right to, and the facility must make prompt efforts by the facility to resolve grievances the (continued on next page)		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident may have . During an interview conducted on 6/1/26 at 1:35 PM, Resident #18 (R18) reported concerns regarding insufficient staffing to adequately meet resident needs. R18 stated he frequently experienced a delay of nearly two hours before staff responded to his call light. He further indicated that the unit lacked an adequate number of Certified Nurse Aides (CNAs) to provide timely assistance and meet residents' care needs. According to R18, he had previously reported these concerns to facility management but had not received a response. During a confidential group interview on 6/2/26 at 11:20 a.m., two confidential Residents indicated they had concerns with staff not answering call lights in a timely manner and reported the following: One confidential Resident reported, Lights are on and the staff does not answer. I couldn't get help one night and the staff here had pizza somewhere. I could not get my pain medication. Another confidential Resident reported, One night the staff shut off the light after 30 minutes. I put my light on again and the nurse finally came.night shift is really bad.Two weeks ago I told the Director of Nursing (DON), the Activity Director (AD), and the Social Worker because I had to wait two hours for my call light to be answered, I have not heard anything from any of them regarding my call light not being answered.		

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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 determine upon admission whether a resident had an existing advance directive or wished to establish one, provide or document information and assistance regarding advance directives, and periodically review the resident's advance directive status, for one Resident (#18) of three residents reviewed for advanced directives. Findings include: Resident #18 (R18) R18 was admitted to the facility on [DATE]. A Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 5/13/26 identified a primary diagnosis of cerebrovascular accident (stroke). The MDS documented a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating intact cognition. The assessment further identified R18 as having adequate hearing, clear speech, the ability to understand others, and the ability to be understood. During an interview conducted on 6/1/26 at 1:35 PM, R18 stated he had resided in the facility for approximately two years. When queried regarding an advance directive, R18 stated he could not recall anyone at the facility discussing advance directives with him. A review of R18's electronic medical record (EMR) on 6/2/26 at approximately 1:00 PM failed to identify an advance directive, defined as a written instruction recognized under state law, such as a living will or durable power of attorney for healthcare, regarding healthcare decisions made when an individual becomes incapacitated. Further review of the EMR revealed no evidence the facility had: Determined upon admission whether R18 had an existing advance directive; Determined whether R18 wished to formulate an advance directive; Provided information or assistance regarding advance directives; Documented that R18 declined information regarding advance directives; or Periodically reviewed R18's right to formulate an advance directive. Additionally, review of the comprehensive care plan failed to identify R18's advance directive status or preferences regarding advance directives. On 6/2/26 at 1:11 PM, a written request was submitted to the Director of Nursing (DON) requesting a copy of R18's advance directive or documentation demonstrating the resident had been offered information regarding advance directives. On 6/3/26 at 7:47 AM, the DON was again asked to provide advance directive documentation for R18. The DON responded via email, stating, There is a progress note charted from 5/22/26 regarding discussion of AD for [R18]. The progress note referenced by the DON was dated 5/22/26 at 1:07 PM and authored by the Social Worker (SW). The note stated: [R18] was asking for a notary. He needed a bill of sale witnessed. When asked about what was being notarized, he did not want to say. As we talked, he eventually talked about his sale of his electric wheelchair. He also mentioned buying a scooter to ride. DON and SW discussed policies and boundaries with this. During this conversation, SW, DON and Activities Director talked about DPOA paperwork. [R18] indicated he had it drawn up but it was in [location redacted]. SW to follow up with his son. If not found, SW will assist with Advanced Directives. Upon further review, it was observed the EMR program generated an asterisk next to the name of the SW in the progress note. A progress note history trail revealed the asterisk was generated to indicate the original note had been amended. The audit trail indicated the original progress note of 5/22/26 was amended on 6/2/26 at 2:11 PM, approximately one hour after the surveyor requested documentation regarding advance directives. According to the EMR, the original version of the progress note read: [R18] was asking for a notary. He needed a bill of sale witnessed. When asked about what was being notarized, he did not want to say. As we talked, he eventually talked about his sale of his electric wheelchair. He also mentioned buying a scooter to ride. DON and SW discussed policies and boundaries with this. The (continued on next page)		

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	original note written on 5/22/26 contained no reference to advance directives, durable power of attorney documentation, follow-up with family, or assistance with advance directives. This information was added during the amendment completed on 6/2/26 at 2:11 PM, after the surveyor requested advance directive documentation on 6/2/26 at 1:11 PM. The Social Worker was interviewed on 6/3/26 at 9:44 AM. The SW stated advance directives were discussed with R18 in May 2026. When asked whether advance directives had been discussed prior to May 2026, the SW stated she did not believe they had been. The SW further stated the discussion had been documented in a progress note dated 5/22/26. When asked whether the note had been amended, the SW acknowledged the note was amended the previous day, on 6/2/26. When asked why the amendment was made, the SW stated she was instructed to amend the note. The SW confirmed she had not maintained contemporaneous documentation and said she was directed by the DON on 6/2/26 to add information regarding advance directives that was not included in the original progress note documentation. The facility was unable to provide evidence that Resident #18's advance directive status had been established, documented, or incorporated into the care plan since admission on [DATE]. The policy titled Residents' Rights Regarding Treatment and Advance Directives dated as reviewed/revised 3/5/24 read, in part: .On admission, the facility will determine if the resident has executed an advance directive, and if not, determine whether the resident would like to formulate an advance directive. Upon admission, should the resident have an advance directive, copies will be made and placed on the chart [EMR]. During the care planning process, the facility will identify, clarify, and review with the resident or legal representative whether they desire to make any changes related to any advance directives. Decisions regarding advance directives and treatment will be periodically reviewed as part of the comprehensive care planning process.		

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. Based on interview and record review, the facility failed to ensure one Resident (#48) of three residents reviewed for activities of daily living received bathing/shower services as scheduled. This deficient practice resulted in the potential for unmet hygiene needs, diminished dignity, and compromised quality of care. Findings include: Resident #48 (R48) During an interview conducted on 6/1/2026, R48 reported she had not been receiving showers routinely. R48 alleged she had received only two showers in the month of May 2026. R48 asserted she was to receive showers on Tuesdays and Fridays each week. A Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 2/23/2026 documented R48's admission date as 2/24/2022, with a primary diagnosis of an orthopedic condition. The MDS indicated R48 scored 15 out of 15 on the Brief Interview for Mental Status (BIMS), reflecting intact cognition. The assessment further documented R48 did not reject care and there were no behaviors exhibited by R48. The MDS coded R48 as requiring partial/moderate staff assistance with bathing and showering. Review of R48's electronic medical record (EMR) revealed an Activities of Daily Living (ADL) care plan indicating the resident required staff assistance with ADLs. A care plan intervention dated 5/27/2025 directed staff to provide SHOWER/BATHE: supervision assist x1 staff. On 6/2/2026 at 1:38 p.m., the Director of Nursing (DON) provided Certified Nurse Aide (CNA) documentation for May 2026. The records reflected R48 received only two showers during the month, documented on 5/12/2026 and 05/29/2026. There was no documentation of shower refusals on the shower sheets or elsewhere in the EMR. During an interview on 6/2/2026, Licensed Practical Nurse (LPN) K stated R48 was scheduled to receive showers twice weekly on Tuesdays and Fridays. The nurse described R48 as alert, oriented, reliable, and unlikely to fabricate information. The nurse further stated it was very rare for R48 to refuse care and said R48 did not refuse staff assistance. In an interview conducted on 6/2/2026 at 2:11 p.m., the DON stated the CNA documentation may not accurately reflect all showers provided and suggested staff may have failed to document the care. The DON stated CNAs were expected to document all showers provided, and document any resident refusals. The DON also confirmed that R48 did not refuse care. The policy titled Resident Rights dated as implemented 1/4/23 read, in part: . The resident has the right to a dignified existence, self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including by not limited to: a. The resident has right to choose activities, schedules . The resident has the right to make choices about aspects of his or her life in the facility that are significant to the resident. The policy titled Resident Showers dated as implemented 6/24/24 read, in part: . It is the practice of this facility to assist residents with bathing to maintain proper hygiene, stimulate circulation and help prevent skin issues as per current standards of practice.		

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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 ensure appropriate coordination and documentation of hospice services, obtain and maintain a physician's order for hospice services, develop and implement a comprehensive care plan addressing the resident's hospice status and services, and maintain hospice documentation in the medical record for one Resident (#6) of one resident reviewed for hospice care. Findings include: Resident #6 (R6) R6 was admitted to the facility on [DATE] with a primary diagnosis of Alzheimer's Disease. Review of the electronic medical record (EMR) revealed R6 was cognitively impaired and dependent on staff for activities of daily living. A review of the EMR conducted on 6/1/26 indicated R6 received hospice services. However, the record did not contain a physician's order authorizing hospice care. Further review failed to identify a facility care plan addressing the resident's hospice status, goals of care, interventions, or coordination of hospice services. The EMR did not contain documentation to ensure coordination of care services, monitoring, or evaluation of care. During review on 6/1/26, the EMR of R6 did not include hospice nursing notes, hospice assessments, hospice visit documentation, or other hospice records demonstrating the provision and coordination of hospice services. The EMR lacked hospice nursing notes, assessments, visit records, or other hospice documentation necessary to demonstrate the provision, monitoring, and coordination of hospice services. During an interview on 6/2/26 at 2:13 PM, the Director of Nursing (DON) stated a physician's order was required for a resident to receive hospice services. The DON further stated care plan development was expected when a resident commenced hospice services. The DON asserted the hospice provider also developed a care plan, which should be scanned into the resident's record and maintained in the EMR. When asked when R6 began receiving hospice services, the DON stated the resident was admitted to hospice on May 21, 2026. The policy Coordination of Hospice Services dated as revised 1/12/26 documented, in part: .When a resident chooses to receive hospice care and services, the facility will coordinate and provide care in cooperation with hospice staff in order to promote the resident's highest practicable physical, mental, and psychosocial well-being. The facility and hospice provider will coordinate a plan of care and will implement interventions. The plan of care will identify the care and services that each entity will provide in order to meet the needs of the resident. The facility will communicate with hospice and identify, communicate, follow and document all interventions put into place by hospice and the facility. The policy Hospice Services Facility Agreement dated as implemented 2/27/23 read, in part: .The designated member of the facility working with hospice representative is responsible for: .obtaining the following information from the hospice: i. The most recent hospice plan of care specific to each resident.iii. Physician certification and recertification of the terminal illness.vii. Hospice physician and attending physician orders specific to each resident. The facility will, under a written agreement, ensure that each resident's written plan of care includes both the most recent hospice plan of care and description of the services furnished by the facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235554	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/03/2026
NAME OF PROVIDER OR SUPPLIER Eastwood Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 900 Maas Street Negaunee, MI 49866	
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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, interview, and record review, the facility failed to ensure accurate delivery of medications for one Resident (#31) of three residents reviewed for medication administration with 2 errors out of 30 opportunities resulting in a medication error rate of 6.67%. Findings include: Resident #31 (R31) On 6/2/2026 at 7:50 AM, during medication administration for (R31), Licensed Practical Nurse (LPN) A was observed touching a pill lying on the surface of the medication cart and not in the medication cup to place it back in the medication cup with their bare hands. LPN A was observed reaching around the medication cart on the left and a medication capsule fell from her hand onto the floor. LPN A did not notice the pill fell to the floor. LPN A then entered R31's room and administered his oral medications and then gave R31 his insulin via subcutaneous injection and held the site for two seconds. On 6/2/26 at 7:55 AM, an interview was conducted with LPN A who was asked how long she was to hold insulin injection site and replied, Five to ten seconds. LPN A was made aware she only held the insulin injection site for two seconds. LPN A was asked if she should have touch R31's medication with bare hands and replied, No. I don't normally touch medications with bare hands. LPN A was asked about the pill which had fallen to the floor and if it belonged to R31 and replied, Oh, I didn't see that. It looks like it might be his Flomax. LPN A picked up the pill on the floor and identified it as R31's Flomax which was omitted during medication pass. On 6/2/2026 at 11:30 AM, an interview was conducted with the Director of Nursing (DON) who was made aware of the medication error rate and was asked what her expectations were regarding the observations made during medication administration and replied, Not to touch medications with bare hands. Hold insulin injections for 6 to 10 seconds per facility policy. Medications are not to be omitted, and nurse should have noticed she dropped the pill and replaced the medication. Review of policy titled, Medication Administration dated 9/25/2017, read in part Policy: To provide a safe and efficient manner for administering medications to residents, the following procedure will be followed. Medications will be administered by licensed personnel only. Procedure: A. Dispense medications following the Five Rights: 1. Right Patient 2. Right Drug 3. Right Amount 4. Right Time 5. Right Route. Review of policy titled, Insulin Pen dated 2/12/24, read in part Policy: It is the policy of this facility to use insulin pens in order to improve the accuracy of insulin dosing, provide increased resident comfort, and serve as a teaching aid to prepare residents for self-administration of insulin therapy upon discharge. Policy Explanation and Compliance Guidelines.j.v. While still pressing the plunger, keep the needle in the skin for up to 6-10 seconds and then remove the needle from the skin.		