STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235628	A. Building B. Wing	01/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Jamieson Nursing Home	790 S U.S. Highway 23, Box 369 Harrisville, MI 48740

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 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on interview and record review, the facility failed to ensure a Registered Nurse (RN) was on duty for eight consecutive hours a day, seven days a week potentially affecting all 21 residents residing in the facility. Findings include:A review of the Centers for Medicare & Medicaid Services (CMS) PBJ (Payroll Based Journal) Staffing Data Report for the 4th quarter of 2025 (July 1 to September 30) revealed the facility triggered for no RN staffing.A review of requested Daily Staffing Sheets from the 4th quarter of 2025 revealed the following dates without RN staffed: 7/4/2025, 7/12/2025, 8/10/2025, 9/1/2025On 1/7/26 at 11:00 AM, Nursing Home Administrator (NHA) was interviewed regarding RN coverage and explained on 7/4/2025 and 7/12/2025, the Director of Nursing (DON) was working the morning shift, however, is salary and does not punch in. The NHA went on to explain that on 8/10/2025 and 9/1/2025 the DON scheduled two Licensed Practical Nurses (LPNs) to work both the morning and night shift and confirmed there was no RN coverage those days.Review of the facilities' ?punch cards' confirmed on 7/4/2025, 7/12/2025, 8/10/2025, and 9/1/2025 there was no RN coverage documented.

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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide appropriate assessments and documentation warranting the use of a physical restraint for four Resident (R #5, R #11, R #18, R #20) of twelve residents reviewed for restraints, resulting in the potential for feelings of helplessness, agitation, decreased physical functioning and injury. Findings include: R #5 (R5) Review of R5's face sheet, dated 7/24/25, revealed admission to the facility on 6/4/25 with diagnoses including weakness and dementia. Review of R5's minimum data set (MDS) assessment, dated 10/2/25, Section GG revealed R5 required partial/moderate assist for toileting hygiene, shower/bathing, upper body dressing, lower body dressing, and putting on/taking off footwear. R5's Brief Interview for Mental Status (BIMS) score was 3/15 indicating severe cognitive impairment. On 1/5/26 at 2:11 p.m., R5's bed was observed against the wall in their room, limiting access in or out on one side, and a bed alarm place. On 1/7/26 at 9:18 a.m., R5 was observed sitting in their recliner chair in their room with a padded alarm underneath them, on and functioning. R5's bed was against the wall. An attempted interview was conducted with R5 who was unable to answer questions appropriately. Review of R5's medical record revealed no consents or physician orders for the use of alarms or to have R5's bed against the wall. R #11 (R11) Review of R11's face sheet, dated 10/21/25, revealed admission to the facility on [DATE] with diagnoses including hemiplegia. Review of R11's MDS assessment dated , 10/29/25, Section GG revealed R11 required substantial/maximal assistance for toileting hygiene, shower/bathing, upper body dressing, and lower body dressing, and putting on/taking off footwear. R11's BIMS score was 1/15 indicating severe cognitive impairment. On 1/5/26 at 2:36 p.m., R11 was observed with a lap buddy in place while sitting in their wheelchair. The room of R11 was observed with the bed was against the wall and a bed alarm was in place and functioning. On 1/7/26 at 10:06 a.m., R11 was observed sleeping in their bed. The bed was against the wall, with a bed alarm was in place and functioning. R11 had a bed bolster restricting movement from the side of the bed not pushed against the wall and a fall mat was noted on the floor. Review of R11's medical record revealed no consents or physician orders for the use of alarms, bolsters, fall mats, or to have R11's bed against the wall. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R #20 (R20) Review of R20's face sheet, dated 10/15/25, revealed admission to the facility on 9/23/24 with diagnoses including dementia and anxiety. Review of R20's MDS assessment, dated 10/15/25, Section GG revealed R20 required substantial/maximal assistance for toileting hygiene, shower/bathing, upper body dressing, and lower body dressing, and putting on/taking off footwear. R20's BIMS score was 3/15 indicating severe cognitive impairment. On 1/7/26 at 9:17 a.m., R20 was observed sitting in her wheelchair in her room. There was a padded alarm located on the back of her wheelchair. An interview was attempted with R20, who was unable to answer questions appropriately. R20's bed was observed against the wall. Review of R20's medical record revealed no consent or physician orders for the use of alarms or to have R20's bed against the wall. Resident #18 (R18) Review of R18's face sheet, dated 9/18/25, revealed admission to the facility on 8/6/25 with diagnoses including multiple myeloma (blood cancer), anemia, hyperlipidemia, and hyperlipidemia. Review of R18's quarterly (MDS) assessment, dated 12/28/25, revealed Section GG of the MDS assessment revealed R18 was partial/moderate assistance on staff for activities of daily living cares including toileting, shower/bathing, upper/lower body dressing, and putting on/taking off footwear. R18's (BIMS) revealed moderate cognitive impairment. On 1/5/26 at 11:41 AM, an observation was made of R18 in their room and lying in bed. R18 was observed to have the right side of their bed pushed up against the wall and a soft wedge on the left side of their bed. R18 also had a bed alarm underneath them. R18 was asked about the bed alarm and wedge and replied, So I don't get up and fall out of bed. On 1/5/26 at 11:45 AM, an interview was conducted with Registered Nurse (RN) C, who was asked if R18 had a consent on file for the bed alarm and replied, I would have to look. On 1/6/26 at 12:40 PM, an observation was made of R18 in the main dining room sitting at a table in their wheelchair with a bed alarm clipped on the back of their shirt. Review of R18's medical records unveiled the lack of a consent for the bed/positioning alarm. On 1/7/26 at 11:35 AM, an observation was made of R18 sitting in a recliner in their room with the bed alarm on them. Review of R18's care plan, dated 8/6/25, read in part, .Focus: (R18's name) is a risk for falls r/t (related to) deconditioning, gait/balance problems.Interventions: Anticipate and meet (R18's name) needs. (R18's name) has bed alarm at night. On 1/7/26 at 9:44 AM, the Director of Nursing (DON) was asked about consents for bed alarms and replied, We don't do consents for the alarms. The DON confirmed that there is no consent on file for (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	bed alarms and beds against the wall have no care plan or reassessed during quarterly assessments. Review of policy, titled Restraint, dated 10/20/17, read in part, .is a restraint free facility. If a restraint is needed for safety of a resident a doctors written order is required with justification for the restraint. Review of policy, titled Bed Rail Restraint, dated 2016, read in part, .is a restraint free facility. If a bed rail is needed for safety, a doctors written order is required with justification for the restraint. And must be approved by family before restraint is applied.

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on observation, interview, and record review the facility failed to implement interventions, assess accurately, and prevent the development of a stage II pressure ulcer for one Resident (Resident #2) of two residents reviewed for pressure ulcer development. Findings include:Resident #2 (R2) R2's face sheet revealed admission to the facility on 7/1/25, with diagnoses including dementia, insomnia, hyperlipidemia, and hypertension.Review of R2's comprehensive minimum data set (MDS) assessment, dated 7/23/25, Section GG revealed R2 required substantial/maximal assistance on staff for activities of daily living cares including toileting, shower/bathing, upper/lower body dressing, personal hygiene, and putting on/taking off footwear. R2's brief interview of mental status (BIMS) revealed severe cognitive impairment. Section M revealed R2 had no pressure ulcers, was at risk for developing pressure ulcers, and lacked any skin treatments or interventions. Review of R2's quarterly MDS assessment, dated 10/15/25, Section M revealed R2 had developed a stage II pressure ulcer.On 1/5/26 at 12:00 PM, an observation was made of R2 resting in their room in a reclining chair with feet elevated, wearing heel protector boots, and their left foot drawn up adding pressure to the heel. R2's room was observed with a regular mattress and not an air mattress and no heels up pad was observed. R2's pressure ulcer risk assessment, dated 9/13/25 (completed 74 days after admission) revealed a score of 14. According to the assessment, a score of eight and above is considered to be HIGH risk for developing pressure ulcers. R2's care plan, dated 10/15/25, read in part .Focus: (R2's name) has an ulcer of the L (left) heel r/t (related to) limited joint mobility.Interventions: Inspect the feet daily. Report changes to the nurse, dressing change done twice daily. R2's physician orders, unveiled the following:On 9/15/25 - wound wash to left heel, cover with bandage, and complete twice daily.On 10/1/25 - wound wash to left heel, cover with bandage, and complete twice daily.On 10/21/25 - cadexomer iodine gel (treatment used for infected or exudating wounds to heal or debride) apply topically to dc (discontinue) skin wound bed and complete twice daily. Reposition every two hours in bed and use pillows.On 10/28/25 - doxycycline (antibiotic) 100 milligrams (mg) twice daily for ten days.On 11/25/25 - wound wash to left heel, apply bandage, and complete twice daily.On 12/1/25 - wound wash to left heel, apply iodine, apply bandage, and complete twice daily. R2's treatment administration record (TAR), unfolded the following:September 2025 TAR- 12 opportunities out of 30 where treatment was not signed out by nursing.October 2025 TAR- 23 out of 62 where treatment was not signed out by nursing.November 2025 TAR- 14 out of 60 where treatment was not signed out by nursing. R2's skin audit tools, dated 8/30/25 through 1/3/26, revealed the following:On 8/30/25 - development of a blister on the left heel.On 9/20/25 - left heel necrosis (tissue death) / ulcer.On 11/11/25 and 11/18/25 - left heel drainage. R2's skin audit tools, dated 8/30/25 through 1/3/26, lacked any pressure ulcer assessments for size, drainage, color, pain, odor, or wound staging. On 1/7/26 at 11:45 AM, an observation was made of R2's wound dressing change with Registered Nurse (RN) C, who was asked when R2 developed the pressure ulcer and replied, A couple months ago. RN C was asked how R2 developed the pressure ulcer and replied, I think they got it from the wheelchair foot pedal or rubbing their heel on the bed. RN C was asked about interventions prior to the development of R2's pressure ulcer was and replied, Float heels. RN C stated that the boots came after the blister developed. The pressure ulcer opened had to be debrided and then R2 was put on antibiotics related to poor healing and developing cellulitis. During R2's pressure ulcer dressing change no measurements were taken. R2's pressure ulcer had some mild serous (clear, thin, and watery) drainage and was in an oblong moon shape (lateral to medial of the heel) on the back of their left heel. R2 had another open area on the lateral side of their left foot that appeared pink. RN C was asked how R2 developed the open area and replied, It looks like a skin tear from tape. R2 also had a q-tip size dark purple area on the ball of their left pinky to pad. On 1/7/26 at 12:15 PM, an interview was conducted with the Director of Nursing (DON), who was asked how R2 developed the pressure ulcer on their left heel and replied, They are constantly moving their feet (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	around, rubbing on the bed, and pounding them on the floor. The DON was asked why pressure ulcer interventions were not placed sooner for R2 and declined to answer. Review of policy titled, Prevention of Pressure Ulcers, dated 3/2005, read in part, Purpose: The purpose of this procedure is to provide information regarding identification of pressure ulcer risk factors and interventions for specific risk factors.General Guidelines.6. The facility should have a system/procedure to assure assessments are timely and appropriate and changes in condition are recognized, evaluated, reported to the practitioner, physician, and family, and addressed.General Preventative Measures.3. For a person in a chair. a. Change position at least every hour.Interventions and Preventative Measures: Residents with Risk Factors.Use a special mattress that contains foam, air, gel, or water.Consider off-loading pressure hourly. Review of policy titled, Pressure Ulcer Treatment, dated 12/2007, read in part, Purpose: The purpose of this procedure is to provide guidelines for the care of existing pressure ulcers and the prevention of additional pressure ulcers.Documentation: The following information should be recorded in the resident's medical record.6. All assessment data (i.e., color, size, pain, drainage, ect.) when inspecting the wound. 7. Resident tolerance of the procedure.9. Resident refusal of the treatment.