STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235588	A. Building B. Wing	04/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maple Valley Nursing Home	1086 W. Burdickville Road Maple City, MI 49664

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49302 This Deficient Practice Statement (DPS) has two parts: A and B. DPS A: Based on observation, interview, and record review, the facility failed to prevent the unauthorized removal of a resident from the facility for approximately 16 hours resulting in the likelihood for serious injury, serious psychosocial harm, or death for one Resident #9 (R9) of one resident reviewed for abuse. Findings Include: The Immediate Jeopardy began on 9/18/23 at 6:07 PM when the facility failed to prevent R9's unauthorized leave from the facility by two former terminated Certified Nurse Aides (CNAs). Former Registered Nurse (RN) M failed to ensure Former CNA/Perpetrator I and J had permission to take R9 from the facility to an unknown location for approximately 16 hours without any medication provided, including potentially necessary hospice medications, or a thickening agent for R9's prescribed therapeutic diet. The Director of Nursing (DON) was notified of the immediate jeopardy on 4/22/24 at 4:37 PM. At that time, a written removal plan was requested from the facility. This surveyor confirmed by interview and record review that the immediacy was removed on 4/22/24 at 11:30 AM, however, noncompliance remains at the potential for more than minimal harm due to sustained compliance which has not been verified by the State Agency (SA). Resident #9 (R9): (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235588	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/25/2024
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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of R9's electronic medical record (EMR) revealed admission to the facility on [DATE] with diagnoses including Huntington's disease (a progressive, fatal genetic disorder that affects the brain and causes involuntary movements, cognitive decline, and emotional problems), aphasia (difficulty processing, using, and/or understanding language), dysphagia (difficulty or inability to swallow), contracture of unspecified hand (a permanent shortening and tightening of muscle fibers that reduces flexibility and makes movement difficult), and alcohol abuse. Record review of R9's Minimum Data Set (MDS) assessment immediately preceding the unauthorized leave of absence (LOA) on 7/20/23, indicated R9 had severely impaired cognition - unable to complete BIMS [Brief Interview for Mental Status]. R9 was admitted to hospice services on 7/20/23. On 4/22/24 at 10:27 AM, R9 was observed sitting in a specialized wheelchair with anti-tip bars, a Velcro lap buddy, back leg rests, and a pressure reducing cushion. A pressure reducing mattress was noted in R9's room. On 4/22/24 at 11:47 AM, a phone interview was conducted with R9's Guardian [H], who disclosed two former facility staff members had taken R9 out overnight without his permission at some point the previous fall. Guardian H indicated the facility called him the morning following the LOA to ask if facility staff that worked the previous evening had asked him for consent prior to R9's departure. Guardian H indicated he did not give approval and was unaware of R9's exit from the facility. On 4/22/24 at 1:04 PM, a follow-up phone interview was conducted with Guardian H who stated the morning following R9's leave of absence, he received a call from the facility informing him that R9 was missing. Guardian H indicated the facility informed him Perpetrator I and Perpetrator J (later identified as former terminated Certified Nursing Assistants [CNAs] at the facility) had taken him out of the facility the previous night and had not returned. Guardian H stated, I was freaking out. I asked if we should file a report with the police. Guardian H reiterated the facility had not called him prior for permission for R9's departure, stating, I was upset with the nursing home and their lack of calling me. The nurse who called me the morning he was missing wasn't sure where [R9] was. I was shocked .shocked that the facility would let somebody out on hospice care and not even call to even verify if it was okay. Guardian H stated that since R9 signed with hospice on 7/20/23, nobody was authorized to take R9 from the facility due to his deteriorating physical and mental condition. Review of R9's progress notes revealed the following entries: 1. 9/18/23 at 18:07 [6:07 PM] written by former Registered Nurse (RN) M: LOA with [Perpetrator J] and [Perpetrator I] to [Perpetrator J's] house at 1807 [6:07 PM]. 2. 9/18/23 at 22:24 [10:24 PM] written by RN D: Resident's responsible party for LOA was called and did not answer. 3. 9/18/23 at 23:44 [11:44 PM] written by RN D: This writer attempted to call [Perpetrator J] and [Perpetrator I] and [Guardian H]. None of them answered. DON aware. 4. 9/18/23 at 23:49 [11:49 PM] written by RN D: This writer attempted to call [Perpetrator J] and [Perpetrator I] and [Guardian H] each multiple times. None of them answered. 5. 9/19/23 at 09:48 [9:48 AM] written by RN K: LOA Returned from [Perpetrator J's] house driven by [Perpetrator J] and [Perpetrator I]. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 4/22/24 at 1:55 PM, a phone interview was conducted with RN D who was asked why R9's responsible party was not called for approval of an LOA until after R9 had already exited the building for approximately 4. 5 hours. RN D stated, I think I was expecting him to be back that night and that's why I called the responsible guardian [H] .or I wasn't certain if he was supposed to return so I was trying to figure it out. RN D was asked why he attempted several subsequent phone calls to Perpetrator J, Perpetrator I, and Guardian H as documented at 11:44 PM and 11:49 PM. RN D stated, I wasn't getting through to people, and I wasn't sure if [R9] was coming back at that time. RN D was asked the protocol for a resident going on a leave of absence. RN D indicated the responsible party would sign the resident out in the Release of Responsibility for Leave of Absence binder and the charge nurse would document the departure in the EMR. When RN D was asked if the process would differ for a resident with a guardian, he stated, If somebody were to want to take a resident and they weren't the guardian, I would contact the guardian to get permission .I'm not sure of the exact protocol, but I would put it into my LOA note [in the resident's EMR]. On 4/22/24 at 2:30 PM, a phone interview was conducted with former Director of Nursing (DON) RN M who verified that Perpetrator J and Perpetrator I came to the facility around 6:00 PM on 9/18/24. RN M stated Perpetrator J and Perpetrator I informed her that they were taking R9 out for a brief leave. RN M stated, They [Perpetrator J and Perpetrator I] had taken him out in the past and they would take him to [Perpetrator J's] house. They would take him over for dinner and bring him back. That's what I would have expected . I got a call from [Perpetrator J] saying that they got him [R9] back to the facility at 9:00 AM the next morning .I was furious. RN M was asked if Perpetrator J and Perpetrator I were authorized to take R9 on a LOA. RN M stated, I didn't look at it [the approved list of responsible parties] that day. When they [Perpetrator J and Perpetrator I] took him out of the facility, I just assumed they were on the approved list. RN M stated no necessary medications, equipment, or supplies per R9's plan of care or physician orders were sent upon his departure. On 4/22/24 at 2:54 PM, an interview was conducted with the Nursing Home Administrator (NHA) and the DON. The NHA verified that former CNAs, Perpetrator J and Perpetrator I, took R9 out of the facility on an unauthorized LOA and did not bring him back until the following morning. The NHA stated that although Perpetrator I did have permission at one time, Guardian H had since stopped anybody from removing R9 the facility following his admission to hospice (on 7/20/23) due to his declining condition. The NHA and DON both confirmed they were unaware of R9's absence from the building until arriving to the facility for work on the morning of 9/19/23. The NHA indicated they called local law enforcement after learning of the situation. The NHA stated, I didn't know what to do .What's the process for this? They basically kidnapped a resident. The NHA and DON stated they did not know why they were not contacted by RN D or former RN M on 9/18/23 after R9 left the facility and did not return. The NHA was asked if Perpetrator J or Perpetrator I had any previous history with R9. The NHA stated Perpetrator I had received disciplinary action in early 2021 after she shaved R9's legs, shaved a letter in the back of R9's hair, and drew inappropriate pictures and phrases on his skin with permanent marker. The NHA did not indicate Perpetrator I had any limited or altered contact with R9 following the incident as part of the remedial action. Review of CMS-2567 form dated 6/10/21 indicated Perpetrator I was, educated on resident's right, abuse and other policies regarding this type of behavior following the incident. The NHA verified Perpetrator I was subsequently terminated on 3/8/23 following a separate incident with a different resident per form CMS-2567 dated 7/3/23. The NHA confirmed Perpetrator J quit working as a CNA on 12/8/21 for reasons related to her vaccination status. Review of, [County Name] County Dispatch - Call Detail Report indicated Business Officer Manager (BOM) L filed a report on 9/19/23 at 9:24 AM that read, in part: (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Patient missing, two people came last night around 1800 HRS [6:00 PM], said they had paperwork to take him [R9] out . [Perpetrator I] .[Perpetrator J] . On 4/22/24 at 3:50 PM, a phone interview was conducted with Perpetrator J who stated, We just took him [R9] out for a good time . Me and [Perpetrator I] took him to my house for dinner and gave him a shower. Perpetrator J stated she informed the nurse on duty, RN M, that they were taking R9 on a LOA. Perpetrator J stated she didn't take any required medications, supplies, or equipment prior to departure besides a couple incontinence briefs. Perpetrator J indicated that she and Perpetrator I transferred R9 into her private vehicle without using the care-planned transfer technique and drove to her private residence. Once there, Perpetrator J indicated R9 ate some ground up stir fry, drank some water, and then she assisted him into the shower. Perpetrator J stated R9 slept in a recliner, propped up so he could breathe. Perpetrator J was asked if she had permission to take R9 on a LOA to which she replied, I had permission before he [R9] was on hospice. Since he was on hospice, the process was different, and I wasn't aware of that. Apparently, I was no longer cleared [to take R9 on a LOA]. Perpetrator J was asked if she was contacted by the facility after leaving with R9. Perpetrator J stated, Yes, that night the facility called me and asked what time R9 was going to be home. I told them, 'He'll be there when we get him there.' On 4/22/24 at 4:19 PM, a phone interview was conducted with Perpetrator I who stated she and Perpetrator J arrived at the facility around dinner time and notified RN M they were taking R9 on a LOA. Perpetrator I stated that CNA R packed R9 an overnight bag. Perpetrator I stated they took R9 to Perpetrator J's personal residence. Perpetrator I stated that R9 ate some pudding, tried a beer, but didn't like it, so he was switched to drinking pop. Perpetrator I verified R9 was given a shower at the residence because, he was covered in food and slop and slept in a recliner. Perpetrator I stated around 10:00 AM on the morning of 9/19/23, she received at text message from RN K asking when R9 was returning to the facility. Perpetuator I indicated to RN K that they were planning on returning R9, in a little bit until RN K stated that we had to bring him back immediately. Perpetrator I indicated that shortly after dropping R9 back off at the facility, she received a call from local law enforcement stating she was being charged with felony kidnapping. However, Perpetrator 'I stated the police officer ended up calling Perpetrator I back, stating R9's family no longer wished to press charges, and that they were instead upset at the facility for not knowing his whereabouts. On 4/22/24 at 4:58 PM, an interview was conducted with RN K who stated he arrived at the facility at the start of his shift around 6:30 AM on 9/19/23. RN K stated he received report from the midnight nurse, former RN M, who indicated R9 was not in the building. RN K stated, She [former RN M] seemed concerned. I don't think she was aware that R9 was going to be out overnight. RN K stated he tried calling Perpetrator J and Perpetrator I several times with no answer. RN K indicated he eventually got in contact with the NHA and BOM L who notified the police. Review of R9's MDS Assessment completed 7/20/23, revealed the following care area requirements: 1. Eating, toilet hygiene, upper body dressing, bed-to-chair transfer, toilet transfer, and car transfer: substantial/maximal assistant - helper does more than half the effort. 2. Shower/bathe self, lower body dressing: Dependent. Review of R9's Plan of Care revealed the following focuses: (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	1. TOILET USE, revised 3/29/23: 2 staff assist with gait belt, grab bar, place transport commode chair behind resident & assist to toilet. I am continent of bowel and occasionally incontinent of bladder. I need help with hygiene to prevent complications/infection. I am unsteady with poor balance coordination and require 2 staff CGA [contact guard assist] + gait belt with toileting. 2. TRANSFER, revised 3/15/23: I require 2 person extensive assist with gait belt during transfer to wheelchair. 3. FALL RISK - HIGH, revised 11/27/23. a. Scoop mattress to define edges of bed. Revision on: 2/6/2019 4. Nutrition Goal: Reduce my risk of aspiration, by following protocol for pureed food and (pudding) moderately thick liquids. Use small spoon and divider plate for my meals. a. Family and staff educated to provide me with pureed foods and moderately thick liquids, (Pudding consistency) for pureed food and drinks. Serve my meals in divided plate using smaller feeding spoons, and my drinks in nosey cups. Nurse to check to ensure fluids are Moderately thick. My liquids will be spooned to me. (Initiated 11/7/17). b. I am on a puree diet, HONEY thick liquids. Mouth must be kept clean. Pop and beer must be thickened (HONEY) and need to be given with supervision. Nursing staff to test consistency of liquids to ensure correct thickness prior to serving resident. (Initiated 6/28/18). Review of R9's Physician Orders revealed the following: 1. Monitor for use of Gait belt when transferring to and from wheelchair (Initiated: 3/16/23). 2. Adaptive equipment/Small feeding spoon as recommended by ST [speech therapy] to facilitate smaller bites due to dysphagia (Initiated: 3/3/23). 3. Prior to ANY consumption of liquids, nurse needs to verify it is thickened to HONEY consistency (Initiated: 2/28/23). On 4/22/24 at 5:11 PM, an interview was conducted with CNA R who stated Perpetrator J and Perpetrator I arrived at the facility around dinner time and stated they would return R9 to the facility around 8:00 PM. CNA R stated, 8:00 PM came around, and he [R9] didn't come back. Then it turned to 9:00 PM and everybody wanted to know, 'where is [R9]?' I tried calling both [Perpetrator J and Perpetrator I] with no answer. It turned to 11:00 PM .I left the facility after my shift but kept calling and texting with no response .I came back [to the facility] the next morning and he still wasn't there. CNA R stated she had not packed R9 an overnight bag because he was supposed to return to the facility that night. CNA R stated R9 was sent on the LOA with two briefs and approximately 6 wash cloths. CNA R stated R9 did not have food, liquid, a food/liquid thickener powder, a gait belt, eating adaptive equipment, medications, or any other medical supplies necessary per R9's plan of care when he left the building on 9/18/23. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 4/23/24 at 9:03 AM, a phone interview was conducted with former DON, N who verified she was the Director of Nursing at the time of R9's unauthorized LOA (9/18/23-9/19/23). DON N recalled she received a text message from RN D around midnight on 9/19/23 which indicated R9 left the previous evening and had not returned. Former DON N stated she arrived for work the next morning and was informed that R9 was still not at the facility. Former DON N was asked if she notified the NHA after she received the text message from RN D around midnight on 9/19/23 indicating R9 was not in the facility. Former DON N replied, I don't think I did because I was repeatedly told not to bother them .when [the NHA] arrived that morning, he was upset. He told me that this could be kidnapping, and he should have been notified immediately. Former DON N was asked if Perpetrator J and Perpetrator I had obtained permission to take R9 on a LOA. Former DON N stated, I know that the guardian in the past had given them permission to take him [R9] out, but I think that was an old, in-the-past type of deal. I think it was assumed by other staff that it was okay. Former DON N was asked if there was a protocol for residents going on a LOA to which she replied, There's a sign-out book. I'm sure there was a protocol, but I don't know if off-hand .if a resident had a guardian, I know the guardian needed to give permission . Former DON N stated she contacted R9's guardian the morning of 9/19/23 to inform him that the police had been notified of R9's unauthorized LOA. Former DON N stated, [R9's] guardian was not happy . he specifically said he did not give permission [to leave the facility]. Former DON N stated Perpetrator J and Perpetrator I were aware of R9's specialized diet but did not take thickener or any other necessary medical supplies with them. When former DON N was asked if either Perpetrator J or Perpetrator I received disciplinary action in the past regarding R9, she stated, I think the one did . I think she shaved his head or drew on him .it was something just bizarre. I believe she got reprimanded for that. On 4/23/24 at 11:01 AM, an interview was conducted with R9 who was able to answer some yes or no questions. R9 confirmed Perpetrator J and Perpetrator I took him on an overnight LOA in September 2023. R9 confirmed he drank pop on the LOA. When R9 was asked if the pop was thickened per his diet orders, he stated, No. When R9 was asked if Perpetrator J and Perpetrator I gave him a shower, he stated, Yes. A follow-up interview was attempted with Guardian H on 4/25/24 at 9:30 AM. A voicemail was left with no return call upon survey exit. Review of facility policy titled, Resident Leave of Absence dated 2/29/23 read, in part: Protocol: Residents may enjoy a leave of absence from the facility with a physician's order. The type and length of leave of absence (LOA) will be in accordance with the resident's assessed physical, mental and emotional ability and with resident and/or resident representative in involvement in requesting/obtaining the LOA . Physician's order should include type of LOA . No physician order for a LOA was identified in R9's EMR. Review of facility policy titled, Incident/Accident Report Policy and Procedure revised 4/27/23 read, in part: .An incident/accident report will be filled out completely by the charge nurse for any incident/accident involving a resident, employee, or visitor . Fill out incident/accident report on [EMR System] to include: (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	a. Name of person involved in incident/accident. b. Date, hour, place of incident/accident. c. Name of person who observed incident/accident. This person shall be interviewed by CHARGE NURSE, DON, OR ADON [assistant director of nursing] for description of what occurred. d. Narrative of the incident and/or accident. Ask resident what happened and document their response or lack of response. e. Document results of initial exam. Include a full set of vital signs . Incident and Accident reports for R9 were requested on 4/23/24 at 11:30 AM. BOM L indicated there was no record for incident or accidents for R9 on 4/23/24 at 1:15 PM. Review of facility policy titled, Resident Abuse, Neglect Mistreatment or Misappropriation Prevention Program reviewed 3/20/24 read, in part: .The resident has the right to be free from verbal, sexual, physical and mental abuse, corporal punishment, and involuntary seclusion. Resident will not be subjected to abuse by any volunteers, staff or other agencies serving the resident, family members or legal guardians, friends, vendors or other individuals . abuse can be resident-to-resident, staff-to-resident, family-to resident, visitor-to-resident .suspected or substantiated cases of resident abuse, neglect, misappropriation of property, mistreatment, exploitation, involuntary seclusion, or any other adverse event shall by thoroughly invested and documented by the Administrator, and reported to the appropriate state agencies, physician, families, and/or representatives . The Immediate Jeopardy which began on 9/18/23 was removed on 4/22/24 when the facility submitted an acceptable removal plan and took the following actions to remove the immediacy. The Facility Removal Plan read as follows: 1. The facility will ensure that all persons requesting to take a resident out on LOA from facility will have a. Authorization either by resident or if deemed incompetent, the resident's guardian or DPOA [durable power of attorney]. b. Necessary medications, equipment, supplies, and instructions will be provided to person signing resident out to ensure the resident will be safe in the environment. c. Charge nurse will assess for appropriateness of LOA and resident's condition at time that request is made to facility. 2. This has the potential to effect [sic] all residents with ability to be taken out on LOA. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An interview was conducted with Social Services Director/Staff G on 4/24/24 at 2:57 p.m. Staff G was asked about the resident-to-resident altercation and stated, (R18) was still threatening (R17) after follow-up of the incident. (R18) would tell me that she would think about smashing (R17's) head against the wall. They (R17, R18) still argue with each other over the situation of the room set up, and how overwhelming it is. I did ask if either one wanted a room move and they both stated no. I felt that it was safe after discussion with both of them. An observation and interview with R18 were conducted on 4/24/24 at 3:05 p.m. R18 was observed to be sitting in a recliner chair in a small sitting room. During this interview, when R18 was asked about an incident between her and R17, R18 stated, I do not like her! She gets crazy and her eyes get really big! Today she yelled at me for no reason, and I had to tell her to back off. My room isn't my room anymore, it's hers and staff just cater to her and her demands! They brought her in a new chair and pushed all my things to the side. When asked if she is afraid of R17, she stated, I'm not afraid of her. I'm afraid of myself. I'm going to hurt her one day, I won't be able to stop myself. Review of the facility's Resident Abuse, Neglect, Mistreatment or Misappropriation Prevention Program - Facility Prevention Program reviewed 3/20/24, read, in part, .Resident will not be subjected to abuse by an volunteers, staff or other agencies serving the resident, family members or legal guardians, friends, vendors or other individuals .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235588	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maple Valley Nursing Home	1086 W. Burdickville Road Maple City, MI 49664

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. 45123 Based on observation, interview, and record review, the facility failed to ensure two Residents (R15 and R20) were free from physical restraints imposed for purposes of convenience, out of twelve residents sampled for review for restraints. This deficient practice resulted in restriction of freedom of movement and the potential for injury. Findings include: Resident #15 (R15) Review of R15's Minimal Data Set (MDS) assessment, dated 10/11/23, revealed R15 had diagnoses that included the following, in part: dementia, anemia, kidney disease, and constipation. R15 was dependent for eating, oral hygiene, toileting, bathing, and dressing. Section P of the MDS assessment revealed R15 did use a form of restraint daily marked as other alarm. Review of R15's complete electronic medical record (EMR) found no physical order, signed consent, or restraint assessment. R15's EMR, revealed, R15 was not their own responsible party and that R15 had a guardian listed as their responsible party. Review of R15's care plan, date revised 12/5/23, read in part, .Goal: Moderate fall risk R/T [related to] cognitive impairment and decreased mobility .Interventions: .I will have a tab alarm attached when in bed. Use motion sensor chair pad when in w/c [wheelchair] or recliner to alert staff that resident may be displaying impulsiveness or has needs . On 4/23/24 at 7:43 AM, an observation was made of R15 sitting in the resident's lounge. R15 was observed sitting in a reclining chair with a tab alarm clipped to the outside of the back of her shirt. Resident #20 (R20) Review of R20's MDS assessment, dated 12/31/23, revealed R20 had diagnoses that included the following, in part: dementia, aphasia, and cerebral infarct. R20 did use a form of restraint daily marked as a wandering/elopement alarm. Review of R20's complete EMR found no physical order, signed consent, or restraint assessment. R20's EMR revealed, his spouse was his responsible party. Review of R20's care plan, date revised 12/5/23, read in part, .Goal: Fall risk R/T [related to] cognitive impairment and impaired mobility .Interventions: .Reminders to CENA's [certified nursing assistants (CNAs)] about making sure that the TAB alarms are clipped to residents . On 4/22/24 at 4:55 PM, an observation was made of R20 sitting in the residents' lounge. No tab alarm was clipped to his shirt. The tab alarm was discovered lying on the floor next to the left side of the reclining chair R20 was sitting in. Registered Nurse (RN) K was asked if the Tab alarm should be clipped to R20 and replied, Yes, it should be clipped to him. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/24/24 at 4:30 PM, an observation was made of R20 sitting in a reclining chair in the resident lounge and did not have his tab alarm clipped on his shirt in the back. R20 was observed leaning forward twice in his reclining chair and the cord was dangling on the floor. Certified Nurse Assistant (CNA) T was asked if R20 needed the tab alarm clipped to him and replied, Oh! Yes! Thank you! On 4/24/24 at 1:25 PM, an interview was conducted with the Director of Nursing (DON) and was asked about the use of the tab alarms and if these devices needed a physician order, assessment, and consent and replied, Yes, all alarms need a consent from the resident if they are their own person or the guardian if they are not. They also need a physician order and should be care planned and reassessed quarterly. Review of policy titled, Policy and Procedure for Restraints, dated 4/27/23, read in part, Physical patient restraints can be useful in protecting the patient/resident from falls and/or wandering or straying. This facility does not advocate the use of physical restraints, unless ordered by the patient's physician and then only for the protection of the patient form (sic) grievous physical harm. The need for a restraint will be documented in the resident's medical chart Continued need of the restraint will be assessed on a regular basis and justification for same will be documented in the medical record 1. Must be ordered by the attending physician. 2. Must have written consent form the resident and/or guardian or responsible party .

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49302 Based on interview and record review, the facility failed to ensure an unauthorized leave of absence was reported timely to the facility administrator and State Agency (SA) for one Resident (#9) of 5 residents reviewed for accident and incident reporting. Findings include: Resident #9 (R9) Review of R9's electronic medical record (EMR) revealed admission to the facility on [DATE] with diagnoses including Huntington's disease (a progressive, fatal genetic disorder that affects the brain and causes involuntary movements, cognitive decline, and emotional problems), aphasia (difficulty processing, using, and/or understanding language), dysphagia (difficulty or inability to swallow), contracture of unspecified hand (a permanent shortening and tightening of muscle fibers that reduces flexibility and makes movement difficult), and alcohol abuse. Record review of R9's Minimum Data Set (MDS) assessment immediately preceding the unauthorized leave of absence (LOA) on 7/20/23, indicated R9 had severely impaired cognition - unable to complete BIMS [Brief Interview for Mental Status]. R9 was admitted to hospice services on 7/20/23. On 4/22/24 at 11:47 AM, a phone interview was conducted with R9's guardian, Guardian H who disclosed two former facility staff members had taken R9 out overnight without his permission at some point the previous fall. Guardian H indicated the facility called him the morning following the LOA to ask if facility staff that worked the previous evening had asked him for consent prior to R9's departure. Guardian H indicated he did not give approval and was unaware of R9's exit from the facility. On 4/22/24 at 1:04 PM, a follow-up phone interview was conducted with Guardian H who stated the morning following R9's leave of absence, he received a call from the facility informing him that R9 was missing. Guardian H indicated the facility informed him Perpetrator I and Perpetrator J (later identified as former terminated Certified Nursing Assistants [CNAs] at the facility) had taken him out of the facility the previous night and had not returned. Guardian H stated, I was freaking out. I asked if we should file a report with the police. Guardian H reiterated the facility had not called him prior for permission for R9's departure, stating, I was upset with the nursing home and their lack of calling me. The nurse who called me the morning he was missing wasn't sure where [R9] was. I was shocked .shocked that the facility would let somebody out on hospice care and not even call to even verify if it was okay. Guardian H stated that since R9 signed with hospice on 7/20/23, nobody was authorized to take R9 from the facility due to his deteriorating physical and mental condition. Review of R9's progress notes revealed the following entries: 1. 9/18/23 at 18:07 [6:07 PM] written by former Registered Nurse (RN) M: LOA with [Perpetrator J] and [Perpetrator I] to [Perpetrator J's] house at 1807 [6:07 PM]. 2. 9/18/23 at 22:24 [10:24 PM] written by RN D: Resident's responsible party for LOA was called and did not answer. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. 9/18/23 at 23:44 [11:44 PM] written by RN D: This writer attempted to call [Perpetrator J] and [Perpetrator I] and [Guardian H]. None of them answered. DON aware. 4. 9/18/23 at 23:49 [11:49 PM] written by RN D: This writer attempted to call [Perpetrator J] and [Perpetrator I] and [Guardian H] each multiple times. None of them answered. 5. 9/19/23 at 09:48 [9:48 AM] written by RN K: LOA Returned from [Perpetrator J's] house driven by [Perpetrator J] and [Perpetrator I]. On 4/22/24 at 1:55 PM, a phone interview was conducted with RN D who was asked why R9's responsible party was not called for approval of an LOA until after R9 had already exited the building for approximately 4. 5 hours. RN D stated, I think I was expecting him to be back that night and that's why I called the responsible guardian [H] .or I wasn't certain if he was supposed to return so I was trying to figure it out. RN D was asked why he attempted several subsequent phone calls to Perpetrator J, Perpetrator I, and Guardian H as documented at 11:44 PM and 11:49 PM. RN D stated, I wasn't getting through to people, and I wasn't sure if [R9] was coming back at that time. On 4/22/24 at 2:30 PM, a phone interview was conducted with former Director of Nursing (DON) RN M who verified that Perpetrator J and Perpetrator I came to the facility around 6:00 PM on 9/18/24. RN M stated Perpetrator J and Perpetrator I informed her that they were taking R9 out for a brief leave. RN M stated, They [Perpetrator J and Perpetrator I] had taken him out in the past and they would take him to [Perpetrator J's] house. They would take him over for dinner and bring him back. That's what I would have expected . I got a call from [Perpetrator J] saying that they got him [R9] back to the facility at 9:00 AM the next morning .I was furious. RN M was asked if Perpetrator J and Perpetrator I were authorized to take R9 on a LOA. RN M stated, I didn't look at it [the approved list of responsible parties] that day. When they [Perpetrator J and Perpetrator I] took him out of the facility, I just assumed they were on the approved list. RN M stated no necessary medications, equipment, or supplies per R9's plan of care or physician orders were sent upon departure. On 4/22/24 at 2:54 PM, an interview was conducted with the Nursing Home Administrator (NHA) and the DON. The NHA verified that former CNAs, Perpetrator J and Perpetrator I, took R9 out of the facility on an unauthorized LOA and did not bring him back until the following morning. The NHA stated that although Perpetrator I did have permission at one time, Guardian H had since stopped anybody from removing R9 the facility following his admission to hospice (on 7/20/23) due to his declining condition. The NHA and DON both confirmed they were unaware of R9's absence from the building until arriving to the facility for work on the morning of 9/19/23. The NHA indicated they called local law enforcement after learning of the situation. The NHA stated, I didn't know what to do .What's the process for this? They basically kidnapped a resident. The NHA and DON stated they did not know why they were not contacted by RN D or former RN M on 9/18/23 after R9 left the facility and did not return. The NHA verified Perpetrator I was subsequently terminated on 3/8/23 following a separate incident with a different resident per form CMS-2567 dated 7/3/23. The NHA confirmed Perpetrator J quit working as a CNA on 12/8/21 for reasons related to her vaccination status. Review of, [County Name] County Dispatch - Call Detail Report indicated Business Officer Manager (BOM) L filed a report on 9/19/23 at 9:24 AM that read, in part: Patient missing, two people came last night around 1800 HRS [6:00 PM], said they had paperwork to take him [R9] out . [Perpetrator I] . [Perpetrator J] . (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/23/24 at 9:03 AM, a phone interview was conducted with former DON, N who verified she was the Director of Nursing at the time of R9's unauthorized LOA (9/18/23-9/19/23). DON N recalled she received a text message from RN D around midnight on 9/19/23 which indicated R9 left the previous evening and had not returned. Former DON N stated she arrived for work the next morning and was informed that R9 was still not at the facility. Former DON N was asked if she notified the NHA after she received the text message from RN D around midnight on 9/19/23 indicating R9 was not in the facility. Former DON N replied, I don't think I did because I was repeatedly told not to bother them .when [the NHA] arrived that morning, he was upset. He told me that this could be kidnapping, and he should have been notified immediately. Former DON N was asked if Perpetrator J and Perpetrator I had obtained permission to take R9 on a LOA. Former DON N stated, I know that the guardian in the past had given them permission to take them out, but I think that was an old, in-the-past type of deal. I think it was assumed by other staff that it was okay. A follow-up interview was conducted on 4/25/24 at 1:06 PM with the NHA highlighted the seriousness of the incident by reiterating that the local law enforcement was involved. When the NHA was asked why the SA was not notified of the incident he stated, I'm not sure, it probably should have been. Review of the facility policy titled, Resident Abuse, Neglect, or Mistreatment Policy and Procedure, undated, read, in part: Each resident shall be free from abuse, neglect, mistreatment, exploitation, and misappropriation of property. Abuse shall include physical harm, pain, mental anguish, verbal abuse (derogatory terms), sexual abuse, or involuntary seclusion from any source . 1. Any alleged violation involving mistreatment, misappropriation of property, abuse, exploitation, or neglect of a resident shall be reported to the Administrator, Director of Nursing, or designee(s) immediately . 3. The Administrator or designee will notify resident's representative, and any State or Federal agencies of allegations and investigation within 24 hours . Review of facility policy, titled Reporting Abuse, revised 3/27/19 read, in part: .the facility shall report all allegations of abuse/neglect of residents. The initial report is made within 2 hours of the allegation. A full written report is due within 5 working days. Review of facility policy titled, Administrator, undated, read, in part: The primary purpose of this position is to direct the day-to-day functions of the facility in accordance with current federal, state, and local standards, guidelines, and regulations that govern nursing facilities in order to assure that the highest degree of quality care can be provided to facility residents at all times . .Other skills and abilities: .knowledge and adherence to the Abuse Prevention Policy . Review of facility policy titled, Resident Abuse, Neglect Mistreatment or Misappropriation Prevention Program - Facility Prevention Program, reviewed 3/20/24 read, in part: (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	.suspected or substantiated cases of resident abuse, neglect, misappropriation of property, mistreatment, exploitation, involuntary seclusion, or any other adverse event shall be thoroughly investigated and documented the by the Administrator, and reported to the appropriate state agencies, physician, families, and/or representative .

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49302 Based on interview and record review the facility failed to investigate an incident of abuse/neglect for one Resident (#9) of two residents reviewed for abuse/neglect. Findings include: Resident #9 (R9) Review of R9's electronic medical record (EMR) revealed admission to the facility on [DATE] with diagnoses including Huntington's disease (a progressive, fatal genetic disorder that affects the brain and causes involuntary movements, cognitive decline, and emotional problems), aphasia (difficulty processing, using, and/or understanding language), dysphagia (difficulty or inability to swallow), contracture of unspecified hand (a permanent shortening and tightening of muscle fibers that reduces flexibility and makes movement difficult), and alcohol abuse. Record review of R9's Minimum Data Set (MDS) assessment immediately preceding the unauthorized leave of absence (LOA) on 7/20/23, indicated R9 had severely impaired cognition - unable to complete BIMS [Brief Interview for Mental Status]. R9 was admitted to hospice services on 7/20/23. On 4/22/24 at 11:47 AM, a phone interview was conducted with R9's guardian, Guardian H who disclosed two former facility staff members had taken R9 out overnight without his permission at some point the previous fall. Guardian H indicated the facility called him the morning following the LOA to ask if facility staff that worked the previous evening had asked him for consent prior to R9's departure. Guardian H indicated he did not give approval and was unaware of R9's exit from the facility. On 4/22/24 at 1:04 PM, a follow-up phone interview was conducted with Guardian H who stated the morning following R9's leave of absence, he received a call from the facility informing him that R9 was missing. Guardian H indicated the facility informed him Perpetrator I and Perpetrator J (later identified as former terminated Certified Nursing Assistants [CNAs] at the facility) had taken him out of the facility the previous night and had not returned. Guardian H stated, I was freaking out. I asked if we should file a report with the police. Guardian H reiterated the facility had not called him prior for permission for R9's departure, stating, I was upset with the nursing home and their lack of calling me. The nurse who called me the morning he was missing wasn't sure where [R9] was. I was shocked .shocked that the facility would let somebody out on hospice care and not even call to even verify if it was okay. Guardian H stated that since R9 signed with hospice on 7/20/23, nobody was authorized to take R9 from the facility due to his deteriorating physical and mental condition. Review of R9's progress notes revealed the following entries: 1. 9/18/23 at 18:07 [6:07 PM] written by former Registered Nurse (RN) M: LOA with [Perpetrator J] and [Perpetrator I] to [Perpetrator J's] house at 1807 [6:07 PM]. 2. 9/18/23 at 22:24 [10:24 PM] written by RN D: Resident's responsible party for LOA was called and did not answer. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. 9/18/23 at 23:44 [11:44 PM] written by RN D: This writer attempted to call [Perpetrator J] and [Perpetrator I] and [Guardian H]. None of them answered. DON aware. 4. 9/18/23 at 23:49 [11:49 PM] written by RN D: This writer attempted to call [Perpetrator J] and [Perpetrator I] and [Guardian H] each multiple times. None of them answered. 5. 9/19/23 at 09:48 [9:48 AM] written by RN K: LOA Returned from [Perpetrator J's] house driven by [Perpetrator J] and [Perpetrator I]. On 4/22/24 at 1:55 PM, a phone interview was conducted with RN D who was asked why R9's responsible party was not called for approval of an LOA until after R9 had already exited the building for approximately 4. 5 hours. RN D stated, I think I was expecting him to be back that night and that's why I called the responsible guardian [H] .or I wasn't certain if he was supposed to return so I was trying to figure it out. RN D was asked why he attempted several subsequent phone calls to Perpetrator J, Perpetrator I, and Guardian H as documented at 11:44 PM and 11:49 PM. RN D stated, I wasn't getting through to people, and I wasn't sure if [R9] was coming back at that time. On 4/22/24 at 2:30 PM, a phone interview was conducted with former Director of Nursing (DON) RN M who verified that Perpetrator J and Perpetrator I came to the facility around 6:00 PM on 9/18/24. RN M stated Perpetrator J and Perpetrator I informed her that they were taking R9 out for a brief leave. RN M stated, They [Perpetrator J and Perpetrator I] had taken him out in the past and they would take him to [Perpetrator J's] house. They would take him over for dinner and bring him back. That's what I would have expected . I got a call from [Perpetrator J] saying that they got him [R9] back to the facility at 9:00 AM the next morning .I was furious. RN M was asked if Perpetrator J and Perpetrator I were authorized to take R9 on a LOA. RN M stated, I didn't look at it [the approved list of responsible parties] that day. When they [Perpetrator J and Perpetrator I] took him out of the facility, I just assumed they were on the approved list. RN M stated no necessary medications, equipment, or supplies per R9's plan of care or physician orders were sent upon departure. On 4/22/24 at 2:54 PM, an interview was conducted with the Nursing Home Administrator (NHA) and the DON. The NHA verified that former CNAs, Perpetrator J and Perpetrator I, took R9 out of the facility on an unauthorized LOA and did not bring him back until the following morning. The NHA stated that although Perpetrator I did have permission at one time, Guardian H had since stopped anybody from removing R9 the facility following his admission to hospice (on 7/20/23) due to his declining condition. The NHA and DON both confirmed they were unaware of R9's absence from the building until arriving to the facility for work on the morning of 9/19/23. The NHA indicated they called local law enforcement after learning of the situation. The NHA stated, I didn't know what to do .What's the process for this? They basically kidnapped a resident. The NHA and DON stated they did not know why they were not contacted by RN D or former RN M on 9/18/23 after R9 left the facility and did not return. The NHA was asked if Perpetrator J or Perpetrator I had any previous history with R9. The NHA stated Perpetrator I had received disciplinary action in early 2021 after she shaved R9's legs, shaved a letter in the back of R9's hair, and drew inappropriate pictures and phrases on his skin with permanent marker. The NHA did not indicate Perpetrator I had any limited or altered contact with R9 following the incident as part of the remedial action. Review of CMS-2567 form dated 6/10/21 indicated Perpetrator I was, educated on resident's right, abuse and other policies regarding this type of behavior following the incident. The NHA verified that Perpetrator I was subsequently terminated on 3/8/23 following a separate incident with a different resident per form CMS-2567 dated 7/3/23. The NHA confirmed Perpetrator J quit working as a CNA on 12/8/21 for reasons related to her vaccination status. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of, [County Name] County Dispatch - Call Detail Report indicated Business Officer Manager (BOM) L filed a report on 9/19/23 at 9:24 AM that read, in part: Patient missing, two people came last night around 1800 HRS [6:00 PM], said they had paperwork to take him [R9] out . [Perpetrator I] . [Perpetrator J] . On 4/23/24 at 9:03 AM, a phone interview was conducted with former DON, N who verified she was the Director of Nursing at the time of R9's unauthorized LOA (9/18/23-9/19/23). DON N recalled she received a text message from RN D around midnight on 9/19/23 which indicated R9 left the previous evening and had not returned. Former DON N stated she arrived for work the next morning and was informed that R9 was still not at the facility. Former DON N was asked if she notified the NHA after she received the text message from RN D around midnight on 9/19/23 indicating R9 was not in the facility. Former DON N replied, I don't think I did because I was repeatedly told not to bother them .when [the NHA] arrived that morning, he was upset. He told me that this could be kidnapping, and he should have been notified immediately. Former DON N was asked if Perpetrator J and Perpetrator I had obtained permission to take R9 on a LOA. Former DON N stated she contacted R9's guardian the morning of 9/19/23 to inform him that the police had been notified of R9's unauthorized LOA. Former DON N stated, [R9's] guardian was not happy . he specifically said he did not give permission [to leave the facility]. Incident and Accident reports for R9 were requested on 4/23/24 at 11:30 AM. BOM L indicated there was no record for incident or accidents for R9 on 4/23/24 at 1:15 PM. A follow-up interview was conducted on 4/25/24 at 1:06 PM with the NHA highlighted the seriousness of the incident by reiterating that the local law enforcement was involved. When the NHA was asked why the SA was not notified of the incident he stated, I'm not sure, it probably should have been. The NHA was unable to provide a documented investigation summary of the incident. The NHA stated the facility staff review all incident and accident reports during their QAPI (Quality Assurance and Performance Improvement) meetings. When asked how the unauthorized LOA incident was discussed in QAPI and how appropriate corrective action was taken if an investigation was never conducted, the NHA was unable to provide a coherent answer. Review of facility policy titled, Abuse Investigation Policy and Procedure, updated 4/15/17 read, in part: It is the policy of this facility that reports of abuse are promptly and thoroughly investigated .when an incident or suspected incident of abuse or neglect is reported, the Administrator will be immediately notified. The administrator will investigate the incident with the assistance of appropriate personnel . .While the investigation is being conducted, accused individuals not employed by the facility will be denied unsupervised access to the resident . .A written Resident Abuse Investigation Report will be completed by the administrator within five (5) working days of the reported incident . Review of facility policy titled, Incident/Accident Report Policy and Procedure revised 4/27/23 read, in part: (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Maple Valley Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 1086 W. Burdickville Road Maple City, MI 49664	

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	.An incident/accident report will be filled out completely by the charge nurse for any incident/accident involving a resident, employee, or visitor . Fill out incident/accident report on [EMR System] to include: a. Name of person involved in incident/accident. b. Date, hour, place of incident/accident. c. Name of person who observed incident/accident. This person shall be interviewed by CHARGE NURSE, DON, OR ADON [assistant director of nursing] for description of what occurred. d. Narrative of the incident and/or accident. Ask resident what happened and document their response or lack of response. e. Document results of initial exam. Include a full set of vital signs .

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34568 Based on interview and record review, the facility failed to notify the resident in writing with the reason for a transfer out of the facility for two Residents (R18, R20) of three residents reviewed for transfers. This deficient practice resulted in limited knowledge of the treatment plan due to lack of written transfer or discharge notification to the resident/resident's representative. R18 A review of R18's Electronic Medical Record (EMR) revealed she was transferred to the hospital on 7/7/23. There was no written notification of transfer given to R18. R18 returned to the facility on [DATE]. A request was made for the facility's transfer policy on 4/25/24. On 4/25/24 at approximately 11:20 a.m. an interview was conducted with Registered Nurse (RN)/Director of Nursing in Training A. RN A confirmed that the facility is not following their policy regarding transfer notification because they are such a small building, and they notify resident/resident representatives individually. 45123 Resident #20 (R20) A review of R20's EMR revealed he was transferred to the hospital on 6/19/23. There was no written notification of transfer given to R20. R20 returned to the facility on [DATE]. A request was made for the facility's transfer policy on 4/25/24. Review of the facility's Facility Initiated Transfer or Discharge reviewed 1/30/24, read, in part, [Facility Name] will facilitate a transfer or discharge to ensure the resident and representatives are informed and as stress free as possible. A resident may be discharged or transferred only under certain situations. Procedure: The administrator shall provide written notice to a resident of pending involuntary transfer or discharge. Additional copies of the notice shall be filed in the resident's chart, forwarded to the Michigan Department of Health and Human Services, sent to the resident's representative .the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. Documentation will include the basis for the transfer/discharge, or in the case that the specific resident need(s) cannot be met the specific need, how [Facility Name] has tried to meet the need and the service that the receiving facility has to meet that need .

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34568 Based on interview and record review, the facility failed to ensure written information was provided to three Resident/Representatives (R18, R20, R24) of three reviewed for written notice of bed hold. This deficient practice resulted in residents/representatives being unaware of incurring expenses related to reserve payment. Findings include: R18 A review of R18's progress notes revealed the following: 7/7/23 16:31 (4:31 PM): Resident being transferred to [Hospital Name] for SOB (shortness of breath), increase HR (heart rate) and irregular. Resident informed as well as daughter. Resident traveling to [Hospital Name] via ambulance . Review of the Clinical Census report revealed R18 was hospitalized from 7/7/23 through 7/10/23. Review of R18's Electronic Medical Record (EMR) revealed there was no Bed Hold Authorization form completed. R24 A review of R24's progress notes revealed the following: 12/12/23 22:45 (10:45 PM): This writer dialed on-call provider number and [Nurse Practitioner (NP) P] ordered ED (Emergency Department) send out. No visible injury, though full assessment was not possible at this time to prevent unnecessary movement after resident's pain response . 2/6/24 18:15 (6:15 PM): Resident was assessed by this nurse after falling in the women's common bathroom. Pressure applied to posterior scalp where bleeding occurred .swelling on posterior head observed .Resident was assisted into a wheelchair by two staff, NP Q notified at 1820 (6:20 PM) of incident and gave the okay for the resident to be sent out to [Hospital Name] . Review of the Clinical Census report revealed R24 was hospitalized from 12/12/23 through 12/13/23 and 2/6/24 with no return date to the facility. Review of R24's EMR revealed there was no Bed Hold Authorization form completed for either the 12/12/23 transfer or the 2/6/24 transfer. An interview was conducted with Registered Nurse (RN)/Director of Nursing in training A on 4/25/24 at 11:20 a.m. RN A stated that the facility is not following their policy regarding transfers or bed holds. RN A stated that the facility is small, and they notify resident/resident representatives individually. RN A stated that they did not have a specific bed hold form, and asked this Surveyor if the one they found online would be sufficient to use in the future. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	45123 Resident #20 (R20) A review of R20's progress notes revealed the following: 6/19/23 06:55 (6:55 AM): Late Entry: .Right hip appears swollen, non tender to touch, skin color appears normal. When resident moves right leg he grimaces and says ouch. [facility Physician's name] notified .EMS [emergency medical services] called. Resident transferred to [local hospital name] for evaluation . Review of the Clinical Census report revealed R20 was hospitalized from 6/19/23. R20 returned to the facility on [DATE]. Review of R20's EMR revealed there was no Bed Hold Authorization form completed for the 6/19/23 transfer. Review of the facility's Attachment F-Admission Contract Policy and Procedure for Bed Holds and Readmission [Facility Name] revised on 1/1/2002 read, in part, [Facility Name] has formally adopted the following policy and procedure regarding the holding open of beds in the event of a resident's temporary absence from the facility. The purpose of this policy is to notify and inform residents of their rights and obligations in the event of a temporary absence .

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assure that each resident's assessment is updated at least once every 3 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45123 Based on interview and record review, the facility failed to submit a quarterly Minimal Data Set (MDS) assessment for one Resident (R15) of twelve residents sampled for timely of MDS assessments. Findings include: Review of R15's complete electronic medical record (EMR), revealed, R15 was originally admitted to the facility on [DATE], with her most recent admitted [DATE]. Review of R15's MDS assessment, dated 10/11/23, revealed R15 had diagnoses that included the following, in part: dementia, anemia, kidney disease, and constipation. R15 was dependent for eating, oral hygiene, toileting, bathing, and dressing. Section P of the MDS assessment revealed R15 did use a form of restraint daily marked as other alarm. Review of R15's MDS assessments, revealed, she was overdue to have a completed quarterly MDS assessment. R15's last MDS was on 10/11/23. MDS assessments are required every 90 days. No current MDS could be found and the facility could not provide an updated MDS for R15. On 4/25/24 at 9:30 AM, an interview was conducted with Licensed Practical Nurse (LPN)/MDS O and was asked if she had ever missed an MDS assessment and replied, No. LPN O was asked how she keeps track of assessment due dates and replied, I use the EMR scheduler. I also use the RAI [resident assessment instrument] tool. If a resident gets discharged and returned the RAI tool helps determine when the next assessment is due to be completed. LPN O was asked if she was aware that R20 was overdue for her quarterly MDS assessment and replied, Are you sure? I have everyone on the scheduler, and it should have alerted me she was overdue. LPN O accessed the EMR and replied, She is not scheduled on the scheduler. I do not know how that happened. It must have gotten deleted. She was due 2/10/24. I better get that started. LPN O was asked if the facility had a policy for MDS assessments and replied, I think there is. This Surveyor requested a copy of the facility policy for MDS assessments, and no policy was provided by the time of the survey exit.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34568 Based on interview and record review, the facility failed to ensure Preadmission Screening (PAS)/Annual Resident Review (ARR) Mental Illness/Intellectual Disability/Related Conditions Identification (form DCH-3878) documents were reviewed, revised, and sent to the local state agency for review and/or evaluation for one Resident (R6) of one sampled resident reviewed for PASSARs. This deficient practice resulted in the potential for residents to be excluded from receiving necessary care and services appropriate to meet their mental health needs. Findings include: A review of R6's Electronic Medical Record (EMR) revealed admission to the facility on [DATE] with diagnoses including dementia with behavioral disturbance, depression disorder, and bipolar disorder. Review of her Annual Minimum Data Set (MDS) assessment dated [DATE] revealed she scored an 8/15 on the Brief Interview for Mental Status (BIMS) score, indicative of mild cognitive impairment. A review of R6's Preadmission Screening (PAS)/Annual Resident Review (ARR) Level I screening dated 12/1/23 was marked as an annual review. In Section II, R6 was marked 'yes' as having a current diagnosis of mental illness or dementia, receiving treatment for mental illness or dementia, routinely received one or more prescribed antipsychotic or antidepressant medications within the last 14 days, presenting evidence of mental illness or dementia including significant disturbance in thought, conduct, emotions, or judgement. When asked to explain any questions answered yes, it read, Dx (diagnosis) Dementia. This form further states: Distribution: If any answer to items 1-6 in Section II is Yes, send ONE copy to the local Community Mental Health Services Program (CMHSP), with a copy of form DCH-3878 if an exemption is requested. The nursing facility must retain the original in the patient record and provide a copy to the patient or legal representative. Further review of R6's EMR showed no DCH-3878 form completed or sent to the local CMHSP. An interview was conducted with Social Services Director/Staff G on 4/24/24 at 2:57 p.m. Staff G stated that she was recently employed with the facility and has been in her position for the last three weeks. Staff G stated that she had not gone through all the residents at this time and cannot explain the missing DCH-3878 form for R6.

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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** 45123 Based on observation, interview, and record review, the facility failed to develop resident centered care plan based on the needs of one Resident (R21) of twelve sampled residents for development of resident centered care plans. Findings include: Resident #21 (R21) Review of R21's face sheet, revealed an original admission into the facility on [DATE] with medical diagnoses of the following, in part: depression, bipolar disorder, paraplegia, and pressure ulcers. On [DATE] at 10:40 AM, an interview was conducted with R21 in his room. R21 confirmed that the facility had been treating his wounds and the wounds were still currently open and undergoing treatments. During the interview an observation, no transmission-based precaution (TBP) signage was located outside of the room door for R21 to alert staff providing direct care that R21 was on enhanced barrier precautions (EBP) related to open wounds. Review of R21's physician order, dated [DATE], revealed the following, in part: attempt resuscitation/CPR [cardiopulmonary resuscitation]. Review of R21's hospital discharge summary, dated [DATE], revealed the following allergies, in part: bee stings - anaphylactic reaction. On [DATE] at 10:30 AM, an interview was conducted with R21 in his room and was asked about smoking and his allergies and replied, I have been going outside to smoke by myself since I was admitted here back in November. I am allergic to bee stings. I was stung when I was younger a bunch of times and I had a sever reaction. R21 was observed to have a lock box in his room and inside the lock box was a set of keys for the lock box. R21 was asked where he kept his cigarettes and lighter and replied, They are in my jacket pocket. I don't know why I have that box because I never use it. Review of R21's progress note, dated [DATE] at 3:06 PM, read in part, Resident's brother came for a visit. Resident's brother brought in the following items: $50 cash .2 packs of [name brand cigarette] Menthol 100's, 2 Breeze Blueberry Vape pens . Review of R21's progress note, dated [DATE] at 4:25 PM, read in part, .Resident outdoors smoking. Resident had removed his patch and has given it to this nurse. Review of R21's care plan, dated [DATE], revealed no care planned focus areas, goals or interventions related to smoking or allergies for R21. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 4:30 PM, an interview was conducted with the DON and was asked if any of the current resident population would require such type of medication related to an allergy and replied, No, not that I am aware of. The DON was made aware that R21 was allergic to bee stings and was observed several times outdoors smoking unsupervised and lacked any orders for emergency lifesaving medication to counter act an anaphylactic allergic reaction and stated, I will immediately notify the physician obtain orders for emergency medication, educate the resident on the use of the medication, provided supervision while outdoors, inform the local emergency medical service, and update the care plan for him related to the nature of the allergy and his reaction to bee stings.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 45123 Based on interview and record review, the facility failed to assess, reassess, obtain consent, and develop care plan interventions for one Residents (R5) of twelve sampled residents for care plan revision. Findings include: Resident #5 (R5) On 4/23/24 at 9:00 AM, an observation was made of R5 in her room sitting in her wheelchair. R5's bed had two side rails/mobility bars on the upper half of each side of her bed. On 4/23/24 at 9:05 AM, an interview was conducted with R5 and was asked if she had signed a consent for the mobility bars and replied, Not that I am aware. On 4/24/24 at 11:00 AM, R5 continued to have the two mobility bars in place. Review of R5's physician order, dated 2/22/23, read in part, .Please use mobility assist bars . Review of R5's Minimum Data Set (MDS) admission assessment, dated 2/23/23, lacked any indication of the use of a bed rail or mobility bar. R5's MDS quarterly assessment, dated 8/26/23 and 11/26/23, lacked any indication of the use of a bed rail or mobility bar. Review of R5's care plan, dated 3/6/23, read in part, .focus: Physical Mobility Impairment/Personal care/ADL's [activities of daily living]: I have limited mobility .Interventions: . R5's care plan lacked an intervention for the use of mobility bars or assessment/reassessment.

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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** 45123 Based on observation, interview, and record review, the facility failed to follow physician order for one Resident (R20) and failed to obtain a physician order for an emergency medication for one Resident (R21) of twelve sampled residents reviewed for physician orders. Findings include: Resident #20 (R20) Review of R20's MDS assessment, dated [DATE], revealed R20 had diagnoses that included the following, in part: dementia, aphasia, and cerebral infarct. Review of R20's physician order, dated [DATE], revealed an order for [NAME] Hose while seated during the day. On [DATE] at 4:10 PM, an observation was made of R20 sitting in a recliner chair in the residents' lounge and no [NAME] hose were observed worn on R20's lower legs. On [DATE] at 10:00 AM, an observation was made of R20 sitting in a recliner chair in the residents' lounge and no [NAME] hose were observed worn on R20's lower legs. On [DATE] at 1:20 PM, an interview was conducted with Registered Nurse (RN) K and was asked if he had seen R20's [NAME] hose and replied, He has not worn them for a while now. I am not sure where they are or if he even still has them. On [DATE] at 3:00 PM, an interview was conducted with the Director of Nursing (DON) and was asked if R20 was to be wearing the [NAME] hose and replied, I am not sure. I would have to check the orders. The DON accessed the electronic medical record (EMR) and replied, I see he has an order for them. If there is a physician order it is expected, they are to be followed. I would need to follow up with the floor nurse. The DON was asked if R20 no longer was required to wear the [NAME] hose if there should still be an order for them and replied, No, they should be discontinued. On [DATE] at 11:40 AM, R20's [NAME] hose order remained in the EMR. On [DATE] at 12:05 PM, an interview was conducted with Certified Nurse Assistant (CNA) U and was asked if R20 had [NAME] hose and replied, I have not seen them in a while. I am not sure if he still has them or where they are. Resident #21 (R21) Review of R21's face sheet, revealed an original admission into the facility on [DATE] with medical diagnoses of the following, in part: depression, bipolar disorder, paraplegia, and pressure ulcers. Review of R21's Minimal Data Set (MDS) assessment, dated [DATE], revealed that R21 was cognitively intact. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R21's physician order, dated [DATE], revealed the following, in part: attempt resuscitation/CPR [cardiopulmonary resuscitation]. Review of R21's hospital discharge summary, dated [DATE], revealed the following allergies, in part: bee stings - anaphylactic reaction. On [DATE] at 10:30 AM, an interview was conducted with R21 in his room and was asked about smoking and his allergies and replied, I have been going outside to smoke by myself since I was admitted here back in November. I am allergic to bee stings. I was stung when I was younger a bunch of times and I had a sever reaction. Review of R21's progress note, dated [DATE] at 4:25 PM, read in part, .Resident outdoors smoking. Resident had removed his patch and has given it to this nurse. Review of R21's complete EMR, smoking assessment, dated [DATE], was the first and only initial smoking assessment and R21 was smoking prior to this assessment on the facility property. Review of R21's physician order, dated [DATE], read in part, Perform smoking assessment . Review of R21's physician order, dated [DATE], read in part, Smoking assessment one time a day every 3 months .Start date [DATE]. On [DATE] at 10:00 AM, an observation was made of R21 outside of the facility siting in his wheelchair near the [NAME] entrance, between the pole barn and the garbage dumpster, and was unsupervised by facility staff. R21 was observed smoking during the following dates and times in the same designated smoking area on: [DATE] at 1:50 PM, [DATE] at 7:25 AM, and [DATE] at 12:15 PM. During the time of the survey and observation was made of the [NAME] entrance, between the pole barn and the garbage dumpster, and the pole barn was noted to have two bee nests located around the main door frame. On [DATE] at 3:57 PM, an interview was conducted with RN K and was asked if the facility had an emergency medication in back-up medication supply for an anaphylactic allergic reaction and replied, Yes, it is kept in the medication room. RN K was asked if any of the current resident population would require such type of medication related to an allergy and replied, No. RN K was made aware the R21 had an allergy that developed into an anaphylactic type of reaction and replied, I did not know that. On [DATE] at 4:30 PM, an interview was conducted with the DON and was asked if any of the current resident population would require such type of medication related to an allergy and replied, No, not that I am aware of. The DON was made aware that R21 was allergic to bee stings and was observed several times outdoors smoking unsupervised and lacked any orders for emergency life saving medication to counter act an anaphylactic allergic reaction and stated, I will immediately notify the physician obtain orders for emergency medication, educate the resident on the use of the medication, provided supervision while outdoors, inform the local emergency medical service, and update the care plan for him related to the nature of the allergy and his reaction to bee stings. On [DATE] at 5:00 PM, an observation was made of R20 outside of the facility siting in his wheelchair near the [NAME] entrance, between the pole barn and the garbage dumpster, and was unsupervised by facility staff. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maple Valley Nursing Home	1086 W. Burdickville Road Maple City, MI 49664

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of policy titled, Emergence Medical Care Anaphylactic Shock, dated [DATE], read in part, Policy: In the event of a Bee Sting or Anaphylactic Shock the following steps should be followed: 1. Obtain Epi Pen from Nurses Med Cart or Resident's lock box 2. Administer Dosage into thigh 3. Call 911 .5. Contact Physician . Review of facility provided document untitled, dated [DATE], read in part, Policy: All residents of [facility name] will be provided with Emergency Medical Care when needed: Procedure .2. Call Physician to notify and obtain orders .

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34568 DPS A: Based on interview and record review, the facility failed to implement appropriate interventions to prevent a fall for one Resident (R24) of one resident reviewed for falls. This deficient practice resulting in R24 sustaining a fall with subsequent injuries requiring staples. Findings include: R24 A review of R24's electronic medical record (EMR) revealed admission to the facility on [DATE] with diagnoses including dementia, history of Urinary Tract Infections (UTI), and osteoarthritis. R24 scored an , d+[DATE] on the [DATE] Brief Interview for Mental Status (BIMS) score indicative of moderate cognitive impairment. R24 did not have a completed Fall Risk Assessment during her stay at the facility. Review of R24's Progress Notes revealed the following entries: [DATE] 22:35 (10:35 p.m.) Resident called out from her room at this time and staff entered. Resident was on floor and stated that she fell and hit her head. Unwitnessed falls protocol initiated. After initial set of vitals, staff attempted to assist her into a seated position to take a seated blood pressure. With very slight movement, she winced and stated that it hurt really bad in her back and neck. Staff did not continue attempt to move her. Resident stated that she felt very dizzy. [DATE] 22:45 (10:45 p.m.) This writer dialed on-call provider number and (Nurse Practitioner (NP) P) ordered ED (Emergency Department) send out. No visible injury, though full assessment was not possible at this time to prevent unnecessary movement after resident's pain response. [DATE] 23:05 (11:05 p.m.) Resident left [facility name] with [name of county] fire and rescue at this time to transport to [hospital name] ED. [DATE] 2:19 a.m. Call received from [hospital name] ER. Resident was evaluated and [hospital name] staff determined pain not related to acute injury, resident was given Tylenol, x-ray was WNL (within normal limits). They will be sending her back to [facility name]. [DATE] 6:30 a.m. She requires up to one assist with ADLs (Activities of Daily Living) due to new required supplemental oxygen .She reports dizziness with some movements and with quick movements . [DATE] 1:45 a.m. She requires assistance of one for transfers, ambulation, toileting, dressing, bathing, and hygiene . (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	[DATE] 18:15 (6:15 p.m.) Resident was assessed by this nurse after falling in the women's common bathroom. Pressure applied to posterior scalp where bleeding occurred, which did stop. Swelling on posterior head observed. Vitals/neuro [neurological] were initiated per fall protocol. Mentation and vitals were at baseline. Resident was able to move her head/neck and all limbs without any c/o (complaint of) pain or discomfort. Resident was assisted into a wheelchair by two staff. NP P notified at 1820 (6:20 p.m.) of incident and gave the okay for the resident to be sent out to [hospital name]. Residents' son was notified of incident at 1824 (6:24 p.m.) and stated that he would like his mother to be sent out to [hospital name] to be evaluated. Ambulance was called at 1835 (6:35 p.m.). Resident left facility at 1850 (6:50 p.m.) . Review from R24's [hospital name] discharge summary revealed the following, in part, This is an [AGE] year-old female who presents after a fall .She was noted to have laceration with bleeding .occipital scalp laceration .3 cm (centimeters) in length, repaired by 4 staples .assessment/plan: fall, closed head injury, scalp laceration . Review of R24's Incident and Accident report dated [DATE] read, in part, This nurse was urgently called to the women's common bathroom by a staff member that was assisting resident. Upon entering the bathroom, the resident was lying flat on her back with her head in front of the toilet. Moderate amount of blood was observed by her posterior head. Resident description: I was backing up toward the toilet and I fell and clunked my head. A witness statement dated [DATE] (incorrect date as the incident had not happened yet) from Certified Nurse Aide (CNA) C read, On February 6th, 2024, I was getting (R24) ready for bed in the women's restroom after dinner. I helped her get into a nightgown, fresh socks, and a new brief before putting her shoes back on. She then stood up so we could pull her brief up, and I asked how she was feeling, to which she replied that she was feeling grand. We then walked out of the stall, and I was in front of her. I handed her a warm washcloth so she could wash her face, and right after she grabbed the washcloth (R24) fell straight backwards and hit her head . Review of R24's Fall/Safety Care Plan read, I am a moderate risk for falls r/t (related to) occasional confusion, R/T impulsiveness due to my diagnosis of dementia. I am unsteady on my feet. I have poor safety awareness and do not remember that I am no longer able to walk or transfer alone. I have recently had anesthesia and have residual effects causing confusion and need for O2 (oxygen) date initiated: [DATE] revision on [DATE] .Assist of one to ambulate and transfer. Date initiated: [DATE] .Provide me with a safe environment .personal items within reach. Date Initiated:[DATE]. CNA C's witness statement did not state if a gait-belt was being used at the time of the incident, nor why CNA C was not providing physical assistance on to R24 per the resident's care plan interventions. DPS B: Based on observation, interview, and record review the facility failed to prevent elopements for one Resident (R17) of one resident reviewed for elopement. This deficient practice resulted in R17's elopement from the facility, with the risk for falls and injury. Findings include: (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of R17's EMR revealed admission to the facility on [DATE] with diagnoses including vascular dementia with agitation. R17's [DATE] MDS assessment revealed she scored a ,d+[DATE] on the BIMS score, indicating she was cognitively intact and had no behaviors of wandering during the look back period. R17 was observed on [DATE] at approximately 12:30 p.m. finishing her lunch meal in the main dining room. R17 then stood up and exited the main dining room towards the front entrance door. R17 held the door handle, and the front door began to alarm. A staff member stated to this surveyor, Oh, that's just (R17) trying to leave again. We go through this almost every day. Review of R17's progress notes revealed the following entries: [DATE] Resident continues to be verbally abusive to staff and continues to go in and out of resident rooms, it is very difficult to redirect this patient at this time . [DATE] Resident went out of the facility via the facility entrance way. Facility activities director attempted to redirect the resident. Resident was very hesitant with attempts of redirecting but did agree to go for a ride with the activity's driver .Resident rode around. With the activity's director and then did return back to the facility. Resident was calm for a few minutes but then started attempting to exit seek once again. [DATE] Resident attempted to break facility windows and alarm keypads by hitting it with a staff bathroom key/stick. Attempts to redirect resident have been unsuccessful . [DATE] Resident outside of the facility through the front entrance and was observed by a staff member. That staff member informed this nurse and other staff members of this occurrence. This nurse and another nurse immediately went outside with the resident and attempted to redirect back inside. The resident was not easily redirected for this nurse. The resident stated, 'I'm not a prisoner. I should make it easy for you and go in the road.' Another nurse was also unsuccessful with redirecting the resident. Resident eventually did agree to go for a ride with the activity's director/facility driver. An interview was conducted with Registered Nurse (RN) K on [DATE] at 10:41 a.m. RN K stated that R17 is still able to read and can read the signs at the keypad and the door alarm. RN K stated that R17 will hold the door handle for 15 seconds and the door will release to open. RN K stated that R17 has gotten out of the facility prior without staff knowledge but she, Doesn't go far. RN K stated that there are no incident or accident reports related to R17 exiting the facility. Review of R17's Safety/Wander/Elopement High Risk Care Plan read, I get confused and agitated in afternoon and evening. I may try to leave facility. Date Initiated: [DATE] Revision on: [DATE] .I wear a Wander-guard ankle bracelet. Check for proper fit, placement, and function Q (every) shift Date Initiated [DATE]. Monitor for attempts to leave facility Date initiated: [DATE] Please remind me that I cannot go outside unsupervised and offer to take me out on occasion Date Initiated: [DATE]. 45123 DPS C: (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Based on observation, interview, and record review, the facility ensure residents were safe to smoke, supervised, and smoking paraphernalia was kept in a secure location for two Residents (R21 and R11) of five sampled residents reviewed for accidents, hazards, and supervision. Findings include: Resident #21 (R21) Review of R21's face sheet, revealed an original admission into the facility on [DATE] with medical diagnoses of the following, in part: depression, bipolar disorder, paraplegia, and pressure ulcers. Review of R21's Minimal Data Set (MDS) assessment, dated [DATE], revealed that R21 was cognitively intact. Review of R21's physician order, dated [DATE], revealed the following, in part: attempt resuscitation/CPR [cardiopulmonary resuscitation]. Review of R21's hospital discharge summary, dated [DATE], revealed the following allergies, in part: bee stings - anaphylactic reaction. On [DATE] at 10:30 AM, an interview was conducted with R21 in his room and was asked about smoking and his allergies and replied, I have been going outside to smoke by myself since I was admitted here back in November. I am allergic to bee stings. I was stung when I was younger a bunch of times and I had a sever reaction. R21 was observed to have a lock box in his room and inside the lock box was a set of keys for the lock box. R21 was asked where he kept his cigarettes and lighter and replied, They are in my jacket pocket. I don't know why I have that box because I never use it. Review of R21's progress note, dated [DATE] at 3:06 PM, read in part, Resident's brother came for a visit. Resident's brother brought in the following items: $50 cash .2 packs of Marlboro Menthol 100's, 2 Breeze Blueberry Vape pens . Review of R21's progress note, dated [DATE] at 4:25 PM, read in part, .Resident outdoors smoking. Resident had removed his patch and has given it to this nurse. Review of R21's complete EMR, smoking assessment, dated [DATE], was the first and only initial smoking assessment and R21 was smoking prior to this assessment on the facility property. Review of R21's physician order, dated [DATE], read in part, Perform smoking assessment . Review of R21's physician order, dated [DATE], read in part, Smoking assessment one time a day every 3 months .Start date [DATE]. On [DATE] at 10:00 AM, an observation was made of R21 outside of the facility siting in his wheelchair near the [NAME] entrance, between the pole barn and the garbage dumpster, and was unsupervised by facility staff. R21 was observed smoking during the following dates and times in the same designated smoking area on: [DATE] at 1:50 PM, [DATE] at 7:25 AM, and [DATE] at 12:15 PM. During the time of the survey and observation was made of the [NAME] entrance, between the pole barn and the garbage dumpster, and the pole barn was noted to have two bee nests located around the main door frame. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On [DATE] at 2:05 PM, and observation was made of R21's lock box in his room and was observed to have the same set of keys as the prior observation of the lock box and no smoking paraphernalia was found within the lock box. R21's cigarettes and lighter were observed on top of a chair in his room. On [DATE] at 3:57 PM, an interview was conducted with RN K who was asked how long R21 had been smoking at the facility and replied, Pretty much since he has been here. He used to have a nicotine patch, but it was discontinued because he continued to smoke and refused the patch. On [DATE] at 5:00 PM, an observation was made of R21 outside of the facility siting in his wheelchair near the [NAME] entrance, between the pole barn and the garbage dumpster, and was unsupervised by facility staff. 49302 Resident #11 (R11) Review of R11's electronic medical record (EMR) revealed admission to the facility on [DATE] with diagnoses including chronic obstructive pulmonary disease, mild cognitive impairment, and nicotine dependence. Review of R11's most recent Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 12, indicative of moderate cognitive impairment. On [DATE] at 10:16 AM, an entrance conference was conducted with the Director of Nursing (DON). The DON stated there were two current smokers who resided at the facility (R11 and R21). When the DON was asked about designated smoking locations and times, she stated there are no official smoking locations but R11 and R21 preferred to smoke out by the garage or in the arbor. The DON stated there were no designated smoking times or direct staff supervision. On [DATE] at 11:13 AM, an interview was conducted with R11 during the initial tour of the building. R11 confirmed that he smoked cigarettes. R11 stated there are no designated smoking times and he prefers to smoke in the arbor near the entrance of the building. R11 was asked the protocol for staff notification prior to leaving the building to smoke to which he replied, I don't tell them [nursing staff] or sign out unless I'm leaving the property. On [DATE] at 11:17 AM, R11 was observed entering the door code at the exit on the west wing and exiting the building without staff observation or knowledge. R11 was subsequently observed sitting in the arbor in a patio area, smoking without supervision. On [DATE] at 10:46 AM, R11 was again observed sitting in the arbor, smoking without supervision. Review of R11's Plan of Care revealed the following focus imitated [DATE]: I am aware that it is not good for me, but do wish to continue smoking with the following interventions: 1. Cigarettes and lighter kept in lockbox inside resident's room, initiated [DATE]. 2. Resident will let staff know when he is going outside and staff will observe from afar that he is safe and in the designated smoking area, initiated [DATE]. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	3. Smoking assessment will be completed quarterly, initiated [DATE]. Review of R11's orders revealed the following, initiated [DATE]: Cigarettes and light to be locked in lock box in his room AT ALL TIMES when not in use. Please verify he is using the lock box q [every] shift and prn [as needed]. Review of R11's EMR revealed an initial smoking assessment was conducted on [DATE]. A subsequent smoking assessment was conducted on [DATE], nearly a year after the original assessment. On [DATE] at 2:14 PM, this surveyor attempted to view the preferred smoking areas from the entrance/exit of the building. This surveyor was unable to visualize either the arbor patio area due to a tree and other vegetation obscuring the view nor the side of the garage which was blocked from view by support pillars to the entryway as well as a parked vehicle. On [DATE] at 8:24 AM, R11 was observed walking back into the facility from outside where he had just finished smoking a cigarette unsupervised. Upon entrance to R11's room, no lock box could be visualized. When asked if he had a lock box, R11 was unable to locate it and stated, I think it's around here somewhere. R11 demonstrated that he stored his cigarettes and lighter in the pocket of his coat when not in use. R11 confirmed he did not utilize a lock box and stated, I sleep with my feet on top of my coat so nobody can steal my cigarettes or lighter. On [DATE] at 2:45 PM, an interview was conducted with the DON who confirmed that smoking assessments were supposed to be completed upon admission as well as quarterly. The DON was asked why R11 went nearly a year without a smoking re-assessment. The DON stated this was brought to her attention and she began to educate staff in [DATE]. The DON confirmed R11's next smoking assessment was due [DATE] to reach compliance with the quarterly re-assessment requirement but it somehow, was missed. The DON was asked how it was determined R11 was safe to smoke unsupervised without regular assessments to evaluate. The DON stated, [R11] goes all over the place . he hasn't been deemed incompetent, but we're [facility staff] seeing things that probably should indicate it . When [R11] first got here, we monitored him for signs of elopement, and he wasn't .I can't remember if he's an elopement risk right now. I know they [nursing staff] watch him from the back door. The DON was asked if it was possible to visualize R11 from the back door to which she replied, I guess it depends on which part of the arbor he's in .there is probably areas we can't watch him. When asked about cigarette and lighter storage the DON said, They're [smoking paraphernalia] supposed to be in a lock box in his drawer, but there's times when we catch him when they're not in the lock box and we have to remind him. Review of facility policy titled, Smoking Assessment Policy and Procedure read, in part: .Residents will not be permitted to engage in smoking activity unless they are assessed during the admission process, ongoing quarterly assessments and as needed to determine the level of supervision required . .Residents who are assessed as requiring supervision for smoking, will be provided with scheduled smoking times in a designated supervised area . (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	.All smoking material or paraphernalia (including cigarettes, cigars, pipes, tobacco, matches, lighters, etc.) must be stored at the nurse's station at all times unless they have been approved for a lock box . DPS E: Based on interview and record review, the facility failed to provide adequate supervision to prevent an unauthorized leave of absence from the facility for one Resident (#9) of five residents reviewed for safety/supervision. This deficient practice resulted in two Former Certified Nursing Assistants (CNAs)/Perpetrator I and J removing R9 from the facility to an unknown location for approximately 16 hours without guardian approval or any potentially necessary hospice medications or medical supplies. Findings include: Review of R9's electronic medical record (EMR) revealed admission to the facility on [DATE] with diagnoses including Huntington's disease (a progressive, fatal genetic disorder that affects the brain and causes involuntary movements, cognitive decline, and emotional problems), aphasia (difficulty processing, using, and/or understanding language), dysphagia (difficulty or inability to swallow), contracture of unspecified hand (a permanent shortening and tightening of muscle fibers that reduces flexibility and makes movement difficult), and alcohol abuse. Record review of R9's Minimum Data Set (MDS) assessment immediately preceding the unauthorized leave of absence (LOA) on [DATE], indicated R9 had severely impaired cognition - unable to complete BIMS [Brief Interview for Mental Status]. R9 was admitted to hospice services on [DATE]. On [DATE] at 11:47 AM, a phone interview was conducted with R9's guardian, Guardian H who disclosed two former facility staff members had taken R9 out overnight without his permission at some point the previous fall. Guardian H indicated the facility called him the morning following the LOA to ask if facility staff that worked the previous evening had asked him for consent prior to R9's departure. Guardian H indicated he did not give approval and was unaware of R9's exit from the facility. On [DATE] at 1:04 PM, a follow-up phone interview was conducted with Guardian H who stated the morning following R9's leave of absence, he received a call from the facility informing him that R9 was missing. Guardian H indicated the facility informed him Perpetrator I and Perpetrator J (later identified as formerly terminated CNAs] at the facility) had taken him out of the facility the previous night and had not returned. Guardian H stated, I was freaking out. I asked if we should file a report with the police. Guardian H reiterated the facility had not called him prior for permission for R9's departure, stating, I was upset with the nursing home and their lack of calling me. The nurse who called me the morning he was missing wasn't sure where [R9] was. I was shocked .shocked that the facility would let somebody out on hospice care and not even call to even verify if it was okay. Guardian H stated that since R9 signed with hospice on [DATE], nobody was authorized to take R9 from the facility due to his deteriorating physical and mental condition. Review of R9's progress notes revealed the following entries: 1. [DATE] at 18:07 [6:07 PM] written by former Registered Nurse (RN) M: LOA with [Perpetrator J] and [Perpetrator I] to [Perpetrator J's] house at 1807 [6:07 PM]. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	2. [DATE] at 22:24 [10:24 PM] written by RN D: Resident's responsible party for LOA was called and did not answer. 3. [DATE] at 23:44 [11:44 PM] written by RN D: This writer attempted to call [Perpetrator J] and [Perpetrator I] and [Guardian H]. None of them answered. DON aware. 4. [DATE] at 23:49 [11:49 PM] written by RN D: This writer attempted to call [Perpetrator J] and [Perpetrator I] and [Guardian H] each multiple times. None of them answered. 5. [DATE] at 09:48 [9:48 AM] written by RN K: LOA Returned from [Perpetrator J's] house driven by [Perpetrator J] and [Perpetrator I]. On [DATE] at 1:55 PM, a phone interview was conducted with RN D who was asked why R9's responsible party was not called for approval of an LOA until after R9 had already exited the building for approximately 4. 5 hours. RN D stated, I think I was expecting him to be back that night and that's why I called the responsible guardian [H] .or I wasn't certain if he was supposed to return so I was trying to figure it out. RN D was asked why he attempted several subsequent phone calls to Perpetrator J, Perpetrator I, and Guardian H as documented at 11:44 PM and 11:49 PM. RN D stated, I wasn't getting through to people, and I wasn't sure if [R9] was coming back at that time. RN D was asked the protocol for a resident going on a leave of absence. RN D indicated the responsible party would sign the resident out in the Release of Responsibility for Leave of Absence binder and the charge nurse would document the departure in the EMR. When RN D was asked if the process would differ for a resident with a guardian, he stated, If somebody were to want to take a resident and they weren't the guardian, I would contact the guardian to get permission .I'm not sure of the exact protocol, but I would put it into my LOA note [in the resident's EMR]. On [DATE] at 2:30 PM, a phone interview was conducted with former Director of Nursing (DON) RN M who verified that Perpetrator J and Perpetrator I came to the facility around 6:00 PM on [DATE]. RN M stated Perpetrator J and Perpetrator I informed her that they were taking R9 out for a brief leave. RN M stated, They [Perpetrator J and Perpetrator I] had taken him out in the past and they would take him to [Perpetrator J's] house. They would take him over for dinner and bring him back. That's what I would have expected . I got a call from [Perpetrator J] saying that they got him [R9] back to the facility at 9:00 AM the next morning .I was furious. RN M was asked if Perpetrator J and Perpetrator I were authorized to take R9 on a LOA. RN M stated, I didn't look at it [the approved list of responsible parties] that day. When they [Perpetrator J and Perpetrator I] took him out of the facility, I just assumed they were on the approved list. RN M stated no necessary medications, equipment, or supplies per R9's plan of care or physician orders were sent upon departure. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235588	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/25/2024
NAME OF PROVIDER OR SUPPLIER Maple Valley Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 1086 W. Burdickville Road Maple City, MI 49664	

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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 0689 Level of Harm - Actual harm Residents Affected - Few	On [DATE] at 2:54 PM, an interview was conducted with the Nursing Home Administrator (NHA) and the DON. The NHA verified that former CNAs, Perpetrator J and Perpetrator I, took R9 out of the facility on an unauthorized LOA and did not bring him back until the following morning. The NHA stated that although Perpetrator I did have permission at one time, Guardian H had since stopped anybody from removing R9 the facility following his admission to hospice (on [DATE]) due to his declining condition. The NHA and DON both confirmed they were unaware of R9's absence from the building until arriving to the facility for work on the morning of [DATE]. The NHA indicated they called local law enforcement after learning of the situation. The NHA stated, I didn't know what to do .What's the process for this? They basically kidnapped a resident. The NHA and DON stated they did not know why they were not contacted by RN D or former RN M on [DATE] after R9 left the facility and did not return. The NHA was asked if Perpetrator J or Perpetrator I had any previous history with R9. The NHA stated Perpetrator I had received disciplinary action in early 2021 after she shaved R9's legs, shaved a letter in the back of R9's hair, and drew inappropriate pictures and phrases on his skin with permanent marker. The NHA did not indicate Perpetrator I had any limited or altered contact with R9 following the incident as part of the remedial action. Review of CMS-2567 form dated [DATE] indicated Perpetrator I was, educated on resident's right, abuse and other policies regarding this type of behavior following the incident. The NHA verified that Perpetrator I was subsequently terminated on [DATE] following a separate incident with a different resident per form CMS-2567 dated [DATE]. The NHA confirmed Perpetrator J quit working as a CNA on [DATE] for reasons related to her vaccination status. Review of, [County Name] County Dispatch - Call Detail Report indicated Business Officer Manager (BOM) L filed a report on [DATE] at 9:24 AM that read, in part: Patient missing, two people came last night around 1800 HRS [6:00 PM], said they had paperwork to take him [R9] out . [Perpetrator I] . [Perpetrator J] . On [DATE] at 3:50 PM, a phone interview was conducted with Perpetrator J who stated, We just took him [R9] out for a good time . Me and [Perpetrator I] took him to my house for dinner and gave him a shower. Perpetrator J stated she informed the nurse on duty, RN M, that they were taking R9 on a LOA. Perpetrator J stated she didn't take any required medications, supplies, or equipment prior to departure besides a couple incontinence briefs. Perpetrator J indicated that she and Perpetrator I transferred R9 into her private vehicle without using the care-planned transfer technique and drove to her private residence. Once there, Perpetrator J indicated R9 ate some ground up stir fry, drank some water, and then she assisted him into the shower. After showering R9, Perpetrator I stated she cut his fingernails and cut his hair. Perpetrator J stated R9 slept in a recliner, propped up so he could breathe. Perpetrator J was asked if she had permission to take R9 on a LOA to which she replied, I had permission before he [R9] was on hospice. Since he was on hospice, the process was different, and I wasn't aware of that. Apparently, I was no longer cleared [to take R9 on a LOA]. Perpetrator J was asked if she was contacted by the facility after leaving with R9. Perpetrator J stated, Yes, that night the facility called me and asked what time R9 was going to be home. I told them, 'He'll be there when we get him there.' (continued on next page)

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Maple Valley Nursing Home	1086 W. Burdickville Road Maple City, MI 49664

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On [DATE] at 4:19 PM, a phone interview was conducted with Perpetrator I who stated she and Perpetrator J arrived at the facility around dinner time and notified RN M they were taking R9 on a LOA. Perpetrator I stated that CNA R packed R9 an overnight bag. Perpetrator I stated they took R9 to Perpetrator J's personal residence where they, sang karaoke and just kind of hung out. Perpetrator I stated that R9 ate some pudding, tried a beer, but didn't like it, so he was switched to drinking pop. Perpetrator I verified R9 was given a shower at the residence because, he was covered in food and slop and slept in a recliner. Perpetrator I stated around 10:00 AM on the morning of [DATE], she received at text message from RN K asking when R9 was returning to the facility. Perpetuator I indicated to RN K that they were planning on returning R9, in a little bit until RN K stated that we had to bring him back immediately. Perpetrator I indicated that shortly after dropping R9 back off at the facility, she received a call from local law enforcement stating she was being charged with felony kidnapping. However, Perpetrator 'I stated the police officer ended up calling Perpetrator I back, stating R9's family no longer wished to press charges, and that they were instead upset at the facility for not knowing his whereabouts. On [DATE] at 4:58 PM, an interview was conducted with RN K who stated he arrived at the facility at the start of his shift around 6:30 AM on [DATE]. RN K stated he received report from the midnight nurse, former RN M, who indicated R9 was not in the building. RN K stated, She [former RN M] seemed concerned. I don't think she was aware that R9 was going to be out overnight. RN K stated he tried calling Perpetrator J and Perpetrator I several times with no answer. RN K indicated he eventually got in contact with the NHA and BOM L who notified to the police that R9 had not returned from a LOA. On [DATE] at 5:11 PM, an interview was conducted with CNA R who stated Perpetrator J and Perpetrator I arrived at the facility around dinner time and stated they would return R9 to the facility around 8:00 PM. CNA R stated, 8:00 PM came around, and he [R9] didn't come back. Then it turned to 9:00 PM and everybody wanted to know, 'where is [R9]?' I tried calling both [Perpetrator J and Perpetrator I] with no answer. It turned to 11:00 PM .I left the facility after my shift but kept calling and texting with no response .I came back [to the facility] the next morning and he still wasn't there. CNA R stated she had not packed R9 an overnight bag because he was supposed to return to the facility that night. CNA R stated R9 was sent on the LOA with two briefs and approximately 6 wash cloths. CNA R stated R9 did not have food, liquid, a food/liquid thickener powder, a gait belt, eating adaptive equipment, medications, or any other medical supplies necessary per R9's plan of care when he left the building on [DATE]. On [DATE] at 9:03 AM, a phone interview was conducted with former DON, N who verified she was the Director of Nursing at the time of R9's unauthorized LOA ([DATE]-[DATE]). DON N recalled she received a text message from RN D around midnight on [DATE] which indicated R9 left the previous evening and had not returned. Former DON N stated she arrived for work the next morning and was informed that R9 was still not at the facility. Former DON N was asked if she notified the NHA after she received the text message from RN D around midnight on [DATE] indicating R9 was not in the facility. Former DON N replied, I don't think I did because I was repeatedly told not to bother them .when [the NHA] arrived that morning, he was upset. He told me that this could be kidnapping, and he should have been notified immediately. Former DON N was asked if Perpetrator J and Perpetra[TRUNCATED]

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34568 Based on interview and record review the facility failed to ensure the provision of trauma-informed care to mitigate triggers that may cause re-traumatization for one Resident (R6) of one resident reviewed for trauma-informed care. Findings include: During an interview on 4/22/24 at approximately 11:45 am., R6 stated that her main concern was another male resident who constantly yells out. R6 stated that the sound scares her because she does not know when he is going to do it, even though he cannot help himself. Review of R6's Electronic Medical Record (EMR) revealed admission to the facility on [DATE] with diagnoses including: dementia with other behavioral disturbance, major depressive disorder, and bipolar disorder. Her 3/14/24 Minimum Data Set (MDS) assessment, revealed no history of trauma or post-traumatic stress disorder (PTSD), but was reflective in her Care Plan. R6 scored an 8/15 on the Brief Interview for Mental Status (BIMS) reflective of moderate cognitive impairment. Review of R6's Social Service Progress Notes dated 12/28/22 read, in part, .Resident was hospitalized psychiatrically throughout life related to Bipolar Disorder, Delusions, Major Depression, PTSD suspected Trauma due to childhood sexual abuse . Review of R6's Care Plans dated 3/25/19 and revised on 2/19/24 read: .Cognition I have impaired cognitive function related to Vascular Dementia with cognitive loss. I have a hx (history of), episodic confusion, paranoia, hallucinations, delusions, and thought disorder .Resident also has a diagnosis of PTSD. Over the years, resident was hospitalized Severe Chronic Bipolar Disorder, PTSD resulting in inpatient psychiatric illness .Interventions: Administer medications as ordered and report any adverse side effects or ineffectiveness, Use my name .approaches that maximize involvement in daily decision making .provide calming measures i.e. food, water, blanket, pillow .provide me with a homelike environment a calendar, low-glare light .remind me to not block the pathway to avoid inadvertent injury from others . An interview was conducted with the Director of Nursing (DON) on 4/24/24 at 11:08 a.m. The DON stated that their previous social worker has left the facility with Social Services Director/Staff G starting approximately three weeks ago. Staff G works in the evenings and on Saturday to accommodate the resident needs. An interview was conducted with Staff G on 4/24/24 at 1:15 p.m. Staff G stated that she has not dove deep into R6's level of care and did not know there was a history of PTSD trauma suspected of child sexual abuse. Staff G stated that she has not begun a social service assessment but would recommend that one be completed for R6 including an interview which could lead to suspected triggers of traumatization. Staff G confirmed she did know that the male resident who yells out does cause distress to R6. When the Care Plan interventions were reviewed for R6, Staff G stated that those are not appropriate interventions and would want to explore more effective/appropriate interventions. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's Trauma Informed Care Policy and Procedure dated 11/2/18 read, in part, All residents of [Facility Name] who have been assessed to be trauma survivors will receive culturally competent, trauma informed care in accordance with professional standards of practice. [Facility Name] will take into account resident's preferences and experience in order to eliminate or mitigate triggers that may cause re-traumatization of the resident. Procedure: MSW (Master Social Worker) will assess each resident on admission and at other times when clinically indicated, for trauma exposure and related symptoms. Assessment tool used will be a culturally competent, standardized and validated instrument. For those residents identified, MSW will develop a plan of care to address symptoms to ensure safety and prevent re-traumatization. MSW to provide support and counseling to assist to trauma residents .Training will be provided during orientation and yearly for all employees . Review of the facility's Post Traumatic Stress Disorder dated 10/6/18 read, in part, Residents will be assessed and provided with treatment and services as appropriate by mental health professionals. It is the policy of [Facility Name] to safe, caring environment by providing training and services .Procedure: Residents with a diagnosis or signs and/or symptoms of PTSD will be referred to the Behavioral Management Team for assessment. PAS/ARR (Preadmission screening and Resident Review) will reflect the Primary Mental Disorder .Care Plan will be developed with IDT (Interdisciplinary Team), BMT (Behavior Monitoring Team), resident and any interested parties of resident's choice and direct care staff. Training will be provided to staff . Staff training will be including understanding of cause, symptoms, treatment, approaches to prevent re-traumatization and individual needs of the resident experiencing PTSD.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. 45123 Based on observation, interview, and record review, the facility failed to ensure appropriate assessment, measurements, and consent for bedrails was completed for one Resident (R5) of one resident reviewed for bedrails. Findings include: On 4/23/24 at 9:00 AM, an observation was made of R5 in her room sitting in her wheelchair. R5's bed had two side rails/mobility bars on the upper half of each side of her bed. On 4/23/24 at 9:05 AM, an interview was conducted with R5 and was asked if she had signed a consent for the mobility bars and replied, Not that I am aware. On 4/24/24 at 11:00 AM, R5 continued to have the two mobility bars in place. A review of the electronic medical record (EMR) revealed no evidence of a consent, gap measurements, or assessment. On 4/24/24 at 10:40 AM, an interview was conducted with the Director of Nursing (DON) was asked if a consent and assessment were required for the mobility bars and replied, Yes. The mobility bars are required to be care planned, assessed, and re-assessed quarterly, have a consent, and physician order. The DON was asked to provide the consent and assessments for R5's mobility bars and no documentation was provided by the time of the exit on 4/25/24. Review of R5's physician order, dated 2/22/23, read in part, .Please use mobility assist bars . Review of the complete EMR for R5, lacked a consent, assessment, re-assessment, and gap measurements for the mobility bars. Review of R5's Minimum Data Set (MDS) admission assessment, dated 2/23/23, lacked any indication of the use of a bed rail or mobility bar. R5's MDS quarterly assessment, dated 8/26/23 and 11/26/23, lacked any indication of the use of a bed rail or mobility bar. Review of policy titled, Bed Rails, dated 4/23/24, read in part, Policy .Upon, receipt of request, the facility will initiate a bed rail assessment. The assessment must show that the bed rail poses little to no risk to the resident and that there is a medical need for the bed rail to be used. All residents/legal representatives are also provided with information regarding the dangers of bed rails upon admission to the facility. Bed rails will only be used when: 1. A full comprehensive assessment has been completed and a medical need has been determined. 2. All least restrictive methods have been attempted without success. 3. Resident is at high risk of injury from falling out of bed. 4. Needed to facilitate in-bed mobility . (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The need for bed rails will be reassessed quarterly or more frequent if condition changes. Procedure for placing bed rails on resident's bed .Bed rails include any devices attached to the bed - side rails of all sizes, halo bars, enabler bars, assist bars, mobility bars, ect. (sic) .

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49302 Based on interview and record review the facility failed to coordinate behavioral health services for one Resident (#4) of four residents reviewed for mood and behavior. Findings include: Resident #4 (R4) Review of R4's electronic medical record (EMR) revealed initial admission to the facility on [DATE] with diagnoses including recurrent major depressive disorder, dementia, and delusional disorders. Review of R4's most recent Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 7, indicative of severe cognitive impairment. On 4/22/24 at 11:00 AM, R4 was observed sleeping in a dark room with the shades drawn. On 4/24/24 at 9:47 AM and 1:11 PM, resident was again observed sleeping in a dark room with the shades drawn. Review of consultation with [Community Mental Health Provider] dated 4/25/23 read, in part: .this consultation in being requested due to violent behaviors, slapping staff members, yelling, out of control since last Friday pm [evening], Patient was sent out to [local hospital] and sent back to the facility . Follow up [in] 3 weeks. Review of R4's EMR revealed no follow-up with the [Community Mental Health Provider] in the 3 weeks following 4/25/23. Review of R4's progress notes revealed the following behavioral entries in the weeks following consultation with the [Community Mental Health Provider] on 4/25/23: 1. 6/19/23: .Resident stated, 'I just want to kill myself.' 2. 6/23/23: .[Resident] replied, 'I just want to leave and if I don't, I will kill myself.' 3. 6/28/23: .Resident then came out of her room and told this nurse, 'I wish you could give me a gun so I could shoot myself.' 4. 8/17/23: Sent [Community Mental Health Provider] request for emergency evaluation d/t [due to] statement: I'm looking for a window to jump out of so I can kill myself . 5. 8/18/23: .The resident stated, 'No one wants me here. You might as well give me a gun so I can shoot myself.' (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	6. 8/20/24: This nurse observed the resident crying in her room. This nurse asked the resident what was wrong. Resident stated, 'Just give me a gun or a knife.' Review of consultation with [Community Mental Health Provider] dated 8/24/23 (over 17 weeks after R4's latest evaluation) read, in part: Complaint: Violent behaviors, agitation, self-harm statements, worsening of symptoms .see back in 8-10 weeks .patient has been violent and hard to redirect .threat to herself and others . Review of R4's EMR revealed no follow-up with the [Community Mental Health Provider] in the following 8-10 weeks. Review of R4's progress notes revealed the following behavioral entries in the weeks following consultation with the [Community Mental Health Provider] on 8/24/23: 1. 9/16/23: Resident stated, 'Just give me a gun. Everybody hates me.' 2. 10/29/23: The resident was agitated and stated, 'Give me a gun so I can shoot myself.' This nurse asked what was wrong. The resident responded, 'no one here likes me.' Resident then started hitting the wall with her hand . 3. 11/6/23: The resident stated, 'Just give me a gun so I can shoot myself.' 4. 11/7/23: Resident stated, 'Nobody likes me here. Everyone is out to get me. I just want to run out in traffic.' 5. 12/19/23: Resident stated, 'Just give me a gun so I can kill myself. Everyone here hates me.' Review of consultation with [Community Mental Health Provider] dated 1/10/24 (over 19 weeks after R4's latest evaluation) read, in part: .[R4] admits to depression at times .follow-up per the request of patient, family, PCP [primary care physician], or facility staff . Review of R4's progress notes revealed the following behavioral entries in the weeks following consultation with the [Community Mental Health Provider] on 1/10/24: 1. 1/16/24: Resident stated, 'They hate me. Just kill me and get it over with.' 2. 1/24/24: .The Resident then shouted, 'Just kill me .Kill me.' 3. 2/14/24: .Resident began crying stating, 'just kill me now.' 4. 2/25/24: .Resident is very tearful after dinner . 'Just take me out back and shoot me.' 5. 3/1/24: Resident stated, 'Everyone hates me, I might as well kill myself.' (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	6. 3/3/24: Resident was observed using her middle finger to flip off a staff member .Resident stated, 'Just kill me. Everyone here hates me.' 7. 3/14/24: .[R4] stated, 'I should just go out in the road and get hit by a truck. That would make them all happy.' Review of R4's EMR did not reveal a request for a follow-up consultation with the [Community Mental Health Provider] despite continual suicidal ideation. On 4/24/24 at 2:12 PM, an interview was conducted with Certified Nursing Assistant (CNA) T who stated R4 continued to demonstrate paranoid behaviors and think, people are talking about her or out to get her. On 4/24/24 at 2:51 PM, an interview was conducted with the DON who was asked why R4 did not routinely see [Community Mental Health Provider] per their recommendations. The DON stated, It's our fault because we didn't have a social worker. Our former social worker never got the chance to train the new social worker before she quit. The DON stated the replacement social worker was fresh out of college and, wasn't equipped to handle the duties of the job. The DON stated, Nobody told me she was overwhelmed, so it probably got missed. She wasn't equipped . it was her first job out of college. She was overwhelmed. She was just in way over her head. On 4/24/24 at 3:02 PM, an interview was conducted with Social Services Director (SSD) G who reported she had been working at the facility for approximately 3 weeks. SSD G acknowledged that R4 was, very depressed, and on my radar for assessment. On 4/24/24 at 4:38 PM, R4 was observed ambulating in the hallway. R4 was asked how she felt to which she replied, If I could, I would walk out that door (exit door) and right into the middle of traffic. On 4/25/24 at 9:48 AM, an interview was conducted with CNA S who stated R4 had a history of unstable behavior and a history of suicidal statements. CNA was asked about her ability to provide care to R4. CNA replied, She has a lot of meltdowns .There's always two of us [CNAs] around because you never know with her. A behavioral health policy was requested from the Business Office Manager (BOM) L on 4/25/24 at approximately 8:38 AM and again at 12:36 PM. A behavioral health policy was requested from the DON on 4/25/24 at 12:40 PM. No facility policy was provided to this surveyor by the time of survey exit.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49302 Based on interview and record review, the facility failed to ensure licensed personnel administered medications to 1 out of 12 Residents (Resident #12) reviewed for medication administration. Findings include: Resident #12 (R12) Review of R12's electronic medical record (EMR) revealed admission to the facility on [DATE] with diagnoses including schizophrenia and chronic kidney disease. Review of R12's most recent Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 14, indicative of intact cognition. Review of R12's progress notes revealed the following entry on 12/27/23 at 19:17 [7:17 PM] by the Director of Nursing (DON): Miralax put in thickened liquid for another resident whose name is [same first name as R12]. Cena [Certified Nursing Assistant (CNA)] didn't realize it had medication in it and gave it to [R12]. [R12] drank it down fast before we could get it back. Review of Medication Related Incident Report revealed the following: Description of Incident: Miralax put in thickened liquid in sippy cup for [Resident] and sat on med [medication] cart. I was distracted and training NA [nursing assistant] trying to be help gave drink to [R12] . .Action to Correct Error: Do not pass meds in areas of high congestion where you can get distracted. On 4/25/24 at 1:02 PM, an interview was conducted with the DON who confirmed she had mixed Miralax with water in a cup, thickened it, and wrote the resident's first name on the cup with marker. The DON stated a nursing assistant in training grabbed it off the medication cart and mistakenly gave the medication to R12. The DON stated, I don't know why she did it. She was impulsive. The DON confirmed that CNAs are not allowed to administer medications and could not recall if the attending physician had been notified after the error. Review of facility policy titled, Medication Error Reporting, undated, read, in part: Medication errors shall be documented in the resident's clinical record and reported to the resident's attending physician . Procedures: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235588	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maple Valley Nursing Home	1086 W. Burdickville Road Maple City, MI 49664

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	. 2. Notify the attending physician promptly of the error . 3. Implement physician's orders and monitor the resident closely for 24 to 72 hours or as directed . 4. Document the following in the resident's clinical record: a. A description of the error. b. Name of physician and time notified. c. Physician's subsequent orders. d. Resident's condition for 24 to 72 hours or as directed . Review of R12's EMR did not reveal a physician communication nor evidence of increase monitoring of signs/symptoms of potential adverse reaction per physician's orders. Review of R12's Medication Administration Record (MAR) did not reveal an order for Miralax at the time of the error. Review of Medication Related Incident Report revealed a physician's signature on 1/9/24, approximately 11 days after the medication error.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45123 Based on interview and record review, the facility failed to ensure monthly regimen reviews (MRR's) were completed monthly and recommendations were reviewed by a physician and follow up for five Residents (R4, R6, R20, and R21) of four residents reviewed for MRR's. Findings include: Resident #20 (R20) A review of R20's EMR revealed admission to the facility on [DATE] with diagnosis including dementia, aphasia, and cerebral infarct. A review of R20's MRR's revealed the pharmacist made recommendations on 12/27/23 and 2/26/24 and lacked any MMR's for the month of October 2023 and November 2023. The facility was unable to find the pharmacists recommendation, the missing MMR's, and the physician's response by the survey exit date of 4/25/24. Resident #21 (R21) A review of R21's EMR revealed admission to the facility on [DATE] with diagnosis including bipolar disorder, paraplegia, and pressure ulcers. A review of R21's MRR's revealed the pharmacist made recommendations on 11/28/23 and 1/29/24. The facility was unable to find the pharmacists recommendation and the physician's response by the survey exit date of 4/25/24. 34568 R6 A review of R6's EMR revealed admission to the facility on [DATE] with diagnosis including: dementia with other behavioral disturbance, type 2 diabetes, major depression disorder, bipolar disorder, stage 4 chronic kidney disease, and repeated falls. A review of R6's MRR's revealed that the pharmacist made recommendations on 9/21/23, 10/24/23, 12/27/23, and 2/26/24. The facility was unable to find the pharmacists recommendation and the physician's response by the survey exit date of 4/25/24. 49302 Resident #4 (R4) Review of R4's electronic medical record (EMR) revealed initial admission to the facility on [DATE] with diagnoses including recurrent major depressive disorder, dementia, and delusional disorders. Review of R4's most recent Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 7, indicative of severe cognitive impairment. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Maple Valley Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 1086 W. Burdickville Road Maple City, MI 49664	

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R4's monthly Medication Regimen Reviews (MRR's) revealed the following recommendations by a licensed pharmacist: 1. 7/27/23: See report for any noted irregularities and/or recommendations. Meds [medications] reviewed, note sent to MD [Medical Doctor]. 2. 9/21/23: See report for any noted irregularities and/or recommendations. Meds reviewed, note sent to nursing. 3. 10/24/23: See report for any noted irregularities and/or recommendations. Meds reviewed, notes sent to nursing. 4. 11/28/23 See report for any noted irregularities and/or recommendations. Meds reviewed, notes sent to nursing. 5. 1/29/24: See report for any noted irregularities and/or recommendations. Meds reviewed, note sent to nursing. Review of R4's EMR did not reveal any reports to the attending physician or Director of Nursing (DON) for the aforementioned dates, nor documentation that the irregularity was reviewed and what action, if any, was taken to address it. On 4/24/24 at 11:58 AM, an interview was conducted the DON who stated she could not locate the pharmacy recommendations. The DON stated the protocol was to upload the pharmacy records to the resident's EMR. The DON indicated she could not find them in the EMR and stated, it's a mystery to me. A facility policy regarding MRR's was requested from the DON at that time who stated, We should have one of those [a MRR policy]. A MRR policy was requested from the Business Office Manager (BOM) L on 4/25/24 at approximately 8:38 AM and again at 12:36 PM. No MRR facility policy was provided to this surveyor by the time of survey exit.

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34568 Based on observation, interview and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety as evidenced by failing to dispose of expired food in kitchen refrigerators. These deficient practices have the potential to result in food borne illness among any and all 23 residents of the facility. Findings include: On [DATE] at 10:00 a.m., the reach in refrigerator was observed to have six expired containers of juice. The six juice containers had expiration dates as far back as [DATE], February 2024, and [DATE]. No container of juice had a received date labeled on top. During this observation, Kitchen Manager/Staff E stated that he had just went through the refrigerators for expired foods and must have missed these juices. The FDA Food Code 2017 states: ,d+[DATE].17 Ready-to-Eat, Time/Temperature Control for Safety Food, Date Marking. (A) Except when PACKAGING FOOD using a REDUCED OXYGEN PACKAGING method as specified under S ,d+[DATE].12, and except as specified in (E) and (F) of this section, refrigerated, READY-TO EAT, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD prepared and held in a FOOD ESTABLISHMENT for more than 24 hours shall be clearly marked to indicate the date or day by which the FOOD shall be consumed on the PREMISES, sold, or discarded when held at a temperature of 5 C (41 F) or less for a maximum of 7 days. The day of preparation shall be counted as Day 1. Pf (B) (1) The day the original container is opened in the FOOD ESTABLISHMENT shall be counted as Day 1; Pf and (2) The day or date marked by the FOOD ESTABLISHMENT may not exceed a manufacturer's use-by date if the manufacturer determined the use-by date based on FOOD safety. Pf

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. 49302 Based on observation, interview, and record review, the facility failed to administer its policies, practices, and procedures in a manner that displayed effective and efficient use of its resources to ensure the achievement and maintenance of the highest practicable physical, mental, and psychosocial well-being for all 22 residents at the facility, as evidenced by the following: 1. The facility administration was not present during the delivery of an Immediate Jeopardy (IJ) regarding resident abuse on 4/22/24 at approximately 5:30 PM despite disclosure of the severity of the concern by state surveyors during an earlier meeting (at 2:54 PM). The IJ was delivered to the Director of Nursing (DON) who stated the Nursing Home Administrator (NHA) had already left the facility for the day (reference tag F600). 2. The facility administration failed to report and investigate an unauthorized leave of absence (LOA) from the facility resulting in a resident's (Resident #9's/R9) location being unknown for approximately 16 hours without required medical supplies and equipment, including potentially necessary hospice medications. These deficient practices resulted in undetected abuse, the potential for continued exposure to potential abuse, and the potential for psychosocial harm (reference tag F600). 3. The facility administration failed to ensure facility staff had the necessary level of support, training, oversight, and adequate liaison to manage in an effective and meaningful manner: a. On 4/23/24 at 9:03 AM, a phone interview was conducted with former DON, N who verified she was the Director of Nursing at the time of R9's unauthorized LOA (9/18/23-9/19/23). Former DON N was asked if she notified the NHA after she received the text message that indicated R9's whereabouts was unknown to facility staff. Former DON N replied, I don't think I did because I was repeatedly told not to bother them . [The NHA] got after me for emailing him too much. They [administrative staff] were always talking vacations and never in the building . Communication is clearly a big problem in that facility . and the lack of support and the lack of [administrative staff] physically being there [at the facility]. Looking back, I had no business being the DON . they [administrative staff] said, 'We'll support you, we'll teach you' .there was nothing. It was minimal . I started working on January 3rd [2023] and in February [2023] the State and Federal surveyors were there for 2 weeks . At that point I should have just bailed . i. On 4/23/24 at approximately 1:30 PM, a policy titled After Hour Hierarchy Call Policy and Procedure, reviewed 10/20/2022, was observed near the staff dining area. The policy read, in part: Purpose: To ensure the availability of after hour Administration support to the facility while being sensitive to time off for personal leave, respite and family time Next to the policy was a typed document that read, [NHA] and [Business Officer Manager (BOM) L] are on vacation from 4/12/24 and will return on 4/23/24. They will not be available by phone, text or email . (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	b. On 4/24/24 at 2:51 PM, an interview was conducted with the DON who was asked why Resident #4 (R4) did not routinely see [Community Mental Health Provider] per their recommendations despite continued violent behaviors, agitation, and self-harm statements. The DON stated, It's our fault because we didn't have a social worker. Our former social worker never got the chance to train the new social worker before she quit. The DON stated the replacement social worker was fresh out of college and, wasn't equipped to handle the duties of the job. The DON stated, Nobody told me she was overwhelmed, so it probably got missed. She wasn't equipped . it was her first job out of college. She was overwhelmed. She was just in way over her head. c. On 4/25/24 at 9:55 AM, MDS Coordinator/Former Infection Preventionist (IP) O was observed storming out of her office with her jacket on and bags packed. MDS Coordinator/Former IP O stated, I have essentially been terminated on the spot. I will not be meeting with you at 10:00 AM for the IC [infection control] meeting or answering any more questions. On 4/25/24 at 10:00 AM, an interview was conducted with the NHA to acquire details regarding MDS Coordinator/Former IP O's termination. The NHA stated, She terminated herself. She back-talked me and chose not to follow direct orders so I sent her home. If she chooses not to show up for future shifts, she will be terminated. 4. The facility administration failed to ensure the IP completed specialized training in infection prevention and control, which placed the entire facility population at risk for infectious disease outbreaks due to knowledge deficits pertaining to current infection prevention and control standards (reference Tag F882). a. On 4/25/24 at 1:06 PM, an interview was conducted with the Nursing Home Administrator (NHA) and the Director of Nursing (DON). The DON verified MDS Coordinator/Former IP O served as the IP from January 2023 through March 2024 without the required certification. The DON stated, I just couldn't get her [MDS Coordinator/Former IP O] to finish them [IP training's]. The NHA stated, Her [MDS Coordinator/Former IP O] excuse was because she didn't have time to do them. 5. The facility administration failed to ensure the Smoking Policy and Procedure was implemented for 2 residents in the facility (Resident #12 and Resident #21), which placed the safety and well-being of residents, visitors, and staff at risk (reference tag F689). 6. The facility administration failed to maintain an effective abuse and dementia management training program and resident rights training requirement for three out of seven staff members reviewed for annual training, including the NHA. This deficient practice resulted in an Immediate Jeopardy (IJ) when Resident (R9) was taken from the facility without knowledge of the guardian, and a resident-to-resident altercation involving Resident #17 and Resident # 18 (reference tag F600). Review of facility policy titled, Administrator, undated, read, in part: The primary purpose of this position is to direct the day-to-day functions of the facility in accordance with current federal, state, and local standards, guidelines, and regulations that govern nursing facilities in order to assure that the highest degree of quality care can be provided to facility residents at all times . Responsibilities and Duties: (continued on next page)

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	235588	A. Building B. Wing	04/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maple Valley Nursing Home	1086 W. Burdickville Road Maple City, MI 49664

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	.Assist Department Heads in the development, implementation and maintenance of the written policies and procedures and professional standards of practice that govern the operation of the facility . .Consults the Department Heads concerning the operations of their departments to assist in eliminating/correcting problem areas, and/or improvement services . .Reviews the facilities policies and procedures at least annually and makes changes as necessary to assure continued compliance with current regulations . .Ensure that all facility personnel, residents, and visitors follow established safety regulations, to include fire protection/prevention, smoking regulations, safe work practice and infection control . .participates in state/federal surveys of the facility . .maintain an adequate liaison with families, residents, employees and community members . .Other skills and abilities: .knowledge and adherence to the Abuse Prevention Policy . .knowledge and adherence to the Corporate Compliance Policy . .Be supportive, cooperative and enthusiastic about the facility policies and goals. Be cognizant of the responsibilities of a team approach to completion of projects and ability to work with Department Supervisors and Administration .

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NAME OF PROVIDER OR SUPPLIER: Maple Valley Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE: 1086 W. Burdickville Road Maple City, MI 49664	

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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 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** 49302 Based on interview and record review, the facility failed to maintain accurate medical records for 1 of 12 residents (Resident #9) reviewed for medication administration. Findings include: Resident #9 (R9) Review of R9's electronic medical record (EMR) revealed admission to the facility on [DATE] with diagnoses including Huntington's disease (a progressive, fatal genetic disorder that affects the brain and causes involuntary movements, cognitive decline, and emotional problems), aphasia (difficulty processing, using, and/or understanding language), dysphagia (difficulty or inability to swallow), contracture of unspecified hand (a permanent shortening and tightening of muscle fibers that reduces flexibility and makes movement difficult), and alcohol abuse. Record review of R9's Minimum Data Set (MDS) on 7/20/23, indicated R9 was severely impaired cognition - unable to complete BIMS [Brief Interview for Mental Status]. Review of the Census list revealed R9 departed the facility on 9/18/23 at 6:07 PM for a leave of absence (LOA). R9 returned to the facility on [DATE] at 9:48 AM. Review of R9's progress notes revealed the following entries: 1. 9/18/23 at 18:07 [6:07 PM] written by former Registered Nurse (RN) M: LOA with [Perpetrator J] and [Perpetrator I] to [Perpetrator J's] house at 1807 [6:07 PM]. 2. 9/19/23 at 09:48 [9:48 AM] written by RN K: LOA Returned from [Perpetrator J's] house driven by [Perpetrator J] and [Perpetrator I]. On 4/22/24 at 4:58 PM, an interview was conducted with RN K who stated he arrived at the facility around 6:30 AM on 9/19/23 and got report from the midnight nurse that R9 was not in the building. RN K verified R9 eventually returned to the facility around 10:00 AM on 9/19/23. Review of R9's 9/19/23 Medication Administration Record (MAR) revealed the following: 1. Famotidine tablet, 20 MG (milligram) administered at 8:00 AM. 2. MiraLax Oral Packet 17 GM (grams) administered at 8:00 AM. 3. Zyrtec Allergy Oral Tablet 10 MG administered at 8:00 AM. 4. Zanaflex Oral Capsule 2 MG administered at 8:00 AM. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/24/24 at 2:43 PM, an interview was conducted with the Director of Nursing (DON). The DON stated timely medication administration is considered an hour before or after the ordered administration time. The DON confirmed if a medication is scheduled to be administered at 8:00 AM, acceptable administration parameters would be considered 7:00 AM - 9:00 AM. The DON indicated if medication occurred outside the acceptable time frame, a progress note is expected to be written in the affected resident's EMR that includes the actual time of administration and the reason for delay. The DON was asked why R9's MAR indicated he was administered medications at 8:00 AM on 9/19/23 despite returning to the facility at 9:48 AM per the census report. The DON stated, [R9's] medications were not administered at 8:00 AM. They should not have been marked. That's wrong. The DON was unable to provide further insight into why administration of R9's was inaccurately documented nor the nurse responsible for indicating such in the MAR. Review of facility policy titled, Medication Error Reporting, undated, read, in part: .Medication errors shall be documented in the resident's clinical record and reported to resident's attending physician . Review of R9's EMR did not indicate documentation of a medication error or evidence of notification to the attending physician.

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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 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** 45123 Based on observation, interview, and record review, the facility failed in implement enhanced barrier precautions (EBP) for one Resident (R21) of twelve sampled residents reviewed for infection control practices. Findings include: Resident #21 (R21) Review of R21's face sheet, revealed an original admission into the facility on [DATE] with medical diagnoses of the following, in part: depression, bipolar disorder, paraplegia, and pressure ulcers. Review of R21's Minimal Data Set (MDS) assessment, dated 11/28/23, revealed that R21 was cognitively intact. Review of R21's wound assessment, dated 11/22/23, revealed he had two wounds, one on his left lower leg and a second on his coccyx that he was admitted with. Review of R21's weekly wound assessment, dated 11/22/23 through 4/1/24, revealed R21's wounds were improving. On 4/22/24 at 10:40 AM, an interview was conducted with R21 in his room. R21 confirmed that the facility had been treating his wounds and the wounds were still currently open and undergoing treatments. During the interview an observation had been made of the lack of transmission-based precaution (TBP) signage outside of the room door for R21 indicating an alert to staff providing direct care that R21 was on enhanced barrier precautions (EBP) related to open wounds. On 4/23/24 at 10:45 AM, an observation was made of Registered Nurse (RN) K. RN K was observed performing wound care on R21's wounds without wearing proper personal protective equipment (PPE) during the dressing changes. On 4/24/24 at 9:25 AM, an observation was made of R21's room door and remained lacking signage indication the need for TBP related to EBP for open wounds. On 4/25/24 at 9:45 AM, an interview was conducted with the Infection Preventionist / RN B and was asked if she was familiar with EBP and replied, Yes. RN B was asked if any resident in the current population should be on EBP and replied, No. Oh, well yeah. One [referred to R21] for wounds. RN B was asked if there was any reason that R21 was not identified as being on EBP related to wounds and signs indicating what staff was expected to do while providing high contact direct patient care and replied, Well, we just haven't educated all the staff yet and we didn't want to confuse anyone and have them not do what they were supposed to do. RN B was then requested to see a copy of the policy related to EBP. Review of policy titled, Enhanced Barrier Precautions Policy and Procedure, dated 4/5/24, read in part, Policy: It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms (MDROs) .

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. 49302 Based on interview and record review, the facility failed to ensure the Infection Preventionist (IP) completed specialized training in infection prevention and control. Findings include: On 4/23/24 at 3:10 PM, an interview was conducted with MDS Coordinator/Former IP O. MDS Coordinator/Former IP O indicated she served as the facility's IP from January 2023 through March 2024. MDS Coordinator/Former IP O stated she began the taking classes for the IP certification but never finished the training. MDS Coordinator/Former IP O stated she would further discuss her struggles with the IP certification process at the Infection Control (IC) meeting scheduled with this surveyor on 4/25/24 at 10:00 AM. On 4/25/24 at 9:55 AM, MDS Coordinator/Former IP O was observed storming out of her office with her jacket on and bags packed. MDS Coordinator/Former IP O stated, I have essentially been terminated on the spot. I will not be meeting with you at 10:00 AM for the IC meeting or answering any more questions. On 4/25/24 at 10:00 AM, an interview was conducted with Current IP B. Current IP B stated she received her IP certification on 3/3/24 and was training under MDS Coordinator/Former IP O until her departure. Current IP B stated MDS Coordinator/Former IP O planned to complete the required training but was unsuccessful for reasons unknown to her. On 4/25/24 at 1:06 PM, an interview was conducted with the Nursing Home Administrator (NHA) and the Director of Nursing (DON). The DON verified MDS Coordinator/Former IP O served as the IP from January 2023 through March 2024 without the required certification. The DON stated, I just couldn't get her [MDS Coordinator/Former IP O] to finish them [IP training's]. The NHA stated, Her [MDS Coordinator/Former IP O] excuse was because she didn't have time to do them. Review of the Centers for Medicare and Medicaid Services (CMS) Form #20054 Infection Prevention, Control and Immunizations, dated 6/2023, revealed that facilities are required to designate at least one qualified Infection Preventionist who completed specialized training prior to assuming the role of Infection Preventionist and that evidence of completion of this specialized training must be available.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235588	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maple Valley Nursing Home	1086 W. Burdickville Road Maple City, MI 49664

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49302 Based on interview and record review, the facility failed to ensure an eligible resident was offered influenza vaccines as recommended by the Centers for Disease Control and Prevention (CDC) for 1 of 5 residents (Resident #20) reviewed for vaccination status. Findings Include: Resident #20 (R20) Review of R20's electronic medical record (EMR) revealed initial admission to the facility on [DATE] with diagnoses including cerebral infarction (stroke), dementia, and aphasia (difficulty processing, using, and/or understanding language). Review of 20's most recent Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 8, indicative of moderate cognitive impairment. Review of R20's vaccination history on the Michigan Care Improvement Registry (MICR), revealed the last dose of the seasonal influenza vaccine (Influenza IIVD) was administered on 10/30/20. The status for eligible vaccinations read, Seasonal Influenza DUE NOW. On 4/25/24 at 10:08 AM, an interview was conducted with Current IP B who stated all vaccination information is uploaded into the respective resident's EMR. Current IP B was unable to locate R20's influenza vaccination offering for the previous 3 years. On 4/25/24 at 10:25 AM, an interview was conducted with Director of Nursing (DON) in training A. The DON in training A was unable to locate an updated influenza vaccine acceptance or declination for R20 and confirmed R20's last documented influenza administration was 10/30/2020. A review of the CDC information (accessed on 4/30/24 and located at https://www.cdc.gov/flu/professionals/acip/summary/summary-recommendations.htm) regarding the influenza vaccination recommendations revealed the following: .Routine annual influenza vaccination is recommended for all persons aged ? [greater than] 6 months who do not have contraindications .For most persons who need only one dose of influenza vaccine for the season, vaccination should ideally be offered during September or October. However, vaccination should continue throughout the season as long as influenza viruses are circulating .

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	235588	A. Building B. Wing	04/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maple Valley Nursing Home	1086 W. Burdickville Road Maple City, MI 49664

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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 0942 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that staff members are educated on resident rights and facility responsibilities to properly care for its residents. 34568 Based on interview and record review, the facility failed to ensure the provision of resident rights training requirements for three of seven employees reviewed for resident rights training. Findings include: A review of staff education records and competencies on 4/25/24 revealed the following staff members had not completed the required resident rights training within the 12-month period: Nursing Home Administrator (NHA) - last completed 2/1/23 Registered Nurse (RN) B - last completed 2/1/23 Agency Certified Nurse Aide (CNA) F - had not completed any training. An interview was conducted with the Director of Nursing (DON) on 4/25/24 at 12:38 p.m. The DON stated that she was primarily responsible for annual training and competencies of the staff at the facility, and that the facility does training based on calendar year. The DON was asked about CNA F training as an agency staff to which she replied, She should have had training completed by the agency. When asked if CNA F had specific training completed for this facility, the DON stated No. Review of the facility's Resident Abuse, Neglect Mistreatment or Misappropriation Prevention Program reviewed on 3/20/24 read, in part, .All facility staff and volunteers shall be in-serviced upon employment, and at least annually thereafter, regarding Resident's Rights .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235588	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/25/2024
NAME OF PROVIDER OR SUPPLIER Maple Valley Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 1086 W. Burdickville Road Maple City, MI 49664	

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F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation. 34568 Based on interview and record review, the facility failed to maintain an effective abuse and dementia management training program for three out of seven staff members reviewed for annual training. Findings include: A review of staff education records and competencies on 4/25/24 revealed the following staff members had not completed the required abuse, neglect and exploitation training and competency evaluation within the required 12- month period: Abuse Training: Nursing Home Administrator (NHA) - last completed 2/1/23 Registered Nurse (RN) B - last completed 2/1/23 Agency Certified Nurse Aide (CNA) F had not completed the facility's abuse training program. Dementia Training: NHA: last completed 2/1/23 CNA F had not completed the facility's dementia training program. An interview was conducted with the Director of Nursing (DON) on 4/25/24 at 12:38 p.m. The DON stated that she was primarily responsible for annual training and competencies of the staff at the facility, and that the facility does training based on calendar year. The DON was asked about CNA F training as an agency staff to which she replied, She should have had training completed by the agency. When asked if CNA F had specific training completed for this facility, the DON stated No. Review of the facility's Resident Abuse, Neglect, Mistreatment, or Misappropriation Prevention Program policy reviewed on 3/20/24 read, in part, .It is the policy of [Facility Name] to maintain an environment free of abuse and neglect, mistreatment, or misappropriation .Resident will not be subjected to abuse by any volunteers, staff or other agencies service the resident, family members or legal guardians, friends, vendors or other individuals .All employees and volunteers will receive information, training and ongoing in-services about: Appropriate interventions to deal with aggressive and/or catastrophic reactions of residents. How staff or visitors should report their knowledge of allegations without fear or reprisal. How to recognize signs of burnout, frustration, and stress that may lead to abuse. What constitutes abuse, neglect, and misappropriation of resident property . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235588	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/25/2024
NAME OF PROVIDER OR SUPPLIER: Maple Valley Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE: 1086 W. Burdickville Road, Maple City, MI 49664	

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F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	All facility staff and volunteers shall be in-serviced upon employment, and at least annual thereafter, regarding Resident's Rights, including freedom from abuse, neglect, mistreatment and misappropriation of property, involuntary seclusion .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235588	A. Building B. Wing	04/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0945 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Include as part of its infection prevention and control program, mandatory training that includes written standards, policies, and procedures for the program. 34568 Based on interview and record review, the facility failed to ensure the provision of infection control training for four of seven employees reviewed for infection control training. Findings include: A review of staff education records and competencies on 4/25/24 revealed the following staff members had not completed the required abuse, neglect and exploitation training and competency evaluation within the required 12- month period: Nursing Home Administrator (NHA): 8/29/24 (this date is in the future) Certified Nurse Aide (CNA) C - did not complete the Infection Control Annual Inservice Director of Nursing (DON) - did not complete the Infection Control Annual Inservice. A note provided by the facility stated that she was not working during class but has been the preventionist for years. No further documentation or certificate was provided by the survey exit date of 4/25/24. Agency CNA F - did not complete the Infection Control Annual Inservice