STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235612	A. Building B. Wing	12/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Freeman Nursing & Rehabilitation Community	1805 Pyle Drive Kingsford, MI 49802

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 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to recognize a change in condition for one Resident (Resident #2) of one resident reviewed for hospitalization. This deficient practice resulted in rehospitalization, insertion of an indwelling catheter, and intravenous diuretic therapy.(All times are recorded in Eastern Standard Time unless otherwise indicated.)Findings include:Resident #2 (R2)On 12/9/25 at 12:53 PM, an interview was conducted with R2 in their room while sitting in their recliner. R2 was asked if they had a recent hospitalization and replied, Yes, I needed diuretics because of having too much fluid on me. They even put a catheter in me because I was peeing so much. The food here is so salty. I asked not to have salt added to my tray and I will not eat gravy on my food because there is a lot of salt in gravy. I weigh myself every day at home and make sure I am not gaining too much weight because of my heart. R2's local hospital admission, dated 11/20/25, revealed in part, R2 was at the skilled nursing facility for rehab and presented to the emergency department on 11/20/25 with gradually worsening dyspnea (shortness of breath) for the past 1 to 3 weeks. R2's lab results revealed she was in fluid volume overload and was admitted to the local hospital for acute (rapid onset) respiratory failure secondary to exacerbation (worsening) acute congestive heart failure. R2 was placed on an intravenous diuretic (medication to help remove excess fluid from the body) drip, indwelling catheter, salt diet restrictions, fluid restrictions, and daily weights. R2 was discharged back to the skilled nursing facility on 11/25/25.Hospitalization records for R2 prior to her initial admission to the facility, dated 10/29/25, indicated she originally fell at her apartment and fractured her right femur. R2 had an emergency room base weight of 138.6 pounds with noted chronic congestive heart failure. There was a disposition note stating to anticipate discharge to skilled nursing facility tomorrow if bed is available. Follow-up with discharge planners. Plan: Orders - medications listed, heart healthy diet, and weight daily.On 12/10/25 at 10:30 AM, the Director of Nursing (DON) was asked for the original discharge paperwork from the hospital for R2 dated 10/30/25 and was not able to locate the discharge paperwork after looking in the electronic medical record and in R2's hard chart. Review of R2's facility documented weights revealed the following:a. 10/30/25 recorded as 139.2 pounds.b. 11/4/25 recorded as 141.0 pounds.c. 11/11/25 recorded as 148.0 pounds (a weight gain of 8.8 pounds since admission and gain of seven pounds in seven days).d. 11/13/25 recorded as 149.4 pounds.e. 11/14/25 recorded as 150.8 pounds.f. 11/15/25 recorded as 151.4 pounds (a weight gain of 12.2 pounds since admission).R2's progress note, dated 11/12/25 read in part .resident weight gain of 7 lbs. (pounds).Review of R2's progress note dated 11/13/25 read in part .Resident seems anxious regarding recent weight gain.3+ pitting edema (swelling from excess body fluid that leaves a temporary indentation [pit] when pressed) noted to BLE (bilateral lower extremities).SOB (shortness of breath) noted during conversation.Review of R2's lab for brain natriuretic peptide (BNP - a hormone released by the heart that helps diagnose heart failure when its levels rise due to heart working too hard) ordered on 11/13/25 and drawn on 11/18/25 disclosed a value of 32,600 pg/ml (picograms per milliliter - a unit of concentration used in medical tests). The BNP lab values normal range is less than 100 pg/ml, a very high range is considered to be greater than 900 pg/ml and is used to measure heart failure.R2's progress notes were reviewed between (continued on next page)

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

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F 0684 Level of Harm - Actual harm Residents Affected - Few	11/15/25 and 11/20/25 and unfolded the following events: a. 11/15/25 read in part .some SOB while speaking.b. 11/17/25 read in part .Resident does c/o (complain of) feeling SOB and will begin to breath (sic) rapidly at times.c. 11/19/25 read in part .Resident has been experiencing SOB especially with exertion.d. 11/20/25 read in part .There is +2 edema in bilateral lower legs.sent her out to the ER (emergency room).family transported her to ED (emergency department).R2's most current weight on 12/10/25 was recorded as 147.2 pounds and reflective of a weight gain of 8 pounds over her normal base weight. R2's weight was approaching around the same weight she was sent out to the ER on [DATE] which was 149.6 pounds.Review of R2's progress note, dated 12/2/25 read in part Resident and family pleasantly expressed concern about any sodium intake d/t (due to) her CHF (congestive heart failure). Stated that she is very sensitive to sodium.R2's progress note dated 12/3/25 read in part Spoke with res. (resident) and her son today regarding her diet. Res. and family had concerns regarding her diet and our menu with sodium content. Res. has hx (history) of heart failure, HTN (hypertension) in the past. Res. use to following a very strict sodium restriction of her own at home and was concerned about her sodium intake here.Res. prefers to not have bacon, sausage, and ham when served . Review of R2's care plan, dated 10/30/25 declared a problem in part .Resident is at risk for complications related to diagnosis of hypertension, congestive heart failure. Goal: Resident's blood pressure will remain within normal limits and will be free of fluid and electrolyte imbalance this quarter. R2's care plan lacked any interventions to monitor for fluid volume overload such as daily weights or assessing for edema. Review of R2's face sheet revealed an admission to the facility on [DATE] with diagnoses including congestive heart failure, acute respiratory failure, and fracture of the right femur. Review of R2's admission minimum data set (MDS) assessment dated [DATE] revealed R2's brief interview for mental status (BIMS) reported intact cognition. Review of R2's facility census data unveiled an original admission to the facility on [DATE] and a discharge on [DATE] and a readmission on [DATE] back to the facility. On 12/10/2025 at 2:30 PM, the DON was asked to review weights for R2 since she was admitted , sent out to the hospital on [DATE], and her current weight gain following readmission to the facility. The DON stated, I can see where she has consistently gained weight. The DON was asked why R2 was not on daily weights at the time she was admitted like the hospital discharge paperwork indicated and replied, I don't know. The DON was asked what kinds of interventions were put in place to manage R2's CHF before she was sent to the local hospital for fluid volume overload and replied, I guess we should have been weighing her daily. I should have done a better job managing her.On 12/10/25 at 2:40 PM, an interview and observation were conducted with R2 in her room. R2 was observed to have 2+ pitting edema in her bilateral lower extremities and elevating her legs in her recliner. R2 voiced concerns about her weight gain. R2 was asked if the nurses listen to her lungs and assess her edema daily and replied, No, not consistently every day.Review of policy titled, Notification of Change, dated 01/2025, read in part, Introduction: The Residents physician and responsible party must be notified when an event involving the resident occurs or when the resident experiences a change in condition, potential discharge, room transfer or death.Outcome Evaluation: Monitor and reassess the residents status and response to interventions. The physician should develop a working diagnosis and guide nursing staff in what to look for, what to monitor, and when to re-contact the physician if the resident progress deviates from the anticipated or expected course.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. All times are Eastern Daylight Savings Time (EDST) unless otherwise noted.Based on observation, interview, and record review, the facility failed to perform hand hygiene during delivery of food which has the potential to result in the spread of illness and cross contamination among any or all 34 residents in the facility who receive meals.Findings include:During an observation on 12/10/25 at 9:06 a.m., Certified Nursing Assistant (CNA) A retrieved a tray from the food cart and delivered the tray of food to a resident in the dining room. CNA A then walked to the food cart and delivered another tray of food to a resident. CNA A continued to deliver two more trays of food to residents in the dining room and failed to use Alcohol Based Hand Rub (ABHR) [hand sanitizer] or wash her hands between meal tray delivery in the dining room.During an observation on 12/11/25 at 1:06 p.m., CNA A delivered a tray of food to a resident in the dining room and then used the resident's silverware to but up the baked potato. CNA A walked to the food cart and obtained another tray of food to a resident and used the resident's silverware to cut up the baked potato. CNA A walked to the beverage cart and obtained a drink for a resident. CNA A walked to the food cart and retrieved another tray of food and grabbed the handles of a wheelchair and moved another resident in the dining room. CNA A continued to deliver two more trays of food to the residents in the dining room. CNA A grabbed the handles of a wheelchair and moved another resident in the dining room. CNA A sat down next to a resident and started to feed the resident. CNA A did not use ABHR between delivery of food trays to the residents, after touching multiple wheelchairs in the dining room, or prior to assisting a resident with a meal.Facility policy titled Resident Dining Services last revised 4/21, read in part .Associates involved in dining services will wash their hands prior to distributing trays to the residents and when serving food to residents.Facility policy titled Hand Washing/Hand Hygiene last reviewed 1/25, read in part .Practicing hand hygiene is a simple effective way to prevent infections by preventing the spread of germs.During an interview on 12/11/25 at approximately 8:45 a.m., the Nursing Home Administrator (NHA) acknowledged the CNA did not perform hand hygiene during meal delivery in the dining room.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure advance directives were reviewed in a timely manner for one Resident (#4) and failed to ensure the documentation of advance directives upon admission for one Resident (#33) of 16 residents reviewed. Findings include:All times recorded in Easter Savings Time (EST), unless otherwise noted. Resident #4 (R4) Review of the electronic medical record (EMR) on 12/9/2025 at 2:30 p.m., revealed R4 was designated as DNR (Do Not Resuscitate). Review of the Medical Treatment Decisions of Resident, signed and dated by R4 on 8/15/2024 revealed the following: I have been informed in writing, in language that I understand, of my rights and all rules and regulations to make decisions concerning medical care, include the right to accept or refuse treatment and the right to formulate and to issue Advanced Directives to be followed if i become incapacitated. In the absence of an advance directive, I understand that any and all life sustaining measures may be used. I may revoke any and all decisions at any time. The section of the form marked for Quarterly Review, held no documentation that care/advance directive had been reviewed with R4 or the resident representative, since originally signed on 8/15/2024. Resident #33 (R33) Review of the EMR on 12/9/2025 at 2:35 p.m., revealed R33 was designated as DNR. No signed document indicating R33 was informed of their right to formulate care/advance directives or designating wishes in the event R33 became incapacitated. The EMR indicated R33 was admitted to the facility on [DATE]. During an interview on 12/10/2025 at 9:25 a.m., the Social Services Designee, Staff B, reported she did not track the review of resident care/advanced directives. Staff B reported the responsibility for ensuring the resident care choices were reviewed fell upon nursing staff. On 12/10/2025 at 9:31 a.m., the Director of Nursing (DON) reported she would search the EMR for review dates and/or updated care/advance directives for R4 and R33. At 10:02 a.m., the DON reported she was unable to locate current documentation indicating R4 and R33's care directives were reviewed. The DON was queried as to the process for ensuring completion and timely review of resident's care directives to which she reported the process was under review. Review of the facility policy titled, Advance Directives, reviewed 1/2025, revealed the following: Upon admission the admission Director or designee will off the advanced directive form to the resident and/or the resident surrogate and request that the form be completed . The facility's Social Service Director will periodically discuss advance directives with the resident and/or the resident's surrogate upon a change in condition. During cardiac or respiratory arrest, the staff will reference and follow the resident's advance directive wishes as indicated on the advance directive form. Facility resident's advanced directives will be assessable for review .