STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235602	A. Building B. Wing	09/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hazel I Findlay Country Manor	1101 S Scott Road Saint Johns, MI 48879

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to implement its own written policies and procedures for Abuse and Neglect for two residents (#6, #15) of 4 residents reviewed. Resident #6 (R6): Per the facility face sheet R6 was admitted to the facility on [DATE]. R6 had stated during the screening process on 9/10/2025 that about two weeks ago she had waited two hours for her call light to be answered. R6 said the RCA (resident certified aid), who she could not recall the name of, entered her room and was disgusted with her, then turned her side to side jerking her side to side; then told her to stop yelling, but she could not because it was hurting her. Review of a SOLUTIONS FORM dated 8/12/25, revealed R6 had reported to her family member that last night she had waited two hours for assistance, and upon receiving that assistance the staff member, who was not identified, .came in and acted disgusted with me, turned me Jerked side to side, and said I am being too loud. Additionally, it was documented on the form that R6 stated she could not help moaning loud because it hurt. Continued review of the SOLUTIONS FORM revealed under, IMMEDIATE ACTIONS for SOLUTION (when concern is made--what did Work Family to resolve concern?) it was documented, Nursing assessment done-0 (zero) new inf (information)/ Resident (R6) stated staff skin assessment done--0 new inf/was in a hurry care plan for 2 w (with)/bed mobility V.S. (vital signs) done. The form was dated 8/12/2025 as the date the concern was resolved. The concern form did not have any documentation of any conversation with R6 in whether the solution was acceptable to R6. The form did not include any interview with R6. The form did not have any documentation that a thorough investigation was to immediately take place to R6 made the allegation of jerking her side to side against. Record review of a Non-Reportable Allegation form dated 8/12/2025, revealed at the top of the document, Use this form to report on the job accidents, injuries, medical situations, criminal activities, work related traffic incidents, etc. A report should be completed within 24 hours of the incident. The form revealed that the incident occurred in R6's room, and a detailed description was documented to say, Resident (R6) stated she waited 2 (hours) for her call light to be answered. & RCA (resident certified aid) came and acted disgusted w (with)/her-felt like it was a fast turn when providing care bed mobility to her and she (R6) yelled, and RCA said she was being loud. When asked to elaborate-She state RCA said others were sleeping and she (R6) said she couldn't help it. (continued on next page)

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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 9/11/2025, Administrator A stated that herself along with Director of Nursing (DON) B spoke with R6 and as R6 if she felt the RCA was rough with her in which R6 reported to them no. Administer A said R6 reported she was painful, could not say who the staff member was, and was painful with light touch. Administrator A said her investigation was documented on the Non-Reportable Allegation form. Administrator A did not identify R6's concern as an allegation of abuse, because she spoke with R6 immediately and R6 said it was because of her pain and being painful when the RCA turned her. Administrator A said she came to the conclusion the incident was related to R6's pain and not an allegation of abuse and therefore did not report the allegation to the state agency. Administrator, who was identified as the Solutions coordinator or the abuse coordinator, did not interview other residents to identify any possible further allegations of abuse, did not interview other staff members, and did not thoroughly investigation R6's allegation of being yelled at and jerked side to side by a staff member. Review of the facility policy and procedure titled, Abuse, Neglect, and Exploitation Protocol dated May of 2005, revealed on page #4 V. Investigation of Alleged Abuse, Neglect and Exploitation, A. An investigation is warranted when suspicion of abuse, neglect of exploitation, or reports of abuse, neglect or exploitation occur. The above statement outlined in the facility policy revealed that an investigation was warranted for a suspicion however, it did not identify that an allegation, which is not the same as a suspicion, of abuse would warrant an immediate reporting to the state agency and the facility requirements to initiate an investigation. Further review of the policy and procedure revealed on page #5 under the same heading, B. Written procedures for investigations include ., d. Identifying and interviewing identified involved persons, including alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations, e. Focus the investigation to determine if abuse, neglect, exploitation, and/or mistreatment had occurred, the extent, and cause, and f. Conduct a comprehensive investigation in accordance with standards of practice. Continued review of the facility policy revealed on page #5 under Reporting/Response A. The facility has written procedures that include A. Reporting alleged violations to the Administrator/Abuse Coordinator/designee, state agency .if needed within specific time frames. 1. Immediately (the Abuse Coordinator has 2 hours to report to the State Agency), after forming suspicion of abuse OR if the allegation involves abuse OR results in serious bodily injury. R6's allegation was not investigated by the facility and was not reported to the state agency per the facility's policy and procedure. Findings included: Resident #15 (R15): Review of the medical record revealed R15 was admitted to the facility 05/12/2025 with diagnoses that included Huntington’s Disease (inherited condition in which nerve cells in the brain break down over time), dry eye syndrome, bilateral myopia (near sightedness), bilateral astigmatism, dysphagia (difficulty swallowing), gastro-esophageal reflux, depression, and insomnia. The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 08/19/2025, revealed R15 had a Brief Interview for Mental Status (BIMS) of 09 (moderate cognitive impairment) out of 15. (continued on next page)

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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During observation and interview on 09/10/2025 at 10:43 a.m. R15 was observed sitting in her electric wheelchair. R15 explained that a staff member was rude to her. R15 could not provide further details nor the name of the staff member. Review of facility grievance forms entitled “Solution Form-to document unresolved grievances or concerns” revealed document dated 07/13/2025 which stated, “(name of another resident) would go unplug (name of R15) fan. (name of resident) called her a stupid bitch and said she doesn’t deserve to have a family. She states she does not feel safe with her as a roommate and would like a new one”. The same document revealed in section of immediate actions “moved (name of roommate) into another room for the night, until long term solution is found, and I helped (R15) with this form”. Review of facility grievance forms entitled “Solution Form-to document unresolved grievance or concerns” revealed document dated 08/06/2025 “Resident stated (name of employee) was being rude to her in the dinning room resident was also crying. Resident didn’t explain to me how he was being rude”. The same document revealed in the section official follow up “verbal education given on customer service and approach. No emotional distress voiced toward (name of employee) as she was tearful about ex-boyfriend.” In an interview on 09/11/2025 at 10:28 a.m. Nursing Home Administrator (NHA) “A” explained that she was the facility abuse coordinator. NHA “A” explained that she had been notified of the allegation regarding R15 and another resident that had occurred on 07/13/25. NHA “A” also explained that she was aware of the allegation regarding R15 and an employee on 08/06/2025. NHA “A” explained that neither of these allegations were reported to the appropriate state agencies because it was her opinion that they did not meet CMS (Center for Medicaid/Medicare Services) guidance for allegation of abuse. NHA “A” explained that R15 was not upset or concerned about her safety and that R15 was tearful related to another reason not related to that events. NHA “A” was asked if she had an investigation file demonstrating that allegations were investigated. NHA “A” responded that she would provide files. Nursing Home Administrator (NHA) “A” provided a document entitled “non-reportable allegation”, dated 7/13/25, which revealed a section that stated “give a detailed description of incident (attach additional pages if necessary): Verbal altercation”. Then hand written on the above document “move immediately and no harm no distress”. No other documentation was provided regarding the allegation or investigation. Nursing Home Administrator (NHA) “A” provided a document entitled “non-reportable allegation”, dated 08/06/2025, which revealed a section that stated “give a detailed description of incident (attach additional pages if necessary): (R15) state staff are rude. They don’t stop and talk. Tearful d/t(related to) issue w/b.f. (with boyfriend). No other documentation was provided regarding the allegation or investigation. In an interview on 09/11/2025 at 12:12 p.m. Nursing Home Administrator (NHA) “A” explained that she did not have any further documents pertaining to the previous allegations list above.

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to report an allegation of abuse to the State Agency for two residents (#6,#15) of four residents reviewed for abuse. Findings Included: Resident #15 (R15) Review of the medical record revealed R15 was admitted to the facility 05/12/2025 with diagnoses that included Huntington’s Disease (inherited condition in which nerve cells in the brain break down over time), dry eye syndrome, bilateral myopia (near sightedness), bilateral astigmatism, dysphagia (difficulty swallowing), gastro-esophageal reflux, depression, and insomnia. The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 08/19/2025, revealed R15 had a Brief Interview for Mental Status (BIMS) of 09 (moderate cognitive impairment) out of 15. During observation and interview on 09/10/2025 at 10:43 a.m. R15 was observed sitting in her electric wheelchair. R15 explained that a staff member was rude to her. R15 could not provide further details nor the name of the staff member. Review of facility grievance forms entitled “Solution Form-to document unresolved grievances or concerns” revealed document dated 07/13/2025 which stated, “(name of another resident) would go unplug (name of R15) fan. (name of resident) called her a stupid bitch and said she doesn’t deserve to have a family. She states she does not feel safe with her as a roommate and would like a new one”. The same document revealed in section of immediate actions “moved (name of roommate) into another room for the night, until long term solution is found, and I helped (R15) with this form”. Review of facility grievance forms entitled “Solution Form-to document unresolved grievance or concerns” revealed document dated 08/06/2025 “Resident stated (name of employee) was being rude to her in the dinning room resident was also crying. Resident didn’t explain to me how he was being rude”. The same document revealed in the section official follow up “verbal education given on customer service and approach. No emotional distress voiced toward (name of employee) as she was tearful about ex-boyfriend.” In an interview on 09/11/2025 at 10:28 a.m. Nursing Home Administrator (NHA) “A” explained that she was the facility abuse coordinator. NHA “A” explained that she had been notified of the allegation regarding R15 and another resident that had occurred on 07/13/25. NHA “A” also explained that she was aware of the allegation regarding R15 and an employee on 08/06/2025. NHA “A” explained that neither of these allegations were reported to the appropriate state agencies because it was her opinion that they did not meet CMS (Center for Medicaid/Medicare Services) guidance for allegation of abuse. NHA “A” explained that R15 was not upset or concerned about her safety and that R15 was tearful related to another reason not related to that events. NHA “A” was asked if she had an investigation file demonstrating that allegations were investigated. NHA “A” responded that she would provide files. (continued on next page)

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Nursing Home Administrator (NHA) “A” provided a document entitled “non-reportable allegation”, dated 7/13/25, which revealed a section that stated “give a detailed description of incident (attach additional pages if necessary): Verbal altercation”. Then hand written on the above document “move immediately and no harm no distress”. No other documentation was provided regarding the allegation or investigation. Nursing Home Administrator (NHA) “A” provided a document entitled “non-reportable allegation”, dated 08/06/2025, which revealed a section that stated “give a detailed description of incident (attach additional pages if necessary): (R15) state staff are rude. They don’t stop and talk. Tearful d/t(related to) issue w/b.f. (with boyfriend). No other documentation was provided regarding the allegation or investigation. In an interview on 09/11/2025 at 12:12 p.m. Nursing Home Administrator (NHA) “A” explained that she did not have any further documents pertaining to the previous allegations list above. Resident #6 (R6): Per the facility face sheet R6 was admitted to the facility on [DATE]. R6 had stated during the screening process on 9/10/2025 that about two weeks ago she had waited two hours for her call light to be answered. R6 said the RCA (resident certified aid), who she could not recall the name of, entered her room and was disgusted with her, then turned her side to side jerking her side to side; then told her to stop yelling, but she could not because it was hurting her Review of a SOLUTIONS FORM dated 8/12/25, revealed R6 had reported to her family member that last night she had waited two hours for assistance, and upon receiving that assistance the staff member, who was not identified, .came in and acted disgusted with me, turned me Jerked side to side, and said I am being too loud. Additionally, it was documented on the form that R6 stated she could not help moaning loud because it hurt. Continued review of the SOLUTIONS FORM revealed under, IMMEDIATE ACTIONS for SOLUTION (when concern is made--what did Work Family to resolve concern?) it was documented, Nursing assessment done-0 (zero) new inf (information)/ Resident (R6) stated staff skin assessment done--0 new inf/was in a hurry care plan for 2 w (with)/bed mobility V.S. (vital signs) done. The form was dated 8/12/2025 as the date the concern was resolved. The concern form did not have any documentation of any conversation with R6 in whether the solution was acceptable to R6. The form did not include any interview with R6. The form did not have any documentation that a thorough investigation was to immediately take place to R6 made the allegation of jerking her side to side against. Record review of a Non-Reportable Allegation form dated 8/12/2025, revealed at the top of the document, Use this form to report on the job accidents, injuries, medical situations, criminal activities, work related traffic incidents, etc. A report should be completed within 24 hours of the incident. The form revealed that the incident occurred in R6's room, and a detailed description was documented to say, Resident (R6) stated she waited 2 (hours) for her call light to be answered. & RCA (resident certified aid) came and acted disgusted w (with)/her-felt like it was a fast turn when providing care bed mobility to her and she (R6) yelled, and RCA said she was being loud. When asked to elaborate-She state RCA said others were sleeping and she (R6) said she couldn't help it. (continued on next page)

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 9/11/2025, Administrator A stated that herself along with Director of Nursing (DON) B spoke with R6 and as R6 if she felt the RCA was rough with her in which R6 reported to them no. Administer A said R6 reported she was painful, could not say who the staff member was, and was painful with light touch. Administrator A said her investigation was documented on the Non-Reportable Allegation form. Administrator A did not identify R6's concern as an allegation of abuse, because she spoke with R6 immediately and R6 said it was because of her pain and being painful when the RCA turned her. Administrator A said she came to the conclusion the incident was related to R6's pain and not an allegation of abuse and therefore did not report the allegation to the state agency.

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to investigate allegations of abuse for two residents (#6,#15) out of four residents reviewed for abuse. Findings Included: Resident #15 (R15) Review of the medical record revealed R15 was admitted to the facility 05/12/2025 with diagnoses that included Huntington’s Disease (inherited condition in which nerve cells in the brain break down over time), dry eye syndrome, bilateral myopia (near sightedness), bilateral astigmatism, dysphagia (difficulty swallowing), gastro-esophageal reflux, depression, and insomnia. The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 08/19/2025, revealed R15 had a Brief Interview for Mental Status (BIMS) of 09 (moderate cognitive impairment) out of 15. During observation and interview on 09/10/2025 at 10:43 a.m. R15 was observed sitting in her electric wheelchair. R15 explained that a staff member was rude to her. R15 could not provide further details nor the name of the staff member. Review of facility grievance forms entitled “Solution Form-to document unresolved grievances or concerns” revealed document dated 07/13/2025 which stated, “(name of another resident) would go unplug (name of R15) fan. (name of resident) called her a stupid bitch and said she doesn’t deserve to have a family. She states she does not feel safe with her as a roommate and would like a new one”. The same document revealed in section of immediate actions “moved (name of roommate) into another room for the night, until long term solution is found, and I helped (R15) with this form”. Review of facility grievance forms entitled “Solution Form-to document unresolved grievance or concerns” revealed document dated 08/06/2025 “Resident stated (name of employee) was being rude to her in the dinning room resident was also crying. Resident didn’t explain to me how he was being rude”. The same document revealed in the section official follow up “verbal education given on customer service and approach. No emotional distress voiced toward (name of employee) as she was tearful about ex-boyfriend.” In an interview on 09/11/2025 at 10:28 a.m. Nursing Home Administrator (NHA) “A” explained that she was the facility abuse coordinator. NHA “A” explained that she had been notified of the allegation regarding R15 and another resident that had occurred on 07/13/25. NHA “A” also explained that she was aware of the allegation regarding R15 and an employee on 08/06/2025. NHA “A” explained that neither of these allegations were reported to the appropriate state agencies because it was her opinion that they did not meet CMS (Center for Medicaid/Medicare Services) guidance for allegation of abuse. NHA “A” explained that R15 was not upset or concerned about her safety and that R15 was tearful related to another reason not related to that events. NHA “A” was asked if she had an investigation file demonstrating that allegations were investigated. NHA “A” responded that she would provide files. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Nursing Home Administrator (NHA) “A” provided a document entitled “non-reportable allegation”, dated 7/13/25, which revealed a section that stated “give a detailed description of incident (attach additional pages if necessary): Verbal altercation”. Then hand written on the above document “move immediately and no harm no distress”. No other documentation was provided regarding the allegation or investigation. Nursing Home Administrator (NHA) “A” provided a document entitled “non-reportable allegation”, dated 08/06/2025, which revealed a section that stated “give a detailed description of incident (attach additional pages if necessary): (R15) state staff are rude. They don’t stop and talk. Tearful d/t(related to) issue w/b.f. (with boyfriend). No other documentation was provided regarding the allegation or investigation. In an interview on 09/11/2025 at 12:12 p.m. Nursing Home Administrator (NHA) “A” explained that she did not have any further documents pertaining to the previous allegations list above. Resident #6 (R6): Per the facility face sheet R6 was admitted to the facility on [DATE]. R6 had stated during the screening process on 9/10/2025 that about two weeks ago she had waited two hours for her call light to be answered. R6 said the RCA (resident certified aid), who she could not recall the name of, entered her room and was disgusted with her, then turned her side to side jerking her side to side; then told her to stop yelling, but she could not because it was hurting her. Review of a SOLUTIONS FORM dated 8/12/25, revealed R6 had reported to her family member that last night she had waited two hours for assistance, and upon receiving that assistance the staff member, who was not identified, .came in and acted disgusted with me, turned me Jerked side to side, and said I am being too loud. Additionally, it was documented on the form that R6 stated she could not help moaning loud because it hurt. Continued review of the SOLUTIONS FORM revealed under, IMMEDIATE ACTIONS for SOLUTION (when concern is made--what did Work Family to resolve concern?) it was documented, Nursing assessment done-0 (zero) new inf (information)/ Resident (R6) stated staff skin assessment done--0 new inf/was in a hurry care plan for 2 w (with)/bed mobility V.S. (vital signs) done. The form was dated 8/12/2025 as the date the concern was resolved. The concern form did not have any documentation of any conversation with R6 in whether the solution was acceptable to R6. The form did not include any interview with R6. The form did not have any documentation that a thorough investigation was to immediately take place to R6 made the allegation of jerking her side to side against. Record review of a Non-Reportable Allegation form dated 8/12/2025, revealed at the top of the document, Use this form to report on the job accidents, injuries, medical situations, criminal activities, work related traffic incidents, etc. A report should be completed within 24 hours of the incident. The form revealed that the incident occurred in R6's room, and a detailed description was documented to say, Resident (R6) stated she waited 2 (hours) for her call light to be answered. & RCA (resident certified aid) came and acted disgusted w (with)/her-felt like it was a fast turn when providing care bed mobility to her and she (R6) yelled, and RCA said she was being loud. When asked to elaborate-She state RCA said others were sleeping and she (R6) said she couldn't help it. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 9/11/2025, Administrator A stated that herself along with Director of Nursing (DON) B spoke with R6 and as R6 if she felt the RCA was rough with her in which R6 reported to them no. Administer A said R6 reported she was painful, could not say who the staff member was, and was painful with light touch. Administrator A said her investigation was documented on the Non-Reportable Allegation form. Administrator A did not identify R6's concern as an allegation of abuse, because she spoke with R6 immediately and R6 said it was because of her pain and being painful when the RCA turned her. Administrator A said she came to the conclusion the incident was related to R6's pain and not an allegation of abuse. Administrator, who was identified as the Solutions coordinator or the abuse coordinator, did not interview other residents to identify any possible further allegations of abuse, did not interview other staff members, and did not thoroughly investigation R6's allegation of being yelled at and jerked side to side by a staff member.

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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. Based on observation, interview, and record review the facility failed to follow professional practice of medication documentation for one resident (#58) of six residents reviewed during medication administration. Findings Included: Resident #58 (R58)Review of the medical record revealed R58 was admitted to the facility 03/13/2019 with diagnoses that included aortic valve stenosis, muscle weakness, dysphagia (difficulty swallowing), congestive heart disease (CHF), bilateral dry eye syndrome, cerebral infarction (stroke), type 2 diabetes, malignant neoplasm of skin (skin cancer), pain in left shoulder, depression, vascular dementia, gastro-esophageal reflux, right sided hemiparesis (muscle weakness or paralysis), atrial fibrillation, anemia (low red blood cells), fatty liver, obesity, hypertension, mood disorder, spinal stenosis (spinal narrowing), osteoarthritis (flexible tissue between bones wears down), rest less leg syndrome, hyperlipemia (high levels of fat in blood), and fibromyalgia (wide spread body pain and tiredness). During observation of medication administration on 09/11/2025 at 07:37 a.m. Licensed Practical Nurse (LPN) C was observed starting to prepare R58's medication to be administered. LPN C was observed placing the following medications in a medication cup: amlodipine 10mg (milligram)-1 tablet, aspirin 81mg- 1 tablet, duloxetine 30mg-1 capsule, iron 325mg-1 tablet, fish oil 1200 mg -1 capsule, lasix 40 mg-1 tablet, hydralazine hydrocholoride 25mg-1 tablet, loratadine 10mg-1 tablet, metoprolol tartrate 100mg-1 tablet, potassium 20 meq (milliequivalent)-1 tablet, ropinirole 0.5 mg-1 tablet, and Tylenol 325mg-1 tablet. At the conclusion of placing the above listed medication in a medication cup LPN C was observed documenting in R58's Medication Administration Record (MAR) that the medication had been given. On 09/11/2025 at 07:45 a.m. Licensed Practical Nurse (LPN) C was observed taking the medication cup into R58's room, who was observed sitting up in her wheelchair. R58 explained that she wanted to be taken to the bathroom and R58 expressed to LPN C that she would not take her medication until she was finished in the bathroom. LPN C was observed returning to the medication cart. LPN C was observed placing a label, that included R58's name, on the medication cup with the medication. LPN C was then observed placing that medication cup in the top drawer of the medication cart. On 09/11/2025 at 07:55 a.m. Licensed Practical Nurse (LPN) C was observed preparing and administrating another resident's medication, at which time LPN C did not lock the mediation cart and left it unattended. LPN C was observed returning to the medication cart on 09/11/2025 at 07:57 a.m. and locking the medication cart. On 09/11/2025 at 08:08 a.m. Licensed Practical Nurse (LPN) C was observed to be notified by R58 that she was ready to take her medication. LPN C was observed to remove the medication cup from the medication cart and proceeded to guide R58 to her room. LPN C was then observed administering R58's medication. Review of R58's Medication Admin Audit Report, dated 09/11/2025, revealed above medication was listed as being given on 09/11/2025 at 07:44 a.m. Review of policy Medication Administration Protocol policy, dated 5/2000 and last reviewed/revised 12/2024, revealed #15. Sign MAR after administered . During an interview on 09/11/2025 at 12:27 p.m. Director of Nursing (DON) B explained that it was her expectation, policy, and professional practice that nurses would document medication as given, in the residents Medication Administration Record (MAR), once the medication had been given to the resident.

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	235602	A. Building B. Wing	09/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hazel I Findlay Country Manor	1101 S Scott Road Saint Johns, MI 48879

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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** During Interview and record review facility failed to follow provider's orders for one (Resident #5) of 20 sampled causing unjust pain.Findings IncludeResident #5 (R5)Review of the medical record reflected that R5 was admitted to the facility on [DATE] and was re-admitted to the facility on [DATE]. Diagnoses of Congestive Heart Failure, Chronic Obstructive Pulmonary Disease, muscle weakness, lack of coordination and difficulty walking.The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 08/08/2025 revealed R5 had a Brief Interview of Mental Status (BIMS) of 09 (moderately impaired) out of 15. Under section G0100, Activities of Daily Living (ADL) Assistance reveals R5 had impaired mobility of both upper and lower extremities, set up and assist for meals, and dependent on all other care. During an interview on 09/10/2025 at 4:15 PM, R5's family member R stated R5 was taking a medication called Neurontin 100 milligram (mg) capsule for his neuropathy in his legs and feet, and it was stopped. R'5 family member R stated R5 had been on it a couple of weeks and it was really helping his neuropathy burning and pain. Family member R stated the facility stopped giving it to him without discussing it with her. Family member R stated once his neuropathy pain came back, it was identified that his neuropathy medication Neurontin 100 mg capsule had been stopped without reason. Family member R stated the facility staff would not have known of this error if R5 had not had his pain and burning returned to his legs and feet.During an interview on 09/15/2025 at 1:45 PM, House Supervisor S asked if writer was talking about Neurontin as she looked up his medications in R5's electronic medical record (EMR). House Supervisor S stated R5's provider ordered Neurontin 100 mg for 2 weeks to evaluate if it was beneficial for his nerve pain. House Supervisor S stated yes it was stopped after 2 weeks, provider was notified and reported it was beneficial and would like to continue it. Record review revealed the August Monthly Administration Record (MAR) for R5 was started on Neurontin 100mg 1 capsule at bedtime on August 26, August 27 and August 28th. August MAR then showed Neurontin 100mg capsule was given 2 times a day at 8:00 am and 8:00 pm on August 28, August 30 and August 31st. September MAR revealed R5 continued taking Neurontin 100 mg capsule 3 times a day at 8:00 am, 1:00 pm and 8:00 pm on September 1, September 2 and September 3, 2025, then stopped. There was a note on the September MAR for September 2, 2025, with the message Re-evaluate effectiveness of Neurontin and call provider with an update which was checked off as completed. During same interview with House Supervisor S stated she knew a form called Nursing Communication and Physician Response Form was sent to the provider on September 2, 2025, at 9:05 am, signed and dated September 3, 2025, when it was returned to the facility. The provider documented that he wanted to continue the Neurontin 100 mg capsules 3 times a day. This provider order was put in R5's EMR on September 9, 2025, and Neurontin 100 mg capsules 3 times a day started on September 10, 2025, not September 3, 2025, as ordered.During an interview on 09/15/2025 at 1:57 PM House Supervisor S stated she did not know how that order for Neurontin 100mg capsules 3 times a day was missed during that time frame of September 3, 2025, to September 10, 2025.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure that the drug regimens for 1 of 5 residents reviewed for antipsychotic drug (#34) use were free of medications used without adequate indications for use, without adequate monitoring, and without a resident-focused, risk-benefit statement completed, resulting in the risk for increased side effects from a potentially unnecessary medication. Findings include:Review of the Face Sheet and Minimum Data Set (MDS) dated [DATE], reflected R34 was a [AGE] year old female admitted to the facility on [DATE], with diagnoses that included vascular dementia without behavioral disturbances, psychotic disturbance, mood disturbance, anxiety, urinary tract infection, and depression. The MDS reflected R34 had a BIM (assessment tool) score of 12 which indicated her ability to make daily decisions was moderately impaired. R34 Face Sheet reflected she had an activated Durable Power of Attorney(DPOA) for medical and financial care.Review of R34 Physican Orders and Medication Administration Record, dated 8/15/25 through current 9/15/25, reflected and order for SEROquel Oral Tablet 50 MG(Quetiapine Fumarate) Give 1 tablet by mouth in the evening for Agitation . The Medication Administration Record reflected R34 had received Seroquel 50mg every evening.Review of R34 Behavior Progress Note, dated 8/15/25 at 2:30 a.m., reflected, Resident attempted to walk out of the front door. She removed her wander guard that was found in her recliner chair and ripped the nurses station phone off the cord. It took two staff members to re-direct her from exiting. Resident is extremely agitated. She is demanding that the door be opened and her to be allowed to leave. She states that she is going to sue the facility and all the workers and have the place shut down. Resident is standing next to the exit door with a blanket and the phone in hand. Nurse attempted to comfort and console resident with no success. Redirection unsuccessful. Nurse called and notified administrator of events. [Named Physician] notified of current behaviors and attempts to elope and notified of previous statements of suicide ideations. [Named Physician] ordered Seroquel 50mg at HS[night], and stated to attempt to give ordered PRN Benadryl. Resident is being monitored closely by staff at this time. During an interview on 9/15/2025 at 1:50 PM, Social Worker (SW) I reported R34 had an activated DPOA and was not her own responsible party. SW I reported R34 admitted to the facility 8/12/25 and was not adjusting well at first and started to become agitated with attemps to elope on 8/14/25 evening into 8/15/25. SW I reported staff attempted to redirect R34 including calling family that were ineffective. SW I reported Physician ordered Seroquel 50mg every evening for agitation on 8/15/25 and reported not an expectable diagnosis for use. SW I reported R34 had not had any additional documented behaviors since 8/15/25. During a telephone interview on 9/15/25 at 2:34 p.m., Licensed Practical Nurse (LPN) T reported was nurse trainee for R34 on evening of 8/14/25 into 8/15/25 when R34 became very agitated and attempting to elope. LPN T reported she was unable to redirect R34 after several attempts and notified Nursing Home Administrator (NHA) A and Physician. LPN T reported Physician gave verbal order to start Seroquel 50mg every night and attempt to administer as needed order of Benadryl to calm down R34. LPN T reported R34 refused to take medications and Emergency Medical Services were in the facility at the time and were able to deescalate R34 on 8/15/25 until Nursing Home Administrator arrived in the morning. During an interview on 9/15/2025 at 3:09 PM, NHA A and Director of Nursing (DON) B, NHA A reported was notified by telephone of R34 behaviors and arrived at facility early that morning and R34 was very angry. NHA A reported was able to calm R34 down by reassuring her because she was overall concerned about the care of her daughter that was recently primary care giver for. DON A reported R34 had difficult time adjusting initially with facility admission and diagnosis but is currently doing very well. DON B reported R34 had not been prescribed antipsicotics prior to 8/15/25 and was unable to located justification for use and planned to attempt gradual dose reduction becuase she had not had any additional documented behaviors since 8/15/25.According to the guidelines outlined in the State Operations Manual for unnecessary medications, the risk/benefit statements must be a resident-focused review of symptoms and co-morbidities (diagnoses) compared to the possible risks of taking an antipsychotic medication for a resident diagnosed with dementia, psychosis and behaviors.According to the United States Black Box Warning, elderly patients with dementia-related psychosis treated with antipsychotics are at an increased risk of death compared to placebo. Most deaths appeared to be either cardiovascular (heart failure, sudden death) or infections (pneumonia, including that caused by aspiration). Anti-psychotics are not approved for the treatment of dementia-related psychosis. Neuroleptic malignant syndrome (life-threatening

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review the facility failed to ensure that all medication used in the facility was secured and stored in accordance with professional standards in one of three medication carts. Findings Included: Resident #58 (R58)Review of the medical record revealed R58 was admitted to the facility 03/13/2019 with diagnoses that included aortic valve stenosis, muscle weakness, dysphagia (difficulty swallowing), congestive heart disease (CHF), bilateral dry eye syndrome, cerebral infarction (stroke), type 2 diabetes, malignant neoplasm of skin (skin cancer), pain in left shoulder, depression, vascular dementia, gastro-esophageal reflux, right sided hemiparesis (muscle weakness or paralysis), atrial fibrillation, anemia (low red blood cells), fatty liver, obesity, hypertension, mood disorder, spinal stenosis (spinal narrowing), osteoarthritis (flexible tissue between bones wears down), rest less leg syndrome, hyperlipemia (high levels of fat in blood), and fibromyalgia (wide spread body pain and tiredness). During observation of medication administration on 09/11/2025 at 07:37 a.m. Licensed Practical Nurse (LPN) C was observed starting to prepare R58's medication to be administered. LPN C was observed placing the following medications in a medication cup: amlodipine 10mg (milligram)-1 tablet, aspirin 81mg- 1 tablet, duloxetine 30mg-1 capsule, iron 325mg-1 tablet, fish oil 1200 mg -1 capsule, lasix 40 mg-1 tablet, hydralazine hydrocholoride 25mg-1 tablet, loratadine 10mg-1 tablet, metoprolol tartrate 100mg-1 tablet, potassium 20 meq (milliequivalent)-1 tablet, ropinirole 0.5 mg-1 tablet, and Tylenol 325mg-1 tablet. At the conclusion of placing the above listed medication in a medication cup LPN C was observed documenting in R58's Medication Administration Record (MAR) that the medication had been given. On 09/11/2025 at 07:45 a.m. Licensed Practical Nurse (LPN) C was observed taking the medication cup into R58's room, who was observed sitting up in her wheelchair. R58 explained that she wanted to be taken to the bathroom and R58 expressed to LPN C that she would not take her medication until she was finished in the bathroom. LPN C was observed returning to the medication cart. LPN C was observed placing a label, that included R58's name, on the medication cup with the medication. LPN C was then observed placing that medication cup in the top drawer of the medication cart. On 09/11/2025 at 07:55 a.m. Licensed Practical Nurse (LPN) C was observed preparing and administrating another resident's medication, at which time LPN C did not lock the mediation cart and left it unattended. LPN C was observed returning to the medication cart on 09/11/2025 at 07:57 a.m. and locking the medication cart. On 09/11/2025 at 08:08 a.m. Licensed Practical Nurse (LPN) C was observed to be notified by R58 that she was ready to take her medication. LPN C was observed to remove the medication cup from the medication cart and proceeded to guide R58 to her room. LPN C was then observed administering R58's medication. During an interview on 09/11/2025 at 12:27 p.m. Director of Nursing (DON) B explained that it was professional practice that medication carts must be locked when not visible or being used by a licensed nurse. DON B also explained that it was her expectation that medication should not be placed in a medication cup and stored in the medication cart to be given to residents at a different time. DON B explained that it would be best practice to wait with the medication until the resident is ready to receive the medication or discard the medication at the time of delay or refusal.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review the facility failed to effectively clean and maintain food service equipment affecting 99 residents. On 09/10/2025 at 08:31 a.m. an initial tour of food services was conducted with Dietary Aide F and then Certified Dietary Manager (CDM) G. The following items were observed:Main Freezer had ice on the floor approximately 1 inch tall and the circumference of a silver dollar. Dietary Aide F explained that it may be coming from the cooler refrigeration fan.Dishwasher was observed to have lime scale on the outside of the machine and floor was visibly soiled around the dishwasher.Hand sink to the right of the entrance was visible soiled and the faucet was covered with lime scale.Hand sink across from the tray line was visible soiled and the faucet was covered with lime scale.The toaster on the tray line had visible breadcrumbs on all sides of the toaster.Soiled sink faucet had visible lime deposit.Oven racks appeared soiled with multiple lays of old burnt color. Those racks were in the oven at this time. Two old racks were observed discolored on top of the oven. Old grease and dust was observed on top of the oven. Dust and cobwebs were observed on the sprinkler system over the stove.Back lower vent hood above stove appeared to be covered with old grease. Lime and red colored deposit was observed in the dishwasher and lime was deposit was observed on the floor around the dishwasher. Five air vents in the ceiling of the kitchen were observed to be soiled with ceiling tiles around the vents to be observed soiled as well. On 09/15/2025 at 07:21 a.m. Tour of kitchen with Certified Dietary Manager (CDM) H the following items were observed:Main freezer ice was observed on the floor.Sinks still observed to have lime deposits.Five air vents in the ceiling of the kitchen were observed to be soiled with ceiling tiles around the vents be observed as well. All sinks and faucets observed on initial tour still were observed stained/soiled with lime deposit.Dishwashing machine was observed to still have lime and red substance on inside and outside of machine. Walk-in cooler had food observed on the floor.