STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235608	A. Building B. Wing	04/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Stratford Pines Nursing and Rehabilitation Center	2121 Rockwell Drive Midland, MI 48642

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation is related to intake # 2676019Based on observation, interview, and record review, the facility failed to provide dignified care for 6 of 12 Confidential Resident Group Interview respondents and 3 residents (R36, R58, and R60) of 4 residents reviewed for dignity.Findings include: Resident #36 (R36) Review of an admission Record revealed R36 admitted to the facility on [DATE] with pertinent diagnoses which included weakness, overactive bladder, and difficulty walking. Review of a Minimum Data Set (MDS) (a tool used for assessing a resident's care needs) assessment for R36, with a reference date of 1/22/2026 revealed a Brief Interview for Mental Status (BIMS) (a scale used to determine a resident's cognitive status) score of 12, out of a total possible score of 15, which indicated R36 was moderately cognitively impaired. Review of current activities of daily living Care Plan interventions for R36, initiated 1/6/2026, directed staff resident required assistance of one staff with ambulation and should assist when verbal or non-verbal indicators communicate toileting needs. In an interview on 3/30/2026 at 12:31 AM, R36 reported she waited up to 30 minutes for her call light to be answered, which sometimes caused her to soil herself. R36 stated soiling herself makes me feel terrible. R36 reported a few weeks ago she called 911 because no one answered her call light and they contacted the front desk. R36 stated, I have to scream to get help. Resident #58 (R58)Review of an admission Record reflects R58 admitted to the facility with diagnoses that included major depression, difficulty in walking and weakness. Review of a Minimum Data Set (MDS) assessment dated [DATE] reflects R58 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15/15. R58 needed partial to moderate assistance with toilet transfers. Review of a Care Plan initiated 1/6/2026, revised 2/17/2026 reflected R58 needed assistance with Activities for Daily Living (ADLS), and required assistance with toileting before and after meals, HS (hour of sleep) and PRN (as needed). The care plan indicated R58 wears incontinence products check and change before and after meals, HS, with rounds and PRN. Assist when verbal or non-verbal indicators communicate toileting needs. Further review of the care plan indicated R58 had excoriation to peri area (initiated on 8/25/25, revised on 9/3/2025). During an observation beginning 3/31/2026 at 10:45 AM, the red call light over the door to room [ROOM NUMBER] was activated. Licensed Practical Nurse (LPN) D was standing at a medication cart a few feet away and did not respond to the call light. 2 unidentified Certified Nurse Aides (CNAs) (continued on next page)

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

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	were also on the unit. At 10:56 AM, the two unknown CNAs left the unit without answering the call light. LPN D moved the medication cart, placing it in front of the room across the hall and facing room [ROOM NUMBER] and did not respond to the call light activated over the door to room [ROOM NUMBER]. At 11:01, the CNAs returned to the unit with an open cart of meal trays, placing the cart directly outside room [ROOM NUMBER] and began passing the noon meals. Neither of the CNAs responded to the call light on outside room [ROOM NUMBER]. At 11:05 AM, one of the unknown CNAs entered room [ROOM NUMBER] and was overheard saying she could not assist the resident to the toilet because it was lunch time. The unknown CNA turned off the call light and left the room. A man's voice was overheard saying This is bulls***! This is unacceptable! . and the call light was again activated over the door to room [ROOM NUMBER]. During an interview and observation on 3/31/2026 at 11:07 AM, R58 was seated in a recliner chair in room [ROOM NUMBER]. Family Member (FM) H was standing next to R58 and was visibly upset. FM H reported R58's call light had been on since 10:30 AM that morning and that this isn't the first time staff take too long to answer R58's call light, sometimes taking up to an hour and a half before assistance is given. FM H also reported staff routinely shut off the call light without meeting R58's needs and said R58 would often skip breakfast because she did not want to eat while sitting in a wet brief. FM H also said that R58 did not like it when he complained about the long wait times because she would tell him she had to live here and did not want to upset staff or get on their bad side. When asked, R58 confirmed that the unknown CNA told her she could not be assisted to the bathroom because it was lunch time which R58 said made her feel very unimportant. R58 reported she was sitting in a soaking wet brief and had a rash in her groin area due to frequently being wet and/or soiled for extended periods of time. R58 also reported that when her assigned CNA goes on break, the other CNA on the hall will often tell her she has to wait until her assigned CNA returns from break before being assisted. Review of Interdisciplinary Documentation) dated 3/12/2026 reflected, Aide came to this nurse to notify her that (R58) has a (sic) open spot to labia and is having some bleeding in the brief. Aide also states that she is having a lot of redness bilateral thigh. Nurse evaluated and had aide place barrier cream to labia and bilateral thighs at this time. Notified provider in provider book to evaluate. Review of Interdisciplinary Documentation dated 3/13/2026 reflected Per the infection assessment (R58) meets Loeb criteria (minimum, evidence-based guidelines developed to assist clinicians in deciding when to initiate antibiotic therapy for nursing home residents) for skin and soft tissue infection. HCP (Healthcare Provider) diagnosis of intertrigo (an inflammatory skin rash caused by friction and moisture in skin folds) to periarea and groin. (R58) is incontinent of bowel and bladder. Encouragement provided to be toileted more frequently either before or after each meal as tolerated. (R58) states she has frequent bowel movements. Review of bathing in the past 2 weeks with 3/4 completed. STCP (Short Term Care Plan) made for further monitoring. CONFIDENTIAL GROUP INTERVIEWDuring a confidential resident group interview on 3/31/2026 at 1:30 PM, 6/12 residents reported they frequently experienced extended call light response times, ranging from 30 minutes to an hour and a half. The residents reported staff often shut the call light off before meeting their needs and promised to return, only to forget until the call light was activated again. One resident reported that twice in the last week they had to wait 45 minutes before they were assisted to the toilet, which caused pain, discomfort, and incontinence which made them feel lousy. Another resident reported that they feel the facility is not using the staff efficiently, especially during mealtimes. One resident reported that they frequently witnessed their roommate waiting a very long time for their call light to be answered which would make their roommate cry. During an interview on (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4/01/2026 at 8:22 AM the Director of Nursing (DON) reported that all staff are to respond to call lights as soon as possible, ideally within 15 minutes. The DON said staff should not walk by call lights and should at least check in with the residents to find out what they needed. The DON said the call light is to be left on until the resident's needs are met. The DON said he was aware call light response time was a concern and did not know if it was because they needed more staff or better coordination of meal service so that more managers could help during these times. Resident #60 (R60) Review of the Electronic Medical Record (EMR) reflected R60 admitted to the facility with pertinent diagnoses that included Parkinson's Disease, Weakness, and Difficulty in Walking. Review of the Minimum Data Set (MDS, a tool to assess a resident's status) dated 1/7/2026 revealed a Brief Interview for Mental Status (BIMS, a tool to assess a resident's cognitive ability) score of 15 out of 15 which indicated the Resident was cognitively intact. Review of the Care Plan for R60 reflected the Resident required assistance of one staff member and a four-wheeled walker for transfers and ambulation. The Care Plan reflected R60 preferred to sleep in his recliner and was at risk for falls. On 3/30/2026 an interview was conducted with R60 in his room. R60 reported a complaint that he often had to wait too long for a response to his call light. R60 reported extended wait times had caused him to poop and pee myself. R60 reported incidents when he had waited 30 to 45 minutes for a response to his call light. R60 reported he was a fall hazard and I'm not supposed to get up by myself. R60 reported times when, unable to wait any longer, he had self-transferred into the bathroom stating I don't have time to walk over to my walker, only time to get myself into the bathroom . Sometimes they find me in the bathroom without my walker . I can't help it if I have to have bowel movements in the middle of the night or have to urinate. R60 reported that sometimes after waiting and urgency approached, he had banged on the wall next to his recliner. R60 reported I'm not deaf, I can hear them talking and laughing walking past my room. R60 pointed to the wall next to his recliner. Multiple marks were observed on the wall. The Resident demonstrated how he had struck the wall with the back of a closed fist when he had heard staff outside his room. R60 reported extended wait times occurred mostly at night but had also occurred during the day. R60 reported he had talked to the Director of Nursing (DON) and Social Worker (SW) L about this without resolution and reported this continued to be my biggest complaint. On 3/31/2026 at 11:56 AM the call light for R60 was observed to be on. -On 3/31/2026 at 12:01 PM an observation was noted that Certified Nurse Aide (CNA) K had entered the room of R60 with a lunch tray and the call light was turned off. Approximately on minute later CNA K left the room with the same lunch tray. -On 3/31/2026 at 12:04 PM R60 was interviewed and reported that he told CNA K that his girlfriend had already brought him lunch but that he needed to go to the bathroom. The Resident reported CNA K told him she would be back and then R60 stated, We'll see. -On 3/31/2026 at 12:06 PM CNA K and two other CNAs were observed delivering food trays to other resident rooms. -On 3/31/2026 at 12:09 PM multiple CNAs were observed walking back and forth in the hall with two (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	CNAs talking about who was going to lunch. Also, during this time Registered Nurse (RN) M and Licensed Practical Nurse (LPN) O were observed as they left the alcove next to the room of R60. -On 3/31/2026 at 12:12 PM RN M and LPN O were observed as they returned to the alcove and LPN O left about one minute later walking past the room of R60 whose light remained off. RN M left the area walking the other direction. -On 3/31/2026 between 12:12 PM and 12:18 PM multiple care and non-care staff were observed walking in the hall past the room of R60. RN M had returned to the hall and was observed to respond to two call lights farther down the hall. -On 3/31/2026 at 12:25 the call light for the room of R60 was observed to illuminate. LPN O returned to the hall at this time and was observed to respond to the Resident's call light. -On 3/31/2026 at 12:35 PM an interview was conducted with LPN O who reported she had assisted R60 to the bathroom. LPN O reported that R60 had not been incontinent. On 4/1/2026 at 8:21 AM an interview was conducted with R60 in his room. When asked about the lunchtime call light wait of 3/31/2026 R60 reported he had waited a half hour for a response. R60 reported that CNA K did not return but that another staff member had taken him to the bathroom after he turned his light on again. R60 reported he had been incontinent in his brief by the time this staff member arrived. R60 stated I pee my pants, I poop my pants, it shouldn't be that way.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on interview and record review, the facility failed to formulate and implement a person-centered comprehensive psychosocial Care Plan in accordance with facility policy for one resident (R95) of three residents reviewed for comprehensive Care Plans. Findings include:Review of the Minimum Data Set (MDS, a tool used to assess a resident status) with a reference date of 3/10/2026 reflected R95 admitted to the facility 3/3/2026 with pertinent diagnoses that included: Anxiety Disorder, Dementia, and Depression. Review of the MDS Brief Interview for Mental Status (BIMS, a tool used to assess cognitive status) revealed a score of 8 out of 15 which indicated that R95 was moderately cognitively impaired.Review of the Physicians Orders for R95 reflected the medication regimen included the psychoactive medications: Buspar (antianxiety medication) with a start date of 3/3/2026, Sertraline (antidepressant) with a start date of 3/4/2026 and Seroquel (atypical antipsychotic) with orders to monitor for the side effects of Antidepressant Medication and Antipsychotic Medication both with start dates of 3/10/2026.The policy provided by the facility titled Care Planning Process: Admission, Comprehensive and Short Term, last revised 11/2017 was reviewed. The policy reflected It is the policy of this facility to utilize the results of the MDS assessment to develop, review, and revise resident care plans. And Comprehensive:1. The interdisciplinary team will review the status in the Care Area Assessment (CAA) triggered areas [from the MDS] for making care plan determinations.The MDS Section V Care Area Assessment (CAA) Summary with a reference date of 3/10/2026 for R95 was reviewed. The review revealed trigger areas checked (yes) included, Cognitive Loss/Dementia, Behavioral Symptoms, Psychotropic Drug Use. However, the CAA Summary reflected that Psychosocial Well-Being Care Area and Psychosocial Care Planning Decision were not checked (No) and Not Assessed/ no information.Review of the Care Plan for R95 revealed a one psychosocial plan of care with a Focus of Resident has the potential for psychosocial distress related to: expressing sadness/ anger/empty feeling over lost roles and status initiated 3/6/2026. The two Goals established reflect adjustment to nursing home placement as evidenced by. socialization and stable BIMS, and The highest practicable level of communication, memory, judgement and orientation will be achieved with psychosocial needs met. Review of the Interventions or how will these goals be accomplished, included five interventions: two indicated monitoring (evaluate for changes and behavior monitoring) allow time to express feelings, acknowledgement of mood and behavior, and maintaining a calm environment. The Focus and all Interventions were initiated on 3/6/2026. Nowhere in this plan of care or in other areas of the Care Plan were the MDS diagnoses of depression or dementia recognized, personalized, or indicated that R95 was prescribed psychoactive medication that required monitoring were included.During an interview conducted 3/31/2026 at 4:19 PM, Social Worker (SW) L reported that a resident on psychoactive medications would not necessarily have a Care Plan for these medications. SW L reported a resident would be more more likely have a Care Plan if the resident had behaviors.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on interview and record review, the facility failed to revise the comprehensive care plan with updated interventions to prevent the development or worsening of a pressure ulcer for 1 resident (R7) out of 19 residents reviewed for care planning. Findings include: Resident #7 (R7)Review of an admission Record reflected R7 admitted to the facility with diagnoses that included lumbar spina bifida without hydrocephalus, pressure ulcer of left heel stage 2 (partial-thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed, without slough or bruising. May also present as an intact or open/ruptured blister), pressure ulcer of left buttock, unstageable (a severe wound with full thickness tissue loss, fully covered by slough or eschar, making its true depth hidden).Review of a Physician Progress Note dated 2/2/2026 reflects Stage IV pressure injuries of left heel and left ischium . Plan: . Cleanse left heel wound with wound cleanser, normal saline, or soap and water and apply Medihoney, cover with Mepilex foam bordered dressing, and apply heel cushion boots every shift. Check skin daily. Continue position changes at least every 2 hours and pressure offloading measures. Encourage high protein diet, proper hygiene, and Foley catheter care to avoid skin breakdown and promote healing.Review of an order dated 12/12/2025 reflected apply heel cushioned boots to bilateral feet to offset pressure. remove boots check skin daily to heels, every shift for let inner heel wound.Review of a Care Plan initiated on 6/10/2024, revised 1/05/2026, indicated R7 had Actual skin impairment to left heel, blister. Interventions in the care plan did not include ensuring R7 wore protective heel cushion boots to relieve pressure on the feet and heels. During an interview on 4/1/2026 at 11:35 AM, the DON reported R7 should have the heel cushion boots in place while she was out of bed and said perhaps the order should be changed to every 4 hours so that there would be eyes on the resident more often to ensure the interventions remained in place. The DON was not aware that the intervention was not mentioned in the Care Plan.Review of a policy Skin at Risk Assessment Documentation, Staging & Treatment, revised 1/2020 reflected the purpose of the policy was To provide prompt identification and intervention for residents at risk of impaired skin integrity corresponding to risk factors. To limit the development of avoidable pressure ulcers and provide evidence-based guidance on effective strategies to promote pressure ulcer healing.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. Based on observation interview and record review, the facility failed to provide services to one Resident (R95) to maintain grooming standards. Findings include:Review of the admission Record reflected R95 admitted to the facility 3/3/2026 with diagnoses that included Parkinson's Disease, Difficulty in Walking and Weakness.On 3/30/2026 at 2:00 PM, an observation and interview were conducted in the room of R95 with the Resident and Family Member (FM) P. It was observed that R95 was unshaven. FM P reported that R95 was rubbing his face often as he was not used to having facial hair. FM P reported she was not sure if the facility would shave the Resident although a nurse did shave the Resident once. FM P reported R95 was scheduled for showers on Tuesdays and Saturdays. FM reported this past Saturday, though, she noted that R95 was unkempt but staff told her the Resident refused a shower earlier that day. FM P indicated she questioned the refusal but that R95 did get a shower after she asked staff to shower the Resident.On Tuesday, 3/31/2026 at 11:39 AM, an observation and interview were conducted with R95 in his room. R95 appeared to have been given a shower but had additional facial hair growth from the previous day. R95 reported he was not trying to grow a beard and had been wanting to get the facial hair mowed.On 3/31/2026 at 1:45 PM, at the room of R95, the Resident was observed in a wheelchair in the bathroom with FM P who was shaving him at the sink. FM P reported she asked staff to transfer the Resident to the wheelchair from the recliner so the Resident could be shaved.On 3/31/2026 at 2:24 PM, an interview was conducted with the Director of Nursing (DON) in his office. The DON reported residents were offered showers twice a week and were offered to be shaved on shower days. The DON reported that if a resident refused to shower, they were re-approached twice more then the nurse was to be informed of the refusal. The DON indicated refusals were documented. The DON reported that R95 is offered showers on Tuesday and Saturday and that R95 did get a shower this past Saturday. The DON was informed that the Resident got the shower because FM P requested this after staff claimed the Resident refused. The DON reported that R95 did get a shower on this day of this interview. The DON was informed that R95 was not shaved as it was indicated that this was to be offered on shower days and that FM P was observed shaving the Resident in his bathroom prior to this interview.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observation, interview, and record review, the facility failed to provide services to gauge and ensure the activities of daily living (ADLs) did not diminish for one Resident (R95) of two residents reviewed for ADLs. Findings include.Review of the admission Record reflected R95 admitted to the facility 3/3/2026 with pertinent diagnoses that included Difficulty in Walking and Weakness. Review of the Minimum Data Set (MDS a tool used to assess a resident's status) Section A reflected R95 admitted from a hospital for short-term care with Section O, Special Treatments, Procedures, and Programs, reflected R95 was receiving physical and occupational therapy.On 3/30/2026 at 2:00 PM, an interview was conducted with Family Member (FM) P in the room of R95. FM P reported R95 was at the facility for therapy but had not progressed enough to go home. FM P reported therapy was going well but progress was slow. FM reported a second appeal had been filed to extend the stay of the Resident as the first appeal had been denied. FM P reported R95 had therapy every morning but would just sit in the recliner the rest of the day. FM M reported the only time staff had walked with R95 was to assist the Resident to the bathroom but no other time. FM P reported she had asked several staff if the family could walk the Resident in the hall during the day but were told no and that only a nurse could walk the Resident. FM P reported staff did not offer to ambulate R95 despite having been asked by family that R95 get up more during the day. FM P indicated she felt progress toward home discharge would improve if R95 did not spend so much of the day sedentary.Review of the Care plan for R95 reflected a Focus of Altered functional mobility and ADL's (Activities of Daily Living) related to Parkinson's Disease that caused unsteady gait, poor balance, Review of the interventions reflected, Resolved: Walking/Ambulation Therapy Only resolved on 3/10/2026. This indicated that after 3/10/2026 staff could walk with R95 as the Resident tolerated. R95 Current interventions for Transfer and Walking/Ambulation required One assist with 2WW (two wheeled walker). Also, that staff would assist with toileting before and after meals. Review of the Goal for Altered functional mobility plan of care for R95 reflected the only staff listed for the Goal was PT/OT (Physical Therapy/ Occupational Therapy) which indicated that nursing staff were not included in the plan of care for the Residents mobility. This Care Plan also reflected that R95 prefers to sleep in his recliner. This indicated that, outside of Therapy sessions and toileting, no plan was offered R95 for tolerable intermittent mobility for the Resident from his recliner.On 3/31/2026 at 11:39 PM, R95 was observed returning to his room with Occupational Therapist (OT) Q. R95 was wearing a gait let and was using a 2 wheeled walker as he was assisted by OT Q to the recliner in his room. OT Q reported that R95 continued to improve but had not yet reached his maximum potential yet. During a follow up interview conducted 4/1/2026 OT Q indicated that facility staff could walk the Resident if the precautions listed in the Care Plan were followed. The Care Plan was reviewed at this time and OT Q verified that there was nothing in the Plan of Care that prevented staff from ambulating with the Resident.On 3/31/2026 at 2:24 PM, an interview was conducted with the Director of Nursing (DON) in his office. The DON was informed that FM P was concerned that, outside of therapy, R95 was mostly sedentary sitting in his recliner but were told by staff the family could not ambulate the Resident. The DON was informed that despite family voicing this concern the facility staff did not offer to ambulate R95. The DON indicated that this concern had not been conveyed to him but that we could get him (R95) on a walking program. The DON reported that R95 was considered to be on the facility rehab (rehabilitation) side and not on the LTC (long-term care) side. The DON reported that the LTC side had a restorative program with range of motion being performed and walk to dine and walk to Activities was performed by floor staff for the residents on that side of the facility.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure safe transfer practices for 1 resident (R92) of 1 resident reviewed for accidents.Findings include:Review of an admission Record revealed R92 admitted to the facility on [DATE] with pertinent diagnoses which included Parkinson's disease and weakness.Review of a current activities of daily living Care Plan intervention for R92, initiated 1/4/2026, revealed resident transferred with a rocking Broda wheelchair.In an observation and interview on 4/1/2026 at 7:44 AM in the dining hall, Licensed Practical Nurse (LPN) D pushed R92 to a dining table in his Broda wheelchair with both of his feet brushing the ground. R92 was not moving his feet to assist with movement. LPN D reported she was not sure where R92's wheelchair foot pedals were.In an interview on 4/1/2026 at 8:20 AM, Registered Nurse (RN) Clinical Care Coordinator (CCC) C reported resident's feet should not be in contact with the ground during wheelchair transfers unless they were moving and assisting the motion with their feet. RN CCC C reported resident's feet should either be elevated off the ground or resting on foot pedals to prevent injury during wheelchair transfers.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235608	A. Building B. Wing	04/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Stratford Pines Nursing and Rehabilitation Center	2121 Rockwell Drive Midland, MI 48642

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 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation is related to intake # 2804821 Based on interview and record review, the facility failed to follow standards of care for one of two resident's (Resident #102) reviewed for peripherally inserted central catheter care. Findings:Resident #102 (R102)Review of an admission Record revealed R102 was a [AGE] year-old female, admitted to the facility on [DATE] with pertinent diagnoses of a right hip fracture that required surgical repair and the use of a PICC line (peripherally inserted central catheter) to administer antibiotics for a urinary tract infection. Review of a nursing admission Assessment for R102 dated 02/26/26, revealed the notation .PICC line noted to the right upper arm. The assessment, completed by a licensed nurse, (a) did not specify the condition of the PICC line site and dressing (ie, was there any redness or swelling at the insertion site, was the dressing transparent (see through) and firmly attached to the skin), (b) did not specify the length of the catheter (necessary to be able to determine if the catheter gets pulled out or pushed in during care), (c) did not specify a measurement of the circumference of the arm just above the catheter insertion site, and (d) did not document the date the catheter and dressing were placed (the dressing must be changed at least every seven days, sooner if needed). Review of a nursing Skin Assessment for R102, dated 02/27/26, only noted .PICC line to right upper extremity. The assessment did not specify the condition of the PICC line insertion site, whether there were any signs or symptoms of infection, nor whether the dressing was intact. Review of a physician Progress Note for R102 reflected the physician saw R102 on 02/27/26 and made no mention of the resident having a PICC line, it's location, whether there were any signs or symptoms of infection at the site, or what the PICC line was being used for. Review of a nursing Skin Assessment for R102, dated 02/28/26, did not reveal the condition of the PICC line insertion site or if there were any signs or symptoms of infection noted. Review of a nursing Skin Assessment for R102, dated 03/01/26, only noted .PICC line to right upper extremity. The assessment did not specify the condition of the PICC line insertion site, whether there were any signs or symptoms of infection noted, nor whether the dressing was intact. Review of all Progress Notes for R102 revealed no documentation that the resident had a PICC line and that it was being monitored every shift. During an interview on 04/01/26 at 8:55 AM, the Director of Nursing (DON) stated that the expectation for caring for a resident with a PICC line included physician orders for (a) flushing the catheter before and after the administration of medications through the catheter and what type of solution used to flush the catheter, (b) monitoring the insertion site of the catheter every shift, (c) and checking the measurement of the catheter at admission and each time the dressing was changed. Review of an Electronic Treatment Administration Record (Etar) for R102, dated February 2026, reflected no physician orders for flushing the catheter before and after medication administration nor physician orders for monitoring the catheter insertion site every shift for signs and symptoms of infection. Review of an Electronic Treatment Administration Record (Etar) for R102, dated March 2026, reflected no physician orders for flushing the catheter before and after medication administration nor physician orders for monitoring the catheter insertion site every shift for signs and symptoms of infection. Review of Care Plans for R102 reflected that a specific care plan (a document used to identify the specific needs of a resident and and interventions that staff use to help the resident reach goals in their care) for the use and care of a PICC line had not been developed for R102 at the time of admission nor at anytime during her five day stay at the facility. Review of a "Kardex (a quick reference care guide that direct care staff use to find important care and safety instructions specific to a resident) for R102 did not reflect instruction for blood pressure not to be taken in the right arm. Review of the EHR (electronic health record) revealed R102 was emergently transferred to the hospital on the morning of 03/02/26. Review of Hospital Records dated 03/02/26, revealed the following observations and treatments initiated for R102: (a) sepsis (infection) workup was initiated as the patient was hypotensive (low blood pressure), tachycardic (fast heart rate), and (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	confused, (b) concerning inflammation (swelling) noted around the PICC line, (c) the PICC line was removed and the tip was sent for culture, and (d) the culture completed on the tip of the PICC line was positive for Candida albicans.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain clear and concise medical records for two residents (R78 and R9) of 20 residents whose records were reviewed.Findings include:Resident #78 (R78) Review of an admission Record revealed R78 admitted to the facility on [DATE] with pertinent diagnoses which included dementia and depression. Review of R78's Physician's Orders revealed an order active 3/31/2026 to place a bordered foam dressing on her forehead every 7 days and PRN (as needed) if the bandage became soiled or loose until healed. In an observation on 3/31/2026 at 7:32 AM in the dining hall, R78 had a dressing on her right and central forehead dated 3/31/26. In an observation and interview on 3/31/2026 at 11:54 AM in the dining hall, R78 no longer had a dressing on her forehead, revealing two wounds that R78 was picking at. Registered Nurse (RN) E reported nursing staff sometimes replaced R78's dressing 10 times a day as she constantly removed the dressing. Review of R78's Electronic Medical Record (EMR) on 3/31/2026 at 3:31 PM revealed no documentation dressing changes had been completed in the month of March. In an interview on 3/31/2026 at 4:15 PM, RN E reported she had changed R78's forehead dressing 4 times already that day but had not documented any of these dressing changes. RN E reviewed the EMR to try to determine why the as needed dressing was not showing up for staff to document. In an interview on 4/1/2026 at 8:20 AM, RN Clinical Care Coordinator (CCC) C reviewed the EMR and reported R78 had a dressing order in place that was placed incorrectly so the dressing change did not generate as a task for nursing to complete. RN CCC C reported frequent as needed dressing changes were being completed but not documented for R78 in the month of March 2026. Resident #9 (R9)Review of an admission Record reflected R9 admitted to the facility with diagnoses that included fibromyalgia, dementia, depression and bipolar disorder. Review of Interdisciplinary Documentation dated 3/27/2026, reflected Spoke with DPOA (Durable Power of Attorney) regarding new abdominal x-ray orders and new medication from HCP (Heath Care Provider) visit on 3/26. (Name of DPOA) agrees with plan of care. No progress notes preceding or after the documentation on 3/27/2026 gave any indication R9 had been having difficulty, why an abdominal x-ray was ordered, or the results of the x-ray were found. Review of the Miscellaneous documents section of the Electronic Medical Record (EMR) did not reflect a recent HCP progress note that could account for the xray ordered or captured a HCP's visit with R9 on 3/26/2026. Review of Xray results reported on 3/30/26 indicated R9 did not have acute obstruction. The record indicated the indication for the x-ray was diarrhea. No further information related to R9's condition around this time was found in the EMR. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/01/2026 at 8:10 AM, the Director of Nursing (DON) reported that R9 will bring things up to the HCP sporadically without telling the nurse. The DON accessed a HCP progress note, dated 3/26/2026, from a system not accessible through the facility EMR. The DON reported R9 told the HCP she felt bloated, had large, hard bowel movements, and diarrhea. The DON said the HCP prescribed an anti-gas medication and abdominal x-ray for R9, despite a review of the EMR showing R9 did not meet criteria for the Bowel Protocol (a regimen implemented when a resident does not have a bowel movement for three days in a row). The DON said he would like to see the nurses document in the clinical record the reason why the resident was seen, as well as the outcome of the tests and medication change. The DON expected HCP progress notes to be accessed and attached to the resident's EMR withing 72 hours of being seen. The information you enter into a patient's individual medical record communicates within the patient's integrated health record the type and frequency of patient care delivered and provides accountability for the care you implemented. This information is then available for all members of the health care team in all settings to review. It is necessary to document all the nursing care you provide for each patient, including assessment data, nursing problems or diagnoses, interventions, and evaluation of patient responses, in the health record. Your data enable providers and outside reviewers of the medical record to track a patient's clinical course. [NAME], [NAME] A.; [NAME], [NAME] Griffin; Stockert, [NAME] A.; Hall, [NAME]. Fundamentals of Nursing - E-Book (p. 365). Elsevier Health Sciences. Kindle Edition. The health care record provides a way for members of the interprofessional health care team to communicate about multiple aspects of patient care, including patient needs and response to care and therapies; clinical decision making; and the content and outcomes of consultations, patient education, and discharge planning. Information communicated in the health care record allows health care providers to know a patient thoroughly, facilitating safe, effective, timely, and patient-centered clinical decision making. The health care record is the most current and accurate, continuous source of information about a patient's health care status, allowing the plan of care to be clear to anyone who accesses the record. To enhance communication and promote safe patient care, you document assessment findings and patient information as soon as possible after you provide care (e.g., immediately after providing a nursing intervention or completing a patient assessment). The quality of patient care depends on your ability to communicate with other members of the health care team (see Chapter 24). When a plan is not communicated to all members of the health care team, care becomes fragmented, tasks are repeated, and delays or omissions in care often occur. The health record is an important means of communication because it is a confidential, permanent, legal documentation of information relevant to a patient's health care. The record is an ongoing current and accurate account of a patient's health care status and is available to all members of the health care team. [NAME], [NAME] A.; [NAME], [NAME] Griffin; Stockert, [NAME] A.; Hall, [NAME]. Fundamentals of Nursing - E-Book (p. 366). Elsevier Health Sciences. Kindle Edition.