STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235569	A. Building B. Wing	04/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ovid Healthcare Center	9480 E M-21 Ovid, MI 48866

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 maintain best practices in the food service area resulting in the potential to spread food borne illness to all residents that consume food from the kitchen. Findings include: On 04/01/2026 at 8:47am observed overhead spray nozzle hanging below the flood rim of the garbage disposal. During this observation, Dietary Manager E stated she was aware that the spray nozzle needs to be above the sink and maintenance knew about it as well. There was a zip tie around the hose, attempting to hold it up. On 04/01/2026 at 9:36am observed the drain line to the ice machine routed directly into drain in the nourishment room. On 04/01/2026 at 12:29 PM observed drain line to ice machine sitting inside drain in the main food storage room.According to the 2022 Food Code, 5-202.13 Backflow Prevention, Air Gap, An air gap between the water supply inlet and the flood level rim of the plumbing fixture, equipment, or nonfood equipment shall be at least twice the diameter of the water supply inlet and may not be less than 25 mm (1 inch).

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to have an active plan for reducing the risk of legionella and other opportunistic pathogens of premise plumbing (OPPP). This deficient practice has the increased potential to result in waterborne pathogens to exist and spread in the facility's plumbing system and an increased risk of respiratory infection among all residents in the facility. Findings include:On 04/01/2026 at 9:41am observed an unused hose with a spray nozzle in the bathroom near the toilet in room [ROOM NUMBER]. During this observation, Maintenance Director C was interviewed on whether the hose near the toilet was flushed on a regular basis to prevent water stagnation, and he said they will flush unused fixtures in the empty rooms, but the hose near the toilet is not flushed. On 04/01/2026 at approximately 9:42am observed an unused hose with spray nozzle in bathroom near toilet in room [ROOM NUMBER]. On 04/01/2026 at approximately 9:44am observed an unused hose with spray nozzle in bathroom near toilet in room [ROOM NUMBER]. On 04/01/2026 at approximately 9:45am observed an unused hose with spray nozzle in bathroom near toilet in room [ROOM NUMBER]. On 04/01/2026 at approximately 9:46am observed an unused hose with spray nozzle in bathroom near toilet in room [ROOM NUMBER]. On 04/01/2026 at 9:49am observed a hopper in the housekeeping storage room. During this observation, Maintenance Director C was interviewed on whether the hopper is used and flushed regularly, and he said he wasn't sure if the hopper is being used and he wasn't sure if the hopper was flushed. On 04/01/2026 10:41 AM record review of the facility's water management plan on ways to intervene when control limits are not met, Remediation Activities establishing remediation activities and plans for addressing any breaches in control limits is crucial. This may involve flushing out stagnant water, adding disinfectant, or other corrective actions. In addition, the water management program policy states, The general principles of an effective water management program include: Preventing water stagnation. According to the facility's flushing logs, it states 1. Run water for a minimum of 3 minutes on all plumbing fixtures that do not get used regularly. Examples of this would be rooms off line, storage areas, mechanical rooms etc . The flushing logs were marked as completed for March, February, and January of 2026, and December 2025. According to the Centers for Disease Control and Prevention, Controlling Legionella in Potable Water Systems dated January 3rd, 2025, Eliminate dead legs, which are sections of no- or low-water flow.According to the Centers for Disease Control and Prevention, Controlling Legionella in Potable Water Systems dated January 3rd, 2025, Flush low-flow piping runs and dead legs at least weekly. Flush infrequently used fixtures (e.g., eye wash stations, emergency showers) regularly as needed to maintain water quality parameters within control limits.

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Through observation, interview and record review the facility failed to maintain the resident's dignity related to smoking for one resident (R2) of one evaluated for independent smoking based on unchanged smoking evaluations before and after appointed guardianship. Findings IncludeResident #2 (R2)Review of the medical record reflected that R2 was admitted to the facility on [DATE]. Diagnoses of paraplegia, migraines, bi-polar, contractors on left hip, right hip, right knee, left knee, muscles spasms, osteoarthritis and PTSD.The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 03/13/2026 revealed R2 had a Brief Interview of Mental Status (BIMS) of 15 (cognitively intact) out of 15. Under section G0100, Activities of Daily Living (ADL) Assistance reveals R2 was independent with eating, but maximal assistance on toileting, showering, dressing lower body, sit to stand and transferring from one surface to another.During an interview on 04/02/2026 at 9:13 AM, R2 asked writer about independent smoking because he has a new guardian and he was told he cannot be an independent smoker if you have a guardian. During an interview on 04/01/2026 at 3:13 PM, Activity Director (AD) was asked by writer who completed R2s smoking evaluation, stated it wasn't her, adding he should be supervised. In all previous assessments R2 was documented as being independent. AD stated because he had a guardian. Writer asked why that would prevent him from smoking independently, she stated because he's not safe. Record review revealed the smoking evaluations for R2 on the dates of 07/01/25, 07/02/25, 09/10/25, 11/28/25, 03/12/26, 04/01/26. Evaluation dated 04/01/26 documented that he was independent and a comment was written in by DON stating Supervised smoker by default due to inability to make consistent safe choices. Has guardian/DPOA/RP. Smoking policy stated it was a decision of the interdisciplinary team to make the decisions together, not one individual. R2 did not use a smoking vest/lap apron, safely holds a cigarette, he has not had to be re-evaluated due to violations or warning for not following the rules to smoke.During an interview on 04/02/2026 at 9:23 AM, DON B, stated they/management team did a smoking evaluation yesterday and R2 was deemed to not be an independent smoker, he was a supervised smoker, Supervised smoker by default due to inability to make consistent safe choices. Has guardian/DPOA/RP. Writer asked why that would stop him from smoking, DON stated he cannot wheel his wheelchair outside by himself, making him a supervised smoker. Writer asked if he had to wear a smoking vest/apron, DON stated no, writer asked if he had not followed the rules for smoking to make him supervised, DON B stated no. Writer asked if they had held an IDT team meeting to discuss this. DON B stated No. During an interview over the phone on 04/02/2026 at 10:17 AM, Guardian Angels P stated the facility had talked to her about another guardian within this facility, but he left the facility and then R2 went to supervised smoking, no explanation on where he went when he left the facility. Guardian Angels P stated she had not seen the policy for smoking and was going by what the facility told her. During an interview on 04/02/2026 at 1:30 PM, LNA A stated R2 had been a supervised smoker all along. LNA A stated it's the wording of the evaluation that says they are independent when we may feel they should be supervised. Writer asked LNA A about the facility smoking policy which says.Based on the interdisciplinary evaluation a decision will be made whether the resident is a safe or unsafe smoker.If the interdisciplinary team determines that the resident is an unsafe smoker, the resident may be required to wear a protective smoking vest/apron and is supervised while smoking.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation, interview, and record review the facility failed to ensure comfortable room temperatures for one (R13) with the potential to effect 60 residents. Findings include: On 3/31/2026 at 10:31 AM, Resident #13 (R13) was observed seated on the side of her bed. R13 motioned me to come into her room. Upon entry into R13's room, it was noticeably warmer from the ambient temperatures in the hallway. R13 had two fans on her and the window in her room was cracked open, however, the heater on the wall was running and blowing out hot air. R13 seemed anxious and began telling me that she felt very hot in her room. R13 explained that she has a diagnosis of Chronic Obstructive Pulmonary Disease and the high temperatures in her room are making her uncomfortable and making it more difficult for her to breath, causing increase discomfort. R13 stated that this has been reported to the facility, however, nothing had been done to address the heat issue in her room which had been ongoing for nearly a week. On 3/31/2026 at 10:35 AM, Maintenance Director C checked the ambient room temperature in the room. The ambient room temperature reached 81.6 degrees Fahrenheit. Maintenance Director C acknowledged this exceeded acceptable temperature ranges.

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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 care planned interventions to prevent falls for one (Resident #56) out of 14 residents reviewed for care plans.Findings include: Resident #56 (R56)Review of the medical record reflected Resident #56 (R56) was admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses that included kidney disease anxiety disorder, restless leg syndrome, dementia, bipolar disorder, fracture of the nasal bones, and type two diabetes. The Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 1/15/2026, reflected R56 scored 14 out of 15 (cognitively intact) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool). On 4/01/2026 at 11:29 AM, R56 was observed in his room lying in bed. R56 had bruising on his face that was mostly resolved. During conversation, R56 stated that the bruising occurred from a fight but later, stated it occurred from a fall. R56 had a regular, flat mattress on his bed and did not have any posted remind to use call light type signs on his walls. Review of a Fall Care plan revealed all fall interventions were in place at the time of observation expect an intervention for a sign placed in view to remind resident to utilize call light for assistance with transfers initiated on 11/15/2025 and an intervention for a perimeter/concave mattress implemented on 11/17/25. On 4/01/2026 at 12:49 PM, R56 did not have a perimeter mattress or a sign posted on the wall in his room,On 4/2//2026 at 2:10 PM, R56 did not have a perimeter mattress or a sign posted on the wall in his room On 4/3/2026 at 10:05 AM, R56 did not have a perimeter mattress or a sign posted on the wall in his room. In an interview on 04/03/2026 at 2:24 PM, Director of Nursing (DON) B confirmed that R56 had sustained a few falls during his admission at the facility. DON B stated that the Interdisciplinary Team discusses interventions and will often round to ensure fall interventions are in place. When asked if R56's concave mattress and sign reminding R56 to use his call light were in place, DON B stated that she did not think that those interventions were currently in place.

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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 observation, interview, and record review the facility failed to ensure orthostatic blood pressures were being monitored correctly (Resident #56) following professional standards.Findings Include Review of the medical record reflected R56 was admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses that included kidney disease anxiety disorder, restless leg syndrome, dementia, bipolar disorder, fracture of the nasal bones, and type two diabetes. The Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 1/15/2026, reflected R56 scored 14 out of 15 (cognitively intact) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool). On 4/01/2026 at 11:29 AM, R56 was observed in his room lying in bed. R56 was alert but did not answer questions appropriately. Review of R56's Electronic Medical Record revealed a long history of prescribed antipsychotics for his medical diagnosis. Review of R56's Physician orders revealed active orders for check ortho bp (orthostatic blood pressure) active from 3/19/26 to 3/20/26. Another Physician Order stated take orthostatic BP (blood pressure) q (every) shift x 3 days (for three days) active from 3/21/26 to 3/23/26. Review of the Medication Administration Record (MAR) and the Vitals section in the Electronic Medical Record revealed inconsistent methods for obtaining the orthostatic blood pressures if they were obtained, and/or, no documentation depicting that the blood pressures were obtained. Review of the MAR for 3/19/26 revealed a y for yes in the section for check ortho BP and 3/20/26 revealed a single recorded blood pressure. Review of the Vitals Tab for the dates of 3/21/26 and 3/22/-26 revealed single blood pressure records.Review of the Vitals Tab for 3/23/26 showed two blood pressure recordings, 7 minutes apart, both noted to be in a seated position. In an interview on 4/03/2026 at 2:24 PM, Director of Nursing DON B stating that the procedure of obtaining orthostatic blood pressures would be to have the resident change positions from lying, sitting, and standing (if able) and obtain blood pressures with each position change. Per the Center for Disease Control and Prevention, the recommended method for obtaining orthostatic blood pressure would be to have the patient lie down for 5 minutes, measure blood pressure and pulse rate, then have the patient stand and repeat blood pressure and pulse rate measurements after standing 1 and 3 minutes.

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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. Based on observation, interview and record review, the facility failed to provide adequate pain management to one resident (R31) of one resident resulting in decline in activities of daily living related to uncontrolled pain. Findings IncludeResident #31 (R31)Record review on 03/31/2026 at 2:07 PM oxycodone HCl Oral Tablet 5 MG Give 2 tablet by mouth every 4 hours as needed for pain management.Observation on 03/31/2026 at 2:07 PM, R31 grimaced and jerked in place trying to explain his illness and the pain was unbearable. Observation on 04/02/2026 at11:05 AM from R31's door, R31 moaning out in pain, talking in his sleep. Writer asked R31 if he was in pain, he stated yes. Writer asked R31 if his pain medication was scheduled or he needed to ask for it. R31 stated he thought it was scheduled, rated it as #8 on scale of 0-10. R31 tried to reposition to try and get some relief on his right hip. Writer asked R31 if he needed something. R31 stated yes if they would give him something for pain, writer reminded R31 to push his call light, observed LPN S walking towards his room to ask about his pain. During an interview on 04/03/2026 at 8:01AM, RN T stated R31 has had a lot of pain especially in his right hip, when he fell, he reinjured it.RN T stated R31 had Tylenol ES 1000mg scheduled three times a day. Some days R31 does not have any pain. RN T stated she had asked provider for something long acting, but he hasn't ordered anything. RN T stated he did decline therapy related to pain. RN T stated they had recommended hospice, he was onboard, but his brother and therapy talked him out of it. RN T stated she had cared for him since his admission, he used to use walker, commode on his own, he could get around in his room independently. R31 rated his pain a #6 on a scale of 0-10, R31 received 2 Tylenol ES 1000mg plus Oxycodone 5mg as needed dose for right hip pain.RN T stated she gowns up for enhanced barriers PPE, doesn't have to gown up until she provides care but it's something she always does, better to be safe. RN T stated she was going to have the doctor come in and see him today. During an interview 04/03/2026 at 10:20 AM Interview with CNA U stated R31 frequently yells out like that, indication of pain, received report that he was more disoriented the last day or two. CNA U stated R31 cannot reposition himself related to his pain. CNA U also stated they pretty much do everything for him now, he yells out in pain. CNA U stated they had to change the linens and give him a bed bath because he misses using the urinal and the bedding is saturated with urine. CNA U stated therapy works with him and the restorative aide also works with him on range of motion. CNA U stated he seemed to always be in pain. During an interview on 04/03/2026 at 10:28 AM, LPN V stated the provider ordered labs. During an interview and observation on 04/03/2026 at 10:31 AM, LPN V reported the changes with R31 to NP W and stated R31 was using his scheduled mediations and prn medications and asked about a longer acting pain medication. NP W stated R31 had not said anything to him about that, but he didn't have a problem ordering that.During an interview on 04/03/2026 at 12:55 PM, Therapy Director O stated she was aware of R31 refusing therapy related to pain. Therapy Director O stated they try to coordinate pain medication administration with therapy. During an interview on 04/03/2026 at 2:06 PM, DON B stated NP W wrote new orders for Urinalysis with Culture & Sensitivity with the labs Complete Blood Count and Complete Metabolic Panel and that order for discontinued Pentoxifylline ER. Oxycodone 10mg tablet every 6 hours scheduled, Flexeril 5mg tablet every 8 hours for muscle pain.