

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

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

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                         |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>235591                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                                | (X3) DATE SURVEY<br>COMPLETED<br><br>07/29/2026 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Roubal Care and Rehabilitation Center                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>N 306 Maple Street<br>Stephenson, MI 49887 |                                                 |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                         |                                                 |
| <p>F 0684</p> <p>Level of Harm - Minimal harm<br/>or potential for actual harm</p> <p>Residents Affected - Few</p>                 | <p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>All times are in Eastern Daylight Time (EDT) unless otherwise noted. This citation pertains to intake #3072295 &amp; #3072396 Based on interview and record review, the facility failed to assess, monitor, and document a change in condition per standards of practice for one Resident (#38) of twelve residents reviewed for quality of care. Findings include: Resident #38 (R38) The medical record for R38 revealed an original admission to the facility on 4/1/23 and was sent out to the hospital on 7/1/26. R38 had diagnoses including diabetes mellitus, cerebral infarct (stroke), and weakness. Review of intake # 3072295 reported to the State Agency (SA), dated 7/1/26, read in part Patient in nursing home was not checked throughout the day and was reported in the afternoon to be having stroke-like symptoms. Patient's last check was previous day. Patient normally verbal and able to move self-using a wheelchair was found to be non-verbal, little to no motor function, and significant facial droop. Review of intake # 3072396 reported to the SA, dated 7/6/26, read in part .on 6/30, the facility noticed drooping on [R38's] face. did not call [family] until 7/1, and they told. she had been unresponsive all day. they did not provide a time. or exactly when they noticed that her face was drooping. [R38] was sent to [out of state hospital] [R38] was diagnosed with a stroke. the doctor told her that they could send her to [another hospital] for more assistance, but it was too late because they did not know how long she had been in that condition. Review of R38's progress notes, dated 6/30/26 and 7/1/26, revealed the following: 6/30/26 at 9:50 PM (Central Time Zone (CTZ)), read Res [resident] had just received a shower on this date and a full assessment along with vital signs were taken in which all were WNL [within normal limits]. It was noted that res was closing her eye left eye a little tighter than right eye. Res does have chronic droopy eye which is per her normal. She did not have any complaints prior to going to bed. Res was more quite (sic) than usual, so writer checked on res a few times in the night. In which all vitals remained WNL. No further issues noted. *Late entry note added on 7/10/26 at 7:12 AM (CTZ), 7/1/26 at 8:30 AM (CTZ), read Resident was noted to be sleeping in her bed this am, which isn't out of the ordinary for her as resident often refuses meals and likes to sleep. CNA provided cares but resident didn't wake up to eat breakfast. Will continue to monitor. *Late entry note added on 7/9/26 at 1:23 PM (CTZ), 7/1/26 at 10:24 AM (CTZ), read Writer performed pain assessment. Resident asleep in her bed with no discomfort or distress noted. *Late entry added on 7/9/26 at 1:35 PM (CTZ), and 7/1/26 at 2:25 PM (CTZ), read Resident has a right facial droop. She is moving her left arm but will not open her eyes or respond. VSS. Daughter notified and will come in to see her and evaluate whether she wants her seen in the ER. Resident has been sleeping all day. 7/1/26 at 2:55 PM (CTZ), physician called and 911 called. At 3:15 PM (CTZ), R38 left in ambulance to emergency room. Review of R38's electronic medical record (EMR), dated 6/30/26 &amp; 7/1/26, lacked vital signs on 6/30/26 and lacked a head to toe and neurological assessment for R38 related to having a change in condition on 7/1/26. On 7/28/26 at 7:39 PM, during a phone interview, Emergency Medical Technician (EMT) P was asked about the transfer on 7/1/26 with R38 and (continued on next page)</p> |                                                                                         |                                                 |

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<br>REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|--------------------------------------------------------------------------|-------|-----------|

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                         |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>235591                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                                | (X3) DATE SURVEY<br>COMPLETED<br><br>07/29/2026 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Roubal Care and Rehabilitation Center                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>N 306 Maple Street<br>Stephenson, MI 49887 |                                                 |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                         |                                                 |
| F 0684<br><br>Level of Harm - Minimal harm<br>or potential for actual harm<br><br>Residents Affected - Few                         | replied, We got a call for signs and symptoms of a stroke for [R38] and went to assist. [R38] unresponsive. Had to wait for doctor approval for transfer. [R38] had facial drooping and no movement. Asked the staff of last known well and replied to last night. There was like a 16-to-12-hour window where no one could say when she was last known well and no one checked on her. [R38's] mouth was wide open when we arrived on site. On 7/28/26 at 8:18 PM, during a phone interview, Family Member Q was asked about the transfer out on 7/1/26 with R38 and replied, The facility told me my mother [R38] had been unresponsive all day and wanted to know what I wanted to do. I got to the facility, and her mouth was wide open, and she was looking off into a distance. Rescue squad arrived and [R38] face was drooping since the day before, identified by nurse [Licensed Practical Nurse (LPN) N] and stated she was just going by what she knew. At the hospital it was noted that [R38] had two blood clots in her carotid arteries. If they had known sooner, they could have prevented, but the facility waited 18 to 20 hours before calling me and sending her out. During an interview on 7/28/26 at 8:36 PM, Certified Nursing Aide (CNA) J was asked about R38 being transferred out on 7/1/26 and replied, I was the CNA that day and I went into her room [R38's] between 6:15 AM and 6:30 AM and she looked like she was sleeping. I got her dressed by myself and she didn't really seem like herself. I got the [Assistant Director of Nursing (ADON) C] and told her something was wrong. Lunch came I did not feed her and tried to wake her up and she would not wake up so I got the nurse [LPN N] around 2:00 PM. [R38] will not normally eat breakfast, but she always eats lunch. The day before she was fine [6/30/26]. The following day she was not fine [7/1/26]. On 7/29/26 at 9:10 AM, an interview was conducted with LPN N regarding the transfer of R38 and replied, I forgot to make a progress note so I added it when I worked next. I went to check on her the day she was transferred out. LPN N was asked what kind of assessment she completed on R38 before calling family and replied, I took her vital signs. LPN N was asked if she did a neurological assessment and replied, No. She [R38] had a history of having a prior stroke and that's what it looked like to me. Only moving one arm and I could not wake her up like she normally arouses. Her level of activity was not normal. I could not pinpoint what was wrong. The CNA came to get me around 2:00 PM and said she felt she was not right. On 7/29/26 at 9:30 AM, an interview was conducted with LPN / Assistant Director of Nursing (ADON) C who was asked what her expectations were about charting and replied, If a change in condition nurses need to be documenting at the time of the change in condition, vital signs, and charting an assessment. ADON C was asked why the charting was added as a late entry nine and ten days after R38's change in condition and replied, I don't know why it would be that late. If it was not charted it was not done. On 7/29/26 at 11:45 AM, an interview was conducted with the Director of Nursing (DON) who was asked about her expectations for nurses charting and replied, If it was not documented it was not done. The nurse should have charted an assessment including neuros and I do not see that it was done. I just saw vital signs were in normal limit. No situation background assessment or report [SBAR] or a change in condition evaluation. On 7/29/26 at 12:00 PM, an interview was held with LPN N regarding the late entry progress note on 7/1/26 which was created on 7/9/26. LPN N was asked why she did not make the note sooner when she worked on 7/2, 7/7, and 7/8 and replied, I don't know. Yes, I was asked to add in a progress note by the DON. Review of policy titled, Notification of Changes, dated 1/23/26, read in part Policy: The purpose of this policy is to ensure the facility promptly informs the resident, consults the resident's physician; and notifies, consistent with his or her authority, the resident's representative when there is a change requiring notification. Definitions: ?Life-Threatening Conditions?; Examples - Heart Attack or Stroke. Compliance Guidelines: The facility must inform the resident, consult with the resident's physician and / or notify the resident's family member or legal representative when there is a change requiring such notification. |                                                                                         |                                                 |