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	05/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maple Valley Nursing Home	1086 W. Burdickville Road Maple Valley, 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 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. Based on interview and record review, the facility failed to report Payroll Based Journal (PBJ) information to CMS (Centers for Medicare and Medicaid). This deficient practice resulted in inaccurate reporting of staffing levels with the potential to affect all residents residing in the facility.Findings include:Review of the CMS PBJ Staffing Data Report FY (fiscal year) Quarter 1 2026 (October 1-December 31) revealed the metric Failed to have Licensed Nursing Coverage 24 Hours/Day Triggered with infraction dates being: 10/4, 10/5, 10/16, 10/18, 10/19, 10/21, 11/02, 11/29, 12/14.A request was made for licensed nursing timecards for those infraction dates was requested on 5/5/26 to the Nursing Home Administrator (NHA).Review of the licensed nursing timecards was completed on 5/6/26. This Surveyor was able to verify that the facility did have 24/7 nursing coverage on those infraction dates, however, the data missing was due to not entering travel nursing data into the PBJ system.An interview was conducted with the NHA on 5/6/26 at 12:30 PM. The NHA stated that the business office manager was responsible for entering data into the CMS PBJ system, but was unavailable at the time of the survey due to entering payroll for their employees.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 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. Based on interview and record review, the facility failed to ensure Medication Regimen Reviews were completed and addressed by the attending physician in the medical records of four Residents (#8, #2, #3, & #7) of five residents reviewed for unnecessary medications. Findings include:Resident #7 (R7) The EMR of R7 indicated a pharmacist conducted a MRR on 2/7/26. The pharmacist documented in the EMR, in part: .See report for any noted irregularities and/or recommendations. The pharmacist's report for the 2/7/26 MRR was not located in the EMR. The EMR of R7 did not include documentation by the attending physician indicating the MRRs of 2/7/26 had been reviewed nor was there documentation by the attending physician on actions taken to address the pharmacist's recommendations. Review of the facility's policy [Facility Name] Statement of Policy for Facility Pharmacy Services, reviewed 1/16/26 read, in part, .Monthly visits by a licensed pharmacist to document drug regimen reviews for each resident.Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physical, medical director, director of nursing and lists, at a minimum, the resident's name, relevant drug, and the irregularity the pharmacist found. These reports will be addressed by physician, or physician extender during weekly visits at facility but no later than 10 days. Resident #8 (R8) The electronic medical record (EMR) of R8 indicated a pharmacist conducted a Medication Regimen Review (MRR) on 2/6/26. The pharmacist documented in the EMR, in part: .See report for any noted irregularities and/or recommendations. The pharmacist's report for the 2/6/26 MRR was not located in the EMR. The EMR of R8 included a pharmacist's MRR for R8 on 3/1/26. The pharmacist documented the following in the EMR, in part: .See Report – Lab Request. The pharmacist's report for the MRR of 3/1/26 was not located in the EMR. The EMR of R8 did not include documentation by the attending physician indicating the MRRs of 2/26/26 and 3/1/26 had been reviewed nor was there documentation by the attending physician on actions taken to address the pharmacist's recommendations. On 5/5/26 at 11:40 AM, the Director of Nursing (DON) said the facility was unable to locate the absent MRRs for R8. Resident #2 (R2) The EMR of R2 revealed an admission date to the facility on 4/13/26. The EMR did not contain an admission MRR. On 5/5/26 at 11:40 AM, the DON was asked if an MRR had been completed for R2. The DON said the pharmacist had not yet completed an MRR for R2. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	According to The American Society of Consultant Pharmacists (ASCP) guidelines titled GUIDANCE COMPONENTS OF A MEDICATION REGIMEN REVIEW IN LONG-TERM CARE FACILITIES found at www.ascp.com/page/policystatements?&hhsearchterms=admission&#rescol_4849366: .MRR is a process conducted by a pharmacist, either upon admission, during routine monthly visits, or if a resident experiences a change in condition. The guidelines define admission MRR as follows: admission MRR: MRR that is performed at the point of admission of a resident to a facility to identify clinically significant medication issues which can affect the resident positively by preventing a condition or reducing risk or avoiding an issue that may exacerbate, cause, or contribute to a symptom, illness, or decline in status . Resident #3 (R3) The pharmacist completed an MRR for R3 on 3/1/26. The pharmacist documented the following in the EMR of R3, in part: .See Report – Lab Request. The pharmacist's report for the MRR of 3/1/26 was not located in the EMR of R3. The EMR of R3 did not include documentation by the attending physician indicating the MRR of 3/1/26 had been reviewed nor was there documentation by the attending physician on actions taken to address the pharmacist's recommendation. On 5/5/26 at 11:40 AM, the DON said the facility was unable to locate the 3/21/26 MRR for R3.

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This deficiency pertains to Intake #2792749Based on interview and record review, the facility failed to protect a resident from misappropriation of resident property for one Resident (#21) of one resident reviewed for misappropriation of property. Findings include:Resident #21 (R21)An admission Minimum Data Set (MDS) assessment dated [DATE] indicated R21 was admitted to the facility on [DATE]. The MDS coded R21 with a Brief Interview for Mental Status (BIMS) score of 15 indicating R15 had intact cognition. The MDS documented R21 had intact short-term memory and long-term memory and had no mood or behavioral conditions.During an interview on 5/4/26 at 10:47 AM, R21 said Certified Nurse Aide (CNA) stole over $500.00 from his cash app account (a mobile app money transfer service that allows users to send and receive money) in February 2026. The alleged perpetrator was identified by R21 as CNA F, who worked the night shift.R21 said he wanted to transfer funds from a credit card but did not know the process to do it, so R21 said CNA F told him she could assist him if he provided her with his Cash App sign-in information. R21 said he provided CNA F with his Cash App sign-in information so she could help him with the money transfer.According to R21, he was reviewing his Cash App transactions shortly after Valentine's Day (2/14/26) and noted two suspicious transactions he had not authorized. R21 said the two transactions reflected CNA F had accessed his account and withdrew funds totaling over $500.00.R21 said he notified the facility social worker (SW) E and the Director of Nursing (DON) who notified the police of the theft. R21 said a police officer visited him, but he was unaware of the current status of the investigation.When asked how he felt about the theft of his funds, R21 said the facility had reimbursed the money, but at the time it occurred he was upset and angry. R21 said, I was upset - I was mad and hurt. That's what I get for letting my guard down and being friendly.The electronic medical record (EMR) of R21 contained a progress note dated 2/19/26 at 7:10 PM. The progress note was authored by SW E and read: Resident reported that he had $$520.49 [sic] taken from his account from the cash app and that it was [name of CNA F redacted] that completed two transactions taking this money from him. SW reviewed the transactions with resident on his cash app and made copies of them in the team office with resident present. SW also phoned [name of DON] and the [name of police department redacted]. Deputy [name of deputy redacted] interviewed resident in my presence in the team office. Resident is pressing charges against [name of CNA F redacted]. The deputy is calling [name of CNA F redacted], APS [Adult Protective Services] and will turn the case over to the prosecuting attorney for charges to be pressed. [Name of CNA F redacted] was a CENA [Competency Evaluated Nursing Assistant] with [name of staffing agency redacted]. [name of DON redacted] is reporting this to the state today. Copies of the deputy report number and cash app transactions scanned into resident's chart. Plan to follow.A progress note dated 2/28/26 at 12:49 PM documented, in part: Collaborated with [name of DON redacted], and she reports that [name of nursing facility redacted] will reimburse resident the #520.49 [sic] that was stolen from him by the [name of staffing agency redacted] CENA.During an interview with SW E on 5/5/26 at 3:04 PM, SW E was asked about the allegation of misappropriation of R21's money. SW E said on 2/19/26, R21 showed her his Cash App interactions from his cell phone and told her CNA F had stolen his money. SW E said the transactions to which R21 were referring documented the initials of CNA F. SW E said she contacted the police and the DON, and the DON reported the theft and CNA F to the state agency. SW E said, [R21] was upset she [CNA F] took his money. SW E said the facility had not received a police report because the investigation was still open.The DON was interviewed on 5/6/26 at 1:10 PM. The DON provided an investigation file of the misappropriation. The file included a photo of a cell phone displaying Cash App transactions. The cell phone reflected two transactions: one occurring on 2/1/26 for $500.26 and one occurring on 2/5/26 for $20.23, totaling $520.49. The first four letters of the recipient of the funds were the same first four letters of the first name of CNA F.The DON said she was contacted by SW E on 2/19/26 and (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	made aware CNA F had stolen money from R21. The DON said she spoke with R21 who said he shared his Cash App information with CNA F. The DON said she contacted the contracted agency who suspended CNA F. The DON confirmed she notified the state agency to report the allegation against CNA F and report the misappropriation of money from R21 by CNA F.Attempts to contact CNA F via telephone were made on 5/5/26 and 5/6/26, but the attempts were futile.The policy Missing Items dated as reviewed and updated 3/21/16 read, in part: .It is the policy and responsibility of the facility to safeguard resident property to the extent possible to assure there is no misappropriation of resident property.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on interview and record review, the facility failed to ensure the Long-Term Care Ombudsman was notified of a resident's discharge from the facility for one Residents (#25) of one resident reviewed for discharge practices.Findings include:Review of R25's Electronic Medical Record (EMR) revealed the resident was discharged from the facility on 4/6/26. Review of the documentation provided to the Long-Term Care Ombudsman in April 2026 indicated they were not notified of the resident's discharge from the facility. An email to the Long-Term Care Ombudsman on 5/5/26 at 11:22 AM confirmed no notification of R25's discharge.On 5/6/26 at 12:21 PM, an interview was conducted with the Nursing Home Administrator (NHA) regarding R25's discharge and notification to the Long-Term Care Ombudsman. The NHA stated they have never sent notification of discharges.Review of the facility's policy titled Discharge of Resident, updated on 2/17/26 read, in part, Purpose: to provide safe departure from the facility, provide continuity of care, and to provide appropriate documentation.She/he will notify Michigan Long Term Care Ombudsman.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed toMaintain documentation in the clinical record to support a new diagnosis of schizophrenia, Care plan and provide interventions for schizophrenia, Monitor for behaviors associated with schizophrenia consistent with Diagnostic and Statistical Manual of Mental Disorders criteria, andMonitor for antipsychotic side effects and adverse reactionsfor one Resident (#3) of five residents reviewed for unnecessary medications. Findings include:Resident #3 (R3)A Minimum Data Set (MDS) assessment dated [DATE], prior to the acute care hospitalization of R3, documented active psychiatric diagnoses of bipolar disorder and anxiety disorder. The MDS indicated R3 did not have an active psychiatric diagnosis of Schizophrenia prior to the hospitalization on 10/1/25.Review of the EMR did not reveal documentation of psychiatric review while R3 was hospitalized , nor did the EMR contain behavior monitoring documentation for schizophrenia.The EMR for R3 did not include a care plan for schizophrenia and there was no documentation found indicating the facility was monitoring for side effects or adverse reactions related to the administration of antipsychotic medications.Social Worker (SW) E was interviewed on 5/5/26 at 3:19 PM, and confirmed R3 returned to the facility after an acute care hospitalization with new diagnosis of schizophrenia and a new antipsychotic medication prescription for risperdal. When asked if there was documentation to support a diagnosis of schizophrenia, SW E said, I don't think so. SW E was asked where behavior documentation for symptoms of schizophrenia was located in the EMR of R3. SW E stated she did not know.Certified Nurse Aide (CNA) C was interviewed on 5/6/26 at 7:06 AM. CNA C said behavior monitoring and tracking is documented by the CNAs and entered in the Resident Tasks in the EMR.Review of behavior monitoring documentation revealed R3 was being monitored for crying/sadness, isolating behaviors, and repetitive anxious complaints. R3 was not monitored for delusions, hallucinations, disorganized speech, disorganized or catatonic behavior, other symptoms of schizophrenia, and/or side effects of the new medication prescribed.MDS nurse D was interviewed on 5/6/26 at approximately 9:00 AM, and was asked for any supporting documentation in the EMR for the diagnosis of schizophrenia for R3. MDS nurse D confirmed the facility only had the diagnosis of schizophrenia for R3 and did not have any documentation from the hospitalization to indicate how the diagnosis was received. MDS nurse D said she would review hospital information to see if psychiatric consultations were completed while R3 was hospitalized .On 5/6/26 at 12:25 PM, MDS nurse D provided her laptop computer for review. MDS nurse D said there was documentation from a psychiatrist contained in the hospital's separate EMR system. MDS nurse D said she had view-only access and was unable to print the information for the medical record of R3. MDS nurse D said she would submit a medical records request to the hospital to obtain the information for placement in the facility's EMR of R3.The hospital psychiatrist's report, dated 10/1/25, read, in part: . [Name of R3 redacted] is a 65 yo [year old] female with a longstanding history of bipolar disorder and more recent diagnosis of ?schizophrenia' who is admitted due to altered mental status/an episode of unresponsiveness yesterday. I am suspicious for the recent diagnosis of ?schizophrenia' at such a late age; it's more likely that either [R3's name redacted] psychotic symptoms went unnoticed/undiagnosed when she was younger, or have just come on in the past couple years in the context of potential new neurocognitive disorder [a condition characterized by a decline in cognitive function that interferes with daily life, caused by medical or neurological conditions rather than psychiatric illness]. Son reports that [R3's name redacted] has been showing signs of declining cognition, but has not yet been diagnosed with dementia.MDS nurse D was asked if any documentation was found indicating who gave the diagnosis of schizophrenia if the psychiatrist at the hospital was suspicious of the diagnosis and questioned the authenticity and accuracy of the diagnosis. MDS nurse D said she did not know and could not locate hospital documentation indicating what provider gave a diagnosis of schizophrenia. According to the DSM (Diagnostic and Statistical (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Manual of Mental Disorders) at American Psychiatric Association, DSM-5 Task Force. (2013). Diagnostic and statistical manual of mental disorders: DSM-5? (5th ed.). American Psychiatric Publishing, Inc https://doi.org/10.1176/appi.books.9780890425596, the diagnostic criterion for schizophrenia includes:Two (or more) of the following, each present for a significant portion of time during a 1-month period (or less if successfully treated). At least one of these must be (1), (2), or (3):1. Delusions.2. Hallucinations.3. Disorganized speech (e.g., frequent derailment or incoherence).4. Grossly disorganized or catatonic behavior.5. Negative symptoms (i.e., diminished emotional expression or avolition). B. For a significant portion of the time since the onset of the disturbance, level of functioning in one or more major areas, such as work, interpersonal relations, or self-care, is markedly below the level achieved prior to the onset (or when the onset is in childhood or adolescence, there is failure to achieve expected level of interpersonal, academic, or occupational functioning).C. Continuous signs of the disturbance persist for at least 6 months. This 6-month period must include at least 1 month of symptoms (or less if successfully treated) that meet Criterion A (i.e., active-phase symptoms) and may include periods of prodromal or residual symptoms. During these prodromal or residual periods, the signs of the disturbance may be manifested by only negative symptoms or by two or more symptoms listed in Criterion A present in an attenuated form (e.g., odd beliefs, unusual perceptual experiences)D. Schizoaffective disorder and depressive or bipolar disorder with psychotic features have been ruled out because either 1) no major depressive or manic episodes have occurred concurrently with the active-phase symptoms, or 2) if mood episodes have occurred during active-phase symptoms, they have been present for a minority of the total duration of the active and residual periods of the illness.E. The disturbance is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition. The Director of Nursing (DON) was interviewed on 5/6/26 at 8:58 AM. The DON confirmed R3 was transferred to the hospital in October 2025 with a medical condition and returned to the facility with a psychiatric diagnosis. The DON was uncertain how the resident was diagnosed with schizophrenia.An annual MDS assessment dated [DATE] coded R3 with a Brief Interview for Mental Status (BIMS) score of 15 which is indicative of fully intact cognition. The MDS documented R3 did not have concerns with inattention or disorganized thinking.R3 was interviewed on 5/6/26 at 9:13 AM. R3 said she was never previously diagnosed with schizophrenia. R3 said she had bipolar disorder, anxiety disorder, and depression. R3 accurately verbalized from memory the medications she was prescribed. R3 said she had never taken Risperdal until she was hospitalized in October. She stated she was receiving Risperdal twice daily but did not know why she was prescribed the medication in the hospital.The Behavior Management policy dated as updated 12/10/25 read, in part: .Residents with behavior problems will be treated by [name of facility redacted] using both non-medication interventions and medication as appropriate.Areas for review during behavior management meetings:.Plan of care review.Medication review including diagnosis & adverse reactions.Review of Behavior Monitoring records.All psychotropic medication use will be monitored closely for effectiveness and adverse reactions.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to:Document wound monitoring and assessments for one Resident (#21) of two residents reviewed for skin conditionsMaintain documentation in the facility reflecting ongoing collaboration and communication between the facility and hospice provider and ensure an updated hospice plan of care was retained in the facility for one Resident (#12) of three residents reviewed for hospice care.Findings include:Resident #21 (R21):An admission Minimum Data Set (MDS) assessment dated [DATE] indicated R21 was admitted to the facility on [DATE] with a primary medical condition of orthopedic aftercare following an amputation. The MDS coded R21 with a Brief Interview for Mental Status (BIMS) score of 15 indicating intact cognition. The MDS documented R21 had an infection of a surgical wound on the foot and received antibiotic medication.During an interview on 5/4/26 at 10:47 AM, R21 was noted to have a wound VAC (Vacuum-Assisted Closure - a medical device that uses negative pressure to promote wound healing) at bed side. The wound VAC tubing was lying atop the bed and was not connected to the wound dressing on the right foot of R21. The wound VAC pump was noted to be turned off.When asked about the disconnected wound VAC, R21 said he occasionally turned the pump off and disconnected the tubing from the wound dressing on his foot because the noise and feeling of the wound VAC on the wound of his foot aggravated him. When asked if the wound was worsening, R21 said he did not know.The electronic medical record (EMR) of R21 was reviewed and revealed the following physician's orders:Order dated 4/15/26: Wound vac to R[right] ft [foot] wound continuously at 125 mmhg [millimeters of mercury, a unit of pressure], Change Q [every] M-W-FR [Monday, Wednesday, and Friday] and PRN [as needed] if needed. Order dated 4/23/26: If Wound Vac fails or resident declines reapplication of Vac, cleanse wound to Rt foot with Wound Cleanser, pat dry, apply a N/S [normal saline] wet to dry [dressing] using sterile 4x4's [4 inch by 4 inch - size of gauze pads] and Kerlex [sic, Kerlix - woven gauze dressing]. Daily PRN per [name of physician redacted]. No [name of antiseptic redacted].The care plan for the surgical site wound on the right foot of R21 did not include wound VAC information nor did the care plan interventions address wound assessment documentation and frequency.The electronic medical record (EMR) of R21 was reviewed for wound assessment documentation. Two wound assessments were identified: a progress note entry on 1/16/26 and a progress note on 4/21/26.A progress note on 1/16/26 at 2:47 PM documented, in part: . Right foot, 4th and 5th toe amputated, incision site remains closed with sutures, approximately 4 cm [centimeter] x [by] 1 cm, no drainage. Right foot 2nd toe has 2 circular scabs on top, both under 0.5 cm in diameter, both closed with no s/s [signs or symptoms] of infection.A progress note dated 4/21/26 at 3:36 PM documented, in part: .Open wound measures 6.5 cm x 2.0 cm wide and 0.3 cm deep. Approximately 1/2 of the wound bed is covered with slough like [non-viable tissue that can impede healing and increase infection], dry, tissue. The remainder of the wound bed is pink granulation [newly formed connective tissue] tissue. Scant bleeding upon cleansing.The progress notes of 1/16/26 and 4/21/26 were the only wound assessments located in the EMR of R21.On 5/5/26 at 9:01 AM The Director of Nursing (DON) was queried regarding wound assessments. The DON said all wounds were assessed at least weekly and documented in the EMR, including surgical site wounds. The DON said all wound assessments were in progress notes or in the Consults portion of the EMR under the Miscellaneous tab.The Consult portion of the Miscellaneous tab in the EMR of R21 contained consultations with a podiatrist. The podiatrist consultations included medication and treatment orders but did not document wound assessments.On 5/6/26 at 1:08 PM, the DON said wound assessments were expected to be documented every time the wound VAC was changed. The DON said wound assessments were expected to include measurements and assessments of the wound appearance.The policy Wound Care Protocol dated as revised 2/3/26 read, in part: .Chart in progress notes length, width, and depth in millimeters [sic], drainage, odor, appearance.Resident #12 (R12)R12 was admitted to the facility on [DATE]. The EMR (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of R12 contained a physician's order dated 11/5/25 that read: Admit to hospice services [name of hospice redacted].An MDS assessment dated [DATE] documented R12 had a primary medical condition of non-traumatic brain dysfunction. The MDS indicated R12 received hospice care services and was dependent on staff for most activities of daily living (ADL).On 5/5/26 at 1:58 PM, the DON and MDS nurse D were asked the location of hospice documentation and hospice plans of care. MDS nurse D provided a binder and said hospice documentation was maintained in the binder.The hospice information in the binder for R12 was reviewed and contained one document dated 1/21/26. There was no other documentation in the binder. The EMR of R12 did not contain an updated hospice care plan, documentation of visits, assessments, or recommendations by the hospice provider.On 5/6/26 at approximately 9:30 AM, MDS nurse D was asked if hospice documentation was available in the facility for R12. MDS nurse D said the facility was unable to locate an updated hospice care plan or hospice documentation for R12. MDS nurse D said the hospice provider was contacted on 5/5/26 and an updated hospice care plan and documentation of visits from hospice were requested.A hospice Plan of Care Update Report was provided by MDS nurse D on 5/6/26 at approximately 10:15 AM. The date and time stamp in the upper right portion of the document was dated 5/5/26 at 3:15 PM indicating the document was issued to the facility on that date and time.MDS nurse D said she had notified hospice on 5/5/26 regarding missing documentation for R12. MDS nurse D said hospice visited several times a week, but they did not have any progress notes or information in the facility for hospice visits for R12.When asked the reason for the delay in receiving updated hospice plans of care and hospice visit documentation, MDS nurse D said, It's not very collaborative. MDS D reiterated she had contacted hospice on 5/5/26 to request hospice visit notes and was still waiting for them to send the notes.The DON was interviewed on 5/6/26 at 1:03 PM. The DON said she oversaw hospice services in the facility but did not know why progress notes, an updated hospice care plan, and hospice documentation was not available in the facility. The DON said she assumed hospice personnel left copies of documentation in the facility when they visited. The DON confirmed the hospice provider was expected to provide timely visit documentation and updated plans of care.On 5/6/26 at 1:33 PM, MDS nurse D provided 24 pages of hospice documentation. The date and time stamp in the upper right corner indicated the documentation was generated on 5/6/26 at 10:49 AM. The documentation included visit notes from 11/3/25 through 5/4/26.

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	05/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maple Valley Nursing Home	1086 W. Burdickville Road Maple Valley, 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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to obtain a physician's order for supplemental oxygen and ensure respiratory equipment was changed and labeled for one Resident (#12) of two residents reviewed for oxygen therapy. Findings include:On 5/4/26 at 12:27 PM, R12 was observed wearing a nasal cannula (flexible tube that delivers supplemental oxygen). The nasal cannula was attached to an oxygen concentrator set to deliver supplemental oxygen at the rate of 3.5 liters per minute (LPM). The nasal cannula tubing was not labeled with a date to indicate when the tubing had last been changed.On 5/5/26 at 8:20 AM, the oxygen concentrator was noted be set to deliver 2 LPM of oxygen. The nasal cannula tubing remained unlabeled with a date.On 5/5/26 at 10:52 AM, the oxygen concentrator was set at 3.5 LPM. The nasal cannula tubing remained unlabeled.According to the electronic medical record (EMR), R12 was admitted to the facility 6/1/22. The diagnoses of R12 included a diagnosis of hypoxemia (low blood oxygen levels).A Minimum Data Set (MDS) assessment dated [DATE] documented R12 had a primary medical condition of non-traumatic brain dysfunction. The MDS indicated R12 utilized oxygen therapy as a respiratory treatment and received hospice care services.Review of physician's orders revealed R12 did not have a physician's order indicating the flow rate of supplemental oxygen. A physician's order dated 9/13/25 read: Replace oxygen tubing, nasal cannula and plastic storage bag at bedside weekly on Saturday during MN [midnight] shift. Label with resident name and date. Clean concentrator filter.Progress notes in the EMR of R12 included a nurse's progress note dated 1/30/26 at 12:36 AM that documented, in part: . O2 via NC [nasal cannula] @ [at] 4L [liters] . A nurse's progress note dated 4/28/26 at 11:48 PM documented, in part: . Oxygen via nasal cannula @ 2L/[per] min .The EMR included a care plan for Ineffective Breathing Pattern AEB [as evidenced by] Hypoxemia, adventitious [abnormal] breath sounds, sudden weight gain and increased edema dated as initiated 6/20/23 and revised 9/24/23 contained intervention that read: O2 via N/C 1-6L to maintain O2 [oxygen] sats [saturation] >90% and monitor my Pulse Ox [pulse oximetry or SPO2 - peripheral oxygen saturation] as ordered to titrate my oxygen needs.There were no orders found to monitor SPO2 as directed by the care plan intervention. There were no SPO2 readings documented on the medication administration record (MAR) or the treatment administration record (TAR). A review of the vitals portion of the EMR revealed no SPO2 documentation since 1/31/26.A hospice document dated 1/21/26 documented R12 had chronic respiratory failure with hypoxia and was dependent on continuous supplemental oxygen. The list of hospice orders included an order dated 11/6/25 that read: Oxygen gas for inhalation at 4 liters by inhalation continuous. The hospice document included SPO2 levels. The nursing assessment read, in part: .O2 screening [SPO2] at 87% on room air, nasal cannula placed back on patient. Vitals signs are stable on 4L nasal cannula.Licensed Practical Nurse (LPN) A was interviewed on 5/5/26 at 11:24 AM. LPN A said R12's oxygen concentrator should be always set between 2-3 LPM. LPN A said the nurses have not obtained SPO2 levels for R12 because the resident received hospice services.An interview with LPN B was conducted on 5/6/26 at 8:05 AM. LPN B said the supplemental oxygen for R12 was to be delivered at 1-2 LPM. LPN B said oxygen tubing was changed on the midnight shift weekly and the facility expectation was to write the date on a piece of medical tape and wrap the tape around the nasal cannula tubing, so staff know when the tubing was changed. When asked the date the nasal cannula tubing was changed for R12, LPN B said she did not know.During an interview with the Director of Nursing (DON) on 5/6/26 at 1:05 PM, the DON said a physician's order was required to use supplemental oxygen therapy, and she expected nurses to obtain SPO2 levels.The undated document Policy & Procedure Oxygen Therapy read, in part: .Oxygen is used only on the order of a physician, except in the case of emergency.Residents with orders for O2 will have documentation on treatment record for flow administered, rate of flow, frequency of administration and reason.The undated policy and procedure Oxygen Concentrator & Oxygen Cylinder Usage & Cleaning in a Nursing (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Home read, in part: .All customers using oxygen require a prescription signed by a physician. If there are any changes in oxygen flow rate or hours of usage, there will be available a prescription signed by the physician indicating the change.[name of supplier of supplemental oxygen redacted] will change the nasal cannula or mask on the concentrator and oxygen tanks being used at least weekly and place a dates ticker on the cannula identifying the change.The undated policy Pulse Oximetry read, in part: .Many of our resident have physician orders for monthly oximetry. Unless otherwise ordered - remove O2 for 5 minutes - record findings in resident record.