STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235641	A. Building B. Wing	08/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chesaning Nursing and Rehabilitation Center	201 South Front Street Chesaning, MI 48616

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 0675 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor each resident's preferences, choices, values and beliefs. (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 0675 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake Numbers: 2590687, 2577760, and 2581464. Based on observation, interview and record review, the facility failed to prevent a decline in the quality of life for one resident (Resident #101) of 6 residents reviewed, resulting in Resident #101 having a change in demeanor of a decrease in activity with an increase in depression of tearfulness. Findings include: Record review of Resident #101's Minimum Data Set (MDS) dated [DATE] quarterly assessment revealed an elderly male resident with medical diagnoses of: Heart failure, Diabetes, anxiety, depression and respiratory failure. Record review of Resident #101's physician orders for the month of August 2025 revealed medications of Abilify (antipsychotic), Lexapro (antidepressant), daily for mood and mental stability. Observation and interview were conducted on 8/19/2025 at 9:55AM with Resident #101 seated up in Wheelchair in the dining room, drinking coffee with other residents. He is interacting with staff members and enjoying himself. The interview revealed that he is just friends with staff nurses and nothing more. But did not want to talk about it. stating It's ridiculous we just joke around and try to have some fun here. I don't have a problem with living here; this is a quiet place. Facility reported incident and hotline complaints received to the state agency identified concerns of a resident and staff inappropriate relations. Investigation of the alleged incident identified that Resident #101 was spoken to by management staff about the relationship with talking to staff members regularly on 08/01/2025. Record review of the investigative file revealed that a signed 3101 form dated 8/1/2025 revealed: Resident #101 was taken into the conference room to have a private area to discuss the details of an allegation by staff that he is having an inappropriate relationship with a unit manager. Resident #101 was questioned to the nature of the relationship he stated, We are just friends, she's a good lady. Resident #101 was asked about a romantic relationship. Resident #101 stated No. They had never kissed, and they were just joking around stating they were getting married. Resident #101 was explained not to go and sit in front of the office door of the unit manager so the manager can complete her work. Record review of Resident #101's nursing progress notes dated 7/29/2025 at 6:40PM of Nurse Practitioner noted no mention of depression or that the resident was having a mood change. Record review of Resident #101's late entry physician progress note, not dated 7/31/2025 at 8:47PM noted that Resident #101's chart was reviewed and patient examined, further note to follow. Hemodynamically and clinically stable, some intermittent mild depressive symptoms, will follow with social worker, psychiatry, and staff for further symptoms. Record review of Resident #101's nursing progress notes late entry on 8/1/2025 at 9:30 AM revealed: Allegation of resident abuse by staff regarding resident's inappropriate relationship with unit manager. Investigation initiated. Record review of Resident #101's 8/1/2025 at 3:30PM nursing progress note revealed: (physician) saw resident and ordered abdominal Xray due to resident complaint of discomfort to area, no report of discomfort to this write. Appetite remains good. Resting quietly in bed at the time. Record review of Resident #101's 8/1/2025 at 5:50PM nursing progress note revealed: Resident has been lying in bed since 2:30PM. He refused his 4pm med stating he doesn't care about it and refuses to get up out of bed. Refused dinner as well. Denies pain and will continue to monitor. Record review of resident #101's 8/1/2025 at 8:28 PM nursing progress note revealed: Resident has been tearful and lying in bed since 2:30PM. He refused all nighttime medications times 3. He stated he did not care. He refused dinner as well. Record review of Resident #101's 8/1/2025 Medication Administration Record (MAR) noted Ativan 1mg Intramuscular injection (IM) one time daily for 1 day. Ativan medication was administered at 8:21PM by the Nursing Home Administrator/Director of Nursing. In an interview on 8/20/2025 at 11:35 AM, the Nursing Home Administrator/Director of Nursing about the Ativan IM injection stated that Resident #101 was just upset that he was going to get a staff member fired, and he did not like the other staff talking about it. He couldn't sleep at night, and I called (physician) and got the Ativan order for IM injection and gave it myself. Record review of Resident #101's Nurse Practitioner's note dated 8/4/2025 revealed investigation initiated 8/1/2025 for allegation of patient abuse by staff regarding patient's inappropriate relationship with a staff member. The nurse spoke with patient on 8/4/2025 in regard to the incident on 8/1/2025. He stared he was not happy staff reported this and stated he wants to get out of here as soon as possible. Patient currently working for community placement. Patient has been tearful related to incident, refusing showers, meds, and to get out of bed .Record review of the facility 'Promoting/Maintaining Resident Dignity' policy, undated, revealed it is the practice of the facility to protect and promote resident rights and treat each resident with respect and dignity as well as care for each

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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** This citation pertains to Intake Numbers 2590687, 2577760, and 2581464. Based on observation, interview and record review, the facility failed to get a signed informed consent for anti-anxiety medication prior to administering it for one resident (R101), resulting in Resident #101 receiving the medication with no written or verbal consent. Findings include: Record review of Resident #101's Minimum Data Set (MDS) dated [DATE] quarterly assessment revealed an elderly male resident with medical diagnosis of: Heart failure, Diabetes, anxiety, depression and respiratory failure. Record review of Resident #101's physician orders for the month of August 2025 revealed medications of Abilify (antipsychotic), Lexapro (antidepressant), daily for mood and mental stability. Observations and an interview were conducted on 8/19/2025 at 9:55AM with Resident #101, who was seated up in Wheelchair in the dining room, drinking coffee with other residents. He is interacting with staff members and enjoying himself. The interview revealed that he is just friends with staff nurse and nothing more. But does not want to talk about it. Stating It's ridiculous we just joke around and try to have some fun here. I don't have a problem with living here. I lived in Oscoda, and this is a quiet place. Facility reported incident and hotline complaints received by the state agency identified concerns of a resident and staff inappropriate relations. Investigation of the alleged incident identified that Resident #101 was spoken to by management staff about the relationship with talking to staff member regularly on 8/1/2025. Record review of the investigative file revealed that a signed by resident #101 form dated 8/1/2025 revealed: Resident #101 was taken into the conference room to have a private area to discuss the details of an allegation by staff that he is having an inappropriate relationship with a unit manager. Resident #101 was questioned of the nature of the relationship he stated, We are just friends, she's a good lady. Resident #101 was asked about a romantic relationship. Resident #101 stated No. they had never kissed and that they were just joking around with stating they were getting married. Resident #101 was explained not to go and sit in front of the office door of the unit manager so the manager can complete her work. Record review of Resident #101's nursing progress notes dated 7/29/2025 at 6:40PM of Nurse Practitioner noted no mention of depression or that the resident was having a mood change. Record review of Resident #101's late entry physician progress not dated 7/31/2025 at 8:47PM noted that Resident #101's chart was reviewed and patient examined, further note to follow. Hemodynamically and clinically stable, some intermittent mild depressive symptoms, will follow with social worker, psychiatry, and staff for further symptoms. Record review of Resident #101's nursing progress notes late entry on 8/1/2025 at 9:30AM revealed: Allegation of resident abuse by staff regarding resident's inappropriate relationship with unit manager. Investigation initiated. Record review of Resident #101's 8/1/2025 at 3:30PM nursing progress note revealed: (physician) saw resident and ordered abdominal Xray due to resident complaint of discomfort to area, no report of discomfort to this writer. Appetite remains good. Resting quietly in bed at the time. Record review of Resident #101's 8/1/2025 at 5:50PM nursing progress note revealed: Resident has been lying in bed since 2:30PM. He refused his 4pm med stating he doesn't care about it and refuses to get up out of bed. Refused dinner as well. Denies pain and will continue to monitor. Record review of resident #101's 8/1/2025 at 8:28 PM nursing progress note revealed: Resident has been tearful and lying in bed since 2:30PM. He refused all nighttime medications times 3. He stated he did not care. He refused dinner as well. Record review of Resident #101's 8/1/2025 Medication Administration Record (MAR) noted Ativan 1mg Intramuscular injection (IM) one time daily for 1 day. Ativan medication was administered at 8:21PM by the Nursing Home Administrator/Director of Nursing. In an interview on 8/20/2025 at 11:35 AM, the Nursing Home Administrator/Director of Nursing about the Ativan IM injection stated that Resident #101 was just upset that he was going to get Staff member fired, and he did not like the other staff talking about it. He couldn't sleep at night, and I called (physician) and got the Ativan order for IM injection and gave it myself. Record review of facility 'Use of Psychotropic Medications' policy undated, revealed it is the intent of the policy to ensure that residents only receive psychotropic medications when other nonpharmacological interventions are clinically contraindicated. Additionally, these medications should only be used to treat the resident's medical symptoms . (1.) A psychotropic drug is any drug that affects brain activities associated with mental process and behavior. Psychotropic drugs include but are not limited to the following categories: Antipsychotics, antidepressants, anti-anxiety, and hypnotics. (3.) Other medications not classified as antipsychotic, antidepressant, antianxiety, or hypnotic medications but can affect brain activity should not be used as a substitution for

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake Number 2585037.Based on observation, interview and record review, the facility failed to ensure a clean, safe, and homelike environment involving the Therapy room and 5 residents' rooms (Rooms 2, 3, 4, 14, and 19) of 20 rooms in total, resulting in the protentional for injury (therapy equipment stored in the therapy area, increases risk of tripping and falling), resident and family complaint's regarding the environment, anger, dissatisfaction and depression.Findings Include: Self-tour of facility on 8/19/2025 at 9:30AM noted Strong urine odors in the back hall noted coming from room [ROOM NUMBER]. Noted 2 male residents to reside in room, Resident #106 the bed by the window was noted with urinal on nightstand with yellow urine noted with no top on it, half full, next to white Styrofoam drinking glass with a straw. Observations on 8/19/2025 throughout the day of the survey, the urinal was noted to be left on the nightstand not emptied and next to the Styrofoam drinking glass. Observation and smells on 8/20/2025 at 8:08AM during a self-tour of the back hall, noted odors of the urine smell and body odors. Observation and smell on 8/20/2025 at 8:55AM of the back hallway on the north side of the building tour noted room [ROOM NUMBER] with smells of body odor coming from room. Observed a large male resident lying in bed. Observation of room [ROOM NUMBER] was noted with Kleenex and paper items on the floor on top of fall matt. Observation on 8/20/2025 at 9:00AM as surveyor walked down hallway strong odors of urine noted in room [ROOM NUMBER]. Resident #106 male residents with urinal half full noted at bedside nightstand with urine waiting to be dumped. Observation and interview on 8/20/2025 at 10:00AM with Certified Nurse Assistant (CNA) L on tour of room [ROOM NUMBER] strong smell of urine noted in hallway. CNA L stated that it is an ongoing issue with the room. Observation of room double occupancy Resident #101 next to the door and Resident #106 bed next to window. Observed Resident #106 seated up in a soft cloth Recliner in room with nightstand and 2 Styrofoam cups with straws and the surveyor Noted a half full urinal of urine with no lid noted at table side. Toured bathroom and room, sink in resident room area. Resident #106 was seated up in recliner and stated that he likes his room. Resident #106 requested more ice for his cup and CNA L took the cup from the nightstand and did not offer or empty the urinal next to the cups. Resident #101 was lying in bed stated having a lazy day. Observed that each male resident has a clothe soft recliner noted at bedside with urine odors smelled. Observation on 8/20/25 at 12:07PM the state surveyor observed a half-filled urinal in room [ROOM NUMBER], right next to Styrofoam glasses on nightstand, still not dumped. Strong odors noted in room. Recliner chair of resident #106 with strong urine smell noted. Both Residents were observed eating the noon meal chicken parmesan in the main dining room. Observation of the facility environment was done on 8/19/25 from 10:00 a.m. through 11:00 a.m.; the following concerns were noted: (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	room [ROOM NUMBER]: No towels in the room by sink. room [ROOM NUMBER]: The trash container was full under sink and a wet washcloth was sitting in pink basin on the floor under the sink. room [ROOM NUMBER]: The room was very cluttered. A urinal was sitting on the sink with no name or bed number. Clothing was being stored on the floor stored under the sink. room [ROOM NUMBER]: A large black fan was blowing on bed 1; dust was noted on the cover, which was blowing directly on the resident in bed. room [ROOM NUMBER]-1: At 11:30 a.m., resident in bed, urinal had urine in it, and it was sitting on the floor. The resident’s breakfast tray was sitting on the bedside table, not touched at all. On the second observation done on 8/19/25 at 12:00 p.m., breakfast tray (with eggs, cheese, bread, oatmeal and 2 sausage links) was not touched and still sitting on tray next to bed (potentially hazardous foods sitting out approximately 4 hours). 2 urinal’s were sitting on the floor next to the bed, with one about 1/4 full of urine. Also, observation of the resident’s wheelchair that was sitting in the hallway, had the oxygen tubing and nasal cannula sitting on the seat, not in a bag for protection; the tubing has a piece of paper on it dated 8/9 (should have been changed on 8/16/25 per oxygen policy dated 11/12/25, weekly). During an interview done on 8/19/25 at 3:00 p.m., the Administrator stated, “We change the oxygen tubing every Sunday.” Observation of the therapy room was done on 8/19/25 at 11:00 a.m.; accompanied by OT “I and the following concerns were noted: Approximately half of the therapy room was being used for the storage of therapy equipment. -x8 wheelchairs -x3 wheeled walkers -x9 to x10 walkers, 1 lift, several [NAME] -several wheelchair foot rests in a large box -x1red power scooter -x1 box of wheelchair cushions The parallel bars have several wheelchairs and walkers in the middle of it; staff had to stop therapy and move the items and then when therapy was completed, move the wheelchairs and walkers back. During a second observation done on 8/20/25 at approximately 9:00 a.m., the therapy room had, x4 wheelchairs, a stand-up lift, a wheeled walker, a red power scooter, a ceiling vent by the air conditioner that had rust on it, and a air conditioning unit that was humming and did not work. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview done on 8/19/25 at 11:00 a.m., OT I stated I just started last week, if I want to use the plinth (bed for resident therapy use) is completely covered with equipment, papers, lefts, and parts of therapy equipment. I have to clean it off, wipe it down, and then use it. I had to move the chairs around when I had to use the parallel bars (has several wheelchairs stored by it and on side of it). During an interview done on 8/19/25 at 12:20pm, CNA “K stated I told them (management) about that (unclean environment), but no one did anything until today; they made me help them put the equipment not being used in the basement. During an interview done on 8/20/25 at 9:00 a.m., PT “O stated “There is to much equipment in the room, the air conditioner does not work it needs Freon; I have to move everything to do therapy and then put it back after.” During an interview done on 8/20/25 at 8:50 a.m., the Infection Control Nurse, LPN “C stated “I do rounds and I get things addressed then, right away; I do not go in therapy.” During an interview done on 8/19/25 at 10:56 a.m., Social Worker “G stated I do gets complaints on this building being dirty about 3 times a week, mainly odors. Our new OT has addressed that room being cluttered, and she can't get to the equipment she needs (parallel bars) to do certain therapy with resident's. Review of the facility Interdepartmental Infection Control Rounds sheets dated 5/25, 6/25, and 7/25, revealed surveillance rounds had been done in resident’s rooms monthly. During an interview done on 8/20/25 at 10:00 a.m., Director of Maintenance “P stated “yes the air conditioner is broken; I have had trouble getting people in here to fix it; it needs freon. I did tell them about the therapy room the day before you came in (on 8/18/25) at the morning meeting.” Review of morning meeting notes dated 8/18/25, written by the Administrator stated “W/C (wheelchair) storage basement.” During an interview done on 8/19/25 at 11:20 a.m., the Administrator stated We talked about the storage yesterday for therapy, (Director of Maintenance #P) said he was going to put it downstairs in the basement. It's not acceptable to me, I have seen it once when I walked around there about 2 months ago. Urinals, they should have names on); if not in use I would put it in a plastic bag. Oxygen nasal cannulas are stored when not in use in bags, tubing is changed every Sunday. During an interview done on 8/20/25 at 8:36 a.m., the Administrator said she was also Director of Nursing and Supervisor of Housekeeping. When this surveyor asked when the housekeepers come in and start work daily she stated “They come in at 7:00 a.m., they can get started on the rooms and the hallways while the resident’s are eating; I am supposed to be checking the room’s, we don’t have a list for a housekeeping supervisor (to fill out for resident room checks).” (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview done on 8/19/25 at 10:56 a.m., Social Worker “G stated I do gets complaints on this building being dirty about 3 times a week, mainly odors. Our new OT has addressed that room being cluttered, and she can't get to the equipment she needs (parallel bars) to do certain therapy with resident's. During an interview and observation done on 8/19/25 at 11:58 a.m., in the hallway near the smoking door, room [ROOM NUMBER]-1 was seen wheeling his wheelchair from the exit door (smoking door) to the hallway with his urinary catheter bag and tubing uncovered (not in a privacy bag) and dragging on the floor. The catheter bag was wet from being outside dragging on the ground and got the floor wet, also it was not in the privacy bag that was hanging on his wheelchair. During an interview done on 8/19/25 at 11:58 a.m., Nursing Assistant/CNA J stated “yes, I see it (the catheter dragging on the floor), he just came in from outside, it should not be on the floor.” During a phone interview done on 8/19/25 at 11:14 a.m., Family Member #1 stated My dad said the Therapy room is dirty and smells, he said it was disgusting. The halls smell and the place is dirty.