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	12/12/2025

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to maintain best practices in the food service area, resulting in the potential to spread food borne illness to all residents who consume food from the kitchen. Findings include:On 12/09/2025 at approximately 11:30 AM during lunch observation with the Certified Dietary Manager E, the rag sanitizer bucket solution was tested with Hydrion QT-40 test strips, and the result was zero. On 12/09/2025 at approximately 11:30 AM during lunch observation with the CDM E, when interviewed on the chemical solution of the rag sanitizer bucket, the CDM E stated that the bucket needed to be changed out, and it is changed when it's visibly soiled or every 2 hours. When asked what the range the chemical solution should be, the CDM E stated it should be 200ppm. According to the 2022 Food Code, 3-304.14 Wiping Cloths, Use Limitation, Cloths in-use for wiping counters and other equipment surfaces shall be .Held between uses in a chemical sanitizer solution at a concentration specified under S 4-501.114 and The sanitizing solution must be changed as needed to minimize the accumulation of organic material and sustain proper concentration. Proper sanitizer concentration should be ensured by checking the solution periodically with an appropriate chemical test kit.

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to 1). have an active and ongoing plan for reducing the risk of legionella and other opportunistic pathogens of premise plumbing (OPPP), 2). ensure 2 of 2 residents' (Resident's #3 and #35) meet the facility criteria for infections, and 3) do infection control environmental rounds of the main dining room, resulting in the potential for increased risk of respiratory infection among all residents in the facility, an increased unnecessary use of antibiotic therapy, and an unsafe dining room environment. Findings include:Resident #3: Review of the Face Sheet, Minimum Data Set (MDS dated 1/25), care plans (dated 9/23/25), and progress notes (dated 9/25), revealed Resident #3 was 67 years-old, admitted to the facility on [DATE], alert and able to make healthcare decisions. The residents' diagnosis included, diabetes, unsteadiness, weakness, and methicillin resistant staphylococcus aureus infection/MRSA (resistant to most antibiotics wound infection). Review of Resident #3's MRSA care plan (dated 9/23/25), stated Give medications as ordered and monitor/document for effectiveness, side effects. Review of the residents' Nurse Practitioner/NP L's order (dated 11/10/25), stated Bactrim (antibiotic) Oral Tablet 800-160 MG, give 1 tablet by mouth two times a day for wound infection for 10 days. Review of the facility infection time line for November, 2025, revealed Resident #3 had documentation that the residents' infection did not meet the McGeer infection criteria, yet was still ordered an antibiotic. The residents' McGeer infection sheet was left entirely blank, no documentation was found of any signs/symptoms of a wound infection. Review of the facility Antibiotic Time Out form (dated 11/11/25), revealed no documentation from the prescribing physician, or Infection Preventionist F regarding why the resident received Bactrim, when they did not meet the facility McGeer infection criteria, or risk versus benefit done for the use of the antibiotic. Review of NP L progress notes (dated 11/11/25), stated Wound to left ankle-stalled due to infection; treatment changed for this week until infection resolves, wound culture positive for MRSA, started on Bactrim. No signs or symptoms of a wound infection was documented in NP L notes. Review of the facility Revised McGeer Criteria for Infection Surveillance Checklist for Resident #3 dated 11/25, revealed this document was completely left blank; no documentation at all. The McGeer Checklist listed under wound infection stated Positive superficial wound swab culture (wound culture) is not sufficient evidence to establish a wound infection. The resident did not have any documentation of a wound infection or risk versus benefit for antibiotic usage. During an interview done on 12/10/25 at 8:35 a.m., Infection Preventionist, LPN F stated It does not meet our criteria (Resident #3's wound & Skin infection), it would benefit if it was on there (a risk versus benefit for antibiotic usage when it does not meet facility infection criteria) because it would be easier for me. Infection Preventionist F said she did not talk with the NP or the physician regarding appropriateness of ordering an antibiotic without meeting the facility criteria for a wound and skin infection, or not about filling out a risk versus benefit. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Resident #35: Review of the Face Sheet, MDS (dated 3/25), care plans (dated 3/17/25), and progress notes (dated 11/25), revealed Resident #35 was 89 years-old, admitted to the facility on [DATE], dependent on staff for Activities of Daily Living/ADL's, and was put on an antibiotic for a urinary tract infection/UTI without any signs or symptoms documented. The residents' diagnosis included, Dementia, chronic lung disease, with a history of UTI's. Review of the physician order dated 11/7/25, revealed the resident was prescribed Macrobid (antibiotic) 100mg two times a day for 7 day's (given for a UTI). Review of the facility infection control tracking sheet dated 11/25, revealed no documentation of any signs or symptoms of a UTI. During an interview done on 12/10/25 at 8:35 a.m., Infection Preventionist F said a urine dip stick used to confirm the resident had a UTI, and did not send the urine to the lab for a urinalysis/UA prior to starting an antibiotic, and stated Her family complained she had a UTI, they dipped her urine at their home and said it was positive, we did not re-dip. Infection Preventionist F said the facility did not have a policy for dipping urine. Review of Nurse Practitioner/NP L's progress notes dated 11/11/25, stated Patients family took her home over weekend, during her stay they dipped her urine and it was positive for UTI, staff had difficulty getting a clean catch with the urine sample in the facility (staff did not get a urine sample in the facility). Macrobid Oral Capsule give 100 mg by mouth two times a day for urinary tract infection, site not specified for 7 days. No documentation of any signs or symptoms was found in NP L's documentation. Review of the facility Revised McGeer Criteria for Infection Surveillance Checklist for Resident #35 dated 11/25, revealed documentation that the residents' UTI did not meet the facility McGeer criteria for UTI infection. During an interview done on 12/10/25 at 9:00 a.m., Infection Preventionist F stated yes, I marked it as not meeting our criteria. Review of the facility Antibiotic Time Out form (dated 11/10/25 and signed by NP L on 11/28/25), revealed no documentation from the prescribing physician, or Infection Preventionist F regarding why the resident received Macrobid, when they did not meet the facility McGeer infection criteria, or risk versus benefit done for the use of the antibiotic. Review of the infection control data dated 10/25, revealed no documentation regarding a plan (education, audits, demonstrations) to address any concerns or issues found. During an interview done on 12/10/25 at 9:00 a.m., Infection Preventionist F said she did not have November's analyzing completed because she worked the floor. Infection Preventionist F stated From now on, I will put how I plan to do it (a plan to address concerns found during the month). Main Dining Room: Observations made on 12/11/25 at 7:40 a.m., revealed several of the resident chairs had rust on the (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	bottom, white paint chipping off, and were uneven when they sat down, rocking back and forth. Also, an extremely large new stove was in the corner of the dining room and covered with a clear plastic wrapping that was tearing off with sections on the floor and several light yellow spots on the top. Residents used this area for three meals per day and for activities. During an interview done on 12/11/25 at 9:15 a.m., Infection Preventionist F stated I don't document my walk throughs for the dining room. Infection Preventionist F said the stove had been in the dining room for months. Review of the facility Infection Prevention and Control Program (un-dated), stated This facility has established and maintains an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections as per accepted national standards and guidelines (as the McGeer infection criteria for antibiotic usage). On 12/09/2025 at 1:04pm-2:00pm, during the environmental tour with the Maintenance Director D, observed a water softener in the basement that appeared to be not in use. On 12/09/2025 at 1:04pm-2:00pm when interviewed on the usage of the water softener, the Maintenance Director D answered the water softener is not in use, the valves are shut off, and it's been that way for a while. When questioned about the dead-end plumbing policy, the Maintenance Director D answered there isn't a policy. On 12/09/2025 at 1:04pm-2:00pm when interviewed on whether chlorine residual is tested on site, the Maintenance Director D answered they have never done chlorine residual testing, but they do test for pH levels. According to the facility's Water Management Plan, under Legionella Water Management Infection Control Program, Decide where control measures should be applied and how to monitor them. Also, Apply control measures to reduce the hazardous conditions, wherever possible, to prevent Legionella growth and spread. Weekly and bi-annual testing will be completed by maintenance. In addition, Monitor that the program is running as designed and is effective. Testing protocols will include where and when necessary: physical controls, temperature management, disinfectant level control, visual inspections, and environmental testing for pathogens. And it states, Interventions when control measures are not met: Document results of testing and corrective action when control limits are not maintained. According to Centers for Disease Control and Prevention, Controlling Legionella in Potable Water Systems dated January 3rd, 2025, Eliminate dead legs, which are sections of no- or low-water flow and Ensure disinfectant residual is detectable throughout the potable water system. According to the State Operations Manual under Water Management, Facilities must be able to demonstrate its measures to minimize the risk of Legionella and other opportunistic pathogens in building water systems such as by having a documented water management program and Measures to prevent the growth of opportunistic waterborne pathogens (also known as control measures), and how to monitor them.

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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** Based on observations, interviews, and record review, the facility failed to protect residents' rights to be free from neglect for 3 residents (#7, #14, #49) of 18 residents reviewed for dignity and the confidential Resident Council group, resulting in verbalizations from the council group of anger regarding call lights not being answered timely, frustration regarding not being able to reach call lights, and a heavy smell of urine in the back hall. Findings Include:Review of the facility's Maintaining Dignity policy, dated 12/25, stated It is the practice of this facility to protect and promote resident rights and treat each resident with respect and dignity as well as care for each resident in a manner and in an environment that maintains or enhances quality of life. Respond to requests for assistance in a timely manner. Call Light Availability and Response Time: Review of the facility Call Lights policy (dated 12/25), stated Staff will ensure the call light is within reach of resident and secured, as needed. The call system will be accessible to resident's while in their bed. All staff members who see or hear an activated call light are responsible for responding. Resident #7: Review of the face Sheet, Minimum Data Set/MDS (dated 10/24), physician orders (dated 9/24), and care plans (dated 10/24), revealed Resident #7 was [AGE] years old, admitted to the facility on [DATE], required assistance with Activities of Daily Living/ADL and supervision and observation due to behaviors. The residents' diagnosis included, chronic lung disease, heart failure, muscle wasting, and delusions.Review of the residents' Impaired respiration, behavior, and falls care plans (dated 10/24), revealed he was a fall risk and required close monitoring and behavior modification.Review of the resident's Activities of Daily Living care plan dated 10/24, stated Keep frequently used items within reach (including call light).During an interview done on 12/10/25 at 2:20 p.m., alert Resident #7 said that second and third shift staff take an hour or more sometimes to answer his call light. He said it does not happen on days.Resident #14:Review of the Face Sheet, MDS (dated 5/25), and care plans (dated 4/25), revealed Resident #14 was 63 years-old, admitted to the facility on [DATE], alert and interviewable with a BIMS of 10 (cognitive assessment, interviewable), and required total assistance with all ADLs. The residents' diagnoses included, sepsis, back pain, muscle weakness, seizures, difficulty walking, epilepsy, respiratory failure, traumatic brain injury with explosive disorder and hemiplegia of left side (weakness). Review of the resident's Falls care plan (dated 4/25/25), stated Keep frequently used items within reach (including call light).Observation made on 12/20/25 at 12:54 p.m., revealed the resident's call light was on the floor, it was not within reach.Resident #49: Review of the Face Sheet, Minimum Data Set (dated 5/25), and physician orders (dated 12/4/25), revealed Resident #49 was 82 years-old, was admitted to the facility on [DATE], was confused, not able to answer questions due to condition and cognition, and was receiving Hospice services. The resident's diagnoses included malnutrition with adult failure to thrive, diabetes, encephalopathy, chronic kidney disease, and had a history of a fall with fracture. Review of Resident #49's Activity of Daily Living and falls care plans (dated 12/4/25), revealed she was to be totally assisted with bed mobility, bathing, and dressing. She was also a fall risk and required supervision to maintain safety. Observation made on 12/10/25 at 8:04 a.m., revealed the resident was in bed with her call light clipped on the privacy curtain halfway to the top, approximately 4 feet from her low bed. The resident was unable to reach her call light. During an interview done on 12/10/25 at 8:10 a.m., Nurse, LPN C came in the resident's room and stated Ya, they (staff) clip the call lights to the curtains, they can't reach them. During a second observation done on 12/12/25 at 9:49 a.m., the resident again was in her bed, and her call light was clipped to the bedside privacy curtain. During an interview done on 12/12/25 at 10:00 a.m., the Director of Nursing/DON walked in the resident's' room and stated They (staff) should not put the call light on the curtain. The DON walked directly out of the residents' room without removing the call light from the curtain. During an interview done on 12/12/25 at 10:05 a.m., Family Member #2 stated It takes (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	about 45 minutes for them (staff) to answer the call lights on second shift. Resident Council: A confidential Resident Council Group meeting was held on 12/10/25 at 1:06 p.m., in the main dining room; with a total of 6 alert residents were in attendance. 2 of 6 resident's verbally had complaint's regarding their call lights not being answered timely on second and third shifts. A confidential Resident stated, it takes up to one hour and a half for them to answer (the call lights). One confidential resident said he had an accident (incontinence episode) due to no one timely answering his call light. Review of the facility Resident Council meeting notes (dated 7/2/25), stated Second and third shift call lights taking up to an hour to be answered. Heavy Urine Smell: Observation done on 12/12/25 at 9:49 a.m., in the back resident hallway (rooms 5 through 12) was noted by this surveyor to have a heavy smell of urine. During an interview done on 12/12/25 at 10:00 a.m., the DON walked down the back hallway and confirmed a heavy urine smell. The DON stated, I can smell it, I will send someone down. During an interview done on 12/12/25 at 10:10 a.m., Nursing Assistant/CNA A was asked what she was supposed to do if there was a smell of urine in a resident's room and she stated, I am supposed to strip their bed.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review, the facility failed to follow policy and procedures for 1) Medication labeling and storage in 2 of 2 medication carts, 2) Storage and handling of medications for one medication room of one reviewed, and 3) Consistently monitor the medication refrigerator temperature in accordance with acceptable pharmaceutical standards of practice, for 11 residents (R3, R8, R10, R12, R19, R28, R35, R37, R40, R42, R50) of 11 sampled residents Findings include: Medication cart for Residents rooms 1-12:Observation and interview on 12/09/2025 at 12:28 PM with Licensed Practical Nurse (LPN) C of Medication cart rooms 1 through 12. Observation on 12/09/2025 at 12:35 PM of Resident R42 Lantus 100unit/ml multi-dose 10ml vial/bottle with the seal off/used with no date on the vial and the box not dated. LPN C reviewed vial/bottle and then wrote a date on the bottle, although she did not open the vial. Observation on 12/09/2025 at 12:40 PM with Licensed Practical Nurse (LPN) C of Resident R50 had Albuterol Sulfate inhalation 200-meter doses, count of 148 doses left on inhaler. The inhaler was not dated with no pharmacy label. Licensed Practical Nurse (LPN) C stated that she had no idea what's going on with that inhaler. Observation on 12/09/2025 at 12:41 PM of Medication Cart Resident R19 medication Trelegy Ellipta inhalation aerosol powder 200 mcg/62.5 mcg/25 mcg Ellipta 30 doses device with 26 doses left and was not dated. Observation on 12/09/2025 12:44 PM of Resident R28's Ketorolac injection 60mg/2ml bottle open seal removed placed back into the plastic bag with 2 other sealed bottles, no date opened. Medication cart for Residents rooms 13-20:Observation and interview on 12/09/2025 at 11:52 AM with Registered Nurse G of the medication cart for resident rooms 13 through 20 revealed Resident R3 medication Lyumjev Injection 100 unit/ml vial top was removed with no date on vial or box. RN G did not know when the insulin vial had been opened. Observation of Resident R35 medication of Stiolto Respimat tiotropium Bromide and olodaterol aerosol inhaler used and not dated on device or box not dated. A random Ventolin HFA 90mcg 200 doses 198 doses left on the device with no date on the bottle or box was also located within the medication cart. Observation of the medication cart supply of opened Blood sugar sticks were not dated. Observation on 12/09/2025 at 12:59 PM with Registered Nurse G of the medication cart for resident rooms 13 through 20 revealed Resident R8 albuterol sulfate 0.083% inhaler was opened and not dated on inhaler or box. Observation on 12/09/2025 at 1:01 PM Resident R10 medication Ipratropium spray 0.06% nasal spray was used and opened not dated on bottle or box. Observation on 12/09/2025 1:02 PM of Resident R40 medication Fluticasone Propionate nasal spray 50mcg with no open dates on bottle or box. Treatment Cart: Observation on 12/10/2025 at 8:40 AM revealed Treatment cart was found unlocked in hallway. The state surveyor was able to access and review ointments and treatment creams: Unsampled Resident R36 had Diclofenac Sodium topical gel 1% open and used with no open date on a 3.53oz tube, no date on box or tube. Resident R12 had hydrocortisone cream 1.05oz opened used, squeezed with no dates note. Unsampled Resident R20 had Mupirocin 2% ointment for scalp, opened and tube squeezed with no date on box or tube. Observation and interview on 12/10/2025 at 9:13 AM of the treatment cart in hallway with Registered Nurse (RN) I revealed that the treatment is usually open, the nurses use it, and the Infection Control nurse does wound care. Observation of multiple-multi-dose ointments and creams opened and used; tubes are squeezed/dented from use by staff upon observation of medications. There are no open dates noted on tubes or boxes. In an interview on 12/10/2025 at 10:20 AM with Licensed Practical Nurse/Infection Control Preventionist/Wound Care Nurse F revealed that the medication carts and the treatment cart are to be always locked when not in use. In an interview on 12/10/2025 at 12:05PM with the Director of Nursing (DON) discussion of Treatment carts should be locked? The don acknowledged that the treatment cart should be locked when not in use. Every time she goes by the cart she must lock the cart. The state surveyor asked about multi-dose medications dated. The DON (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	stated that vials/bottles/pens or containers should be dated when opened because you must discard within 30 days or earlier per the pharmacy recommendations or manufacturer. Discussion of the tube feeding process/label: DON stated that the product should have a resident name, time hung, rate of infusion, amount to be infused and the product name. Refrigerator Temperature log:Observation and interview on 12/11/2025 at 8:36 AM with Licensed Practical Nurse (LPN) C Review of medication room Refrigerator temperature log reviewed with missing daily temperatures on 12/8/25, 12/9/25. Observation in the refrigerator of Floor stock Afluria influenza vaccine multi-dose 5ml dose vial, not dated seal is missing from the top of vial. Located on the bottom of the refrigerator floor was Resident #37 Ativan/lorazepam 10ml vial/bottle injectable with no date seal gone from vial top, no date on the bag either, bottle with 3 quarters full. The surveyor Had LPN C look for dates on all items in refrigerator with no dates found. Record review of the facility 'Daily Temperature Log' form dated December 2025 noted that nursing check temperatures on the first and second shift. Normal range is 36-46 degrees . Record review of the first shift log revealed that on the dates of 12/8/2025 and 12/9/2025 were noted to be blank. Record review of the facility 'Monitoring of Cooler/Freezer Temperature' dated 12/11/2025 revealed 1) Logs for recording temperatures for each refrigerator or freezer will be posted in a visible location outside the refrigerator unit . a.) Temperatures will be checked and logged at least twice per day by designated personnel. Observation and interview on 12/11/2025 at 8:44 AM with the Director of Nursing (DON) of the medication room refrigerator of pneumonia vaccine box with on syringe with the cap removed, with a needle on the syringe. The DON stated that it should have been thrown away and not kept. There was no date on the open syringe. Observation of Resident #37's Lorazepam 10ml vial/bottle with the seal off, no date on vial, no date on bag. The DON could not give a date of when the vial was opened and used. Review of Afluria influenzas vaccine multi-dose 5ml vial seal off the top and not dated on vial or box. Record review of the pharmacy 'Medication Dating and Storage Guide' undated revealed that multi-dose vials should be discarded in 30 days from open date, Insulin products should be discarded with 28 days from open date, nasal products should be discarded within 6 weeks from open date, and glucometer strips/sticks should be discarded 90 days from open date. Record review and interview on 12/12/2025 qt 8:05AM with the Director of Nursing of Resident #37's Lorazepam injectable 2mg/ml-'controlled substance proof-of-use record' noted that the medication was received by the facility on 11/15/2024 and the first dose was signed out as administered on 12/6/2024. The lorazepam 10ml was in the medication cart reviewing the pharmacy-controlled substance proof-of-use record last used 2/7/2025. The DON could not account for why the medication was in the refrigerator opened and used for over a year. Record review of the facility 'Multi-dose Vials' policy dated 12/10/2025 revealed it is the policy of the facility to ensure proper and safe use of multi-dose vials of medication, 2.) Multi-dose vials will be re-labeled with beyond use date, 28 days after the vial is opened or punctured. 3.) The medication label will also include the initials of the nurse who opened the vial. 5.) Visually inspect the vial before each use to double check the expiration date, beyond use date if previously opened, and ensure there is no visible contamination . 7.) Unit manager will perform random checks of opened multi-dose vials for appropriate dating.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement Mood/Behaviors care plan interventions for 1 resident (Resident #14) of 18 residents reviewed for care plans, resulting in lack of documentation of any interventions for mood or behaviors and a lack of follow-up with intervention effectiveness. Findings Include:Resident #14:Review of the Face Sheet, MDS (dated 5/25), and care plans (dated 4/25), revealed Resident #14 was 63 years-old, admitted to the facility on [DATE], alert and interviewable with a BIMS of 10 (cognitive assessment, interviewable), and required total assistance with all Activities of Daily Living/ADL's. The residents' diagnosis included, sepsis, back pain, muscle weakness, seizures, difficulty walking, epilepsy, respiratory failure, traumatic brain injury with explosive disorder and hemiplegia of left side (weakness).Review of resident #14's Aggressive/ Behavioral care plan dated 5/7/25, stated Monitor & Document observed behavior and attempted interventions in behavior log (on the Activities of daily Living/ADL sheets).Review of the residents' facility Mood/Behavior ADL sheet dated 11/25 (documentation of behaviors), revealed on 11/13/25 Repeated movements, on 11/19/25 yelling, abusive language, rejection of care, and on 11/26/25, Yelling, screaming and threating behaviors. No documentation was found on the behavior log regarding interventions or follow-up for each of the behaviors listed. Review of progress notes for the month of 11/25, revealed no documentation of any interventions or follow-up done regarding interventions effectiveness was found.On 12/11/25 at 11:20 a.m., a review of the residents' electronic medical record (nursing notes, physician notes, care plans, and behavior documentation on ADL sheets for 11/25) was done with the Director of Nursing/DON and Social Service H, revealed no documentation at all of any behavioral interventions done on the targeted dates of 11/13/25, 11/19/25, and 11/26/25, regarding resident behaviors. The DON and Director of Social Service H both agreed there was no documentation at all of interventions for targeted behaviors for the month of 11/25.During an interview done on 12/11/25 at 11:40 a.m., the DON stated The nurses should have documented interventions and effectiveness (of the interventions), I think we need to monitor the progress notes are done. During an interview done on 12/11/25 at 11:40 a.m., Social Service H stated I did not document anything, we did discuss residents with behaviors in our morning meetings but no one documented what they did about it. We need a better procedure, it's important. Review of the facility Behavioral Health Services policy dated 12/11/25 (same date the residents behaviors were reviewed), stated Facility staff will implement person-centered care approaches designed to meet the individual goals and needs of each resident. The Social Service Director shall serve as the facility's contact person for questions regarding behavioral services provided by the facility.

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	12/12/2025

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

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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 observation, interview and record review, the facility failed to update care plan interventions for one resident (Resident #2) of 4 sampled residents reviewed. Findings include:Resident R2:Interview and observation on 12/09/2025 at 10:31 AM of Resident #2 (R2) refused to respond to questions but was triggered as a wound infection on the CMS 802 form, so I will need further review. R2 was observed with a blanket pulled over her head and not receptive to conversation from surveyor. Record review of the facility provided CMS 802 form dated 12/9/2025 identified Resident #2 (R2) as not having any pressure ulcer but was identified as having a wound infection. Record review of Resident #2 Minimum Data Set (MDS) quarterly 11/7/2025 revealed an elderly female with moderately impaired cognitive abilities with decisions poor, requiring cues and supervision. Section GG- Functional abilities of dependent with eating, oral hygiene, toileting, bath/showers, dressing, and personal hygiene. Resident non-weight baring, mechanical lift assist for mobility. Bowel bladder functions with indwelling catheter and colostomy. Medical diagnosis included: Medically complex conditions, anemia, seizure disorder, and bipolar disorder. Section M- Skin conditions noted no unhealed pressure ulcers/injuries. In an interview on 12/09/2025 at 2:19 PM with a family member stated that Resident #2 (R2) has a new pressure area in the crack of her butt, with redness on the lower butt area. The family member was told that they are going to try Silvadene to dry the skin and get it to heal. The resident had a pressure ulcer when she first came to the facility and they should be aware of that, so she is concerned with a new area or re-opening of a skin injury/wound. They should be doing better. Observation and interview on 12/12/2025 at 8:36 AM of Resident #2 (R2) sacrum pressure/injury with Registered Nurse I and Certified Nurse assistant (CNA) I. R2 was observed to be lying in bed and was positioned flat on the back. Observation of Foley Catheter with a right leg strap in place dated 11/27/25, right abdomen colostomy intact. R2 was repositioned rolled onto the left side by CNA I. Observed an estimated 8 inch by 8-inch heart shaped foam boarder dressing to the sacrum/coccyx area dated 12/11/2025. The sacrum/coccyx dressing peeled back, and wound packing fell out of the wound. Observation of the wound was estimated to be 2cm in length x 1cm wide, depth was visible with a beefy red base of the wound. Observation of surrounding skin was noted with red area fungal in appearance with irregular boarders. Record review of Resident #2 (R2) nursing care plans pages 1-16 revealed Resident #2 had an actual skin impairment upon admission and is at risk for reopening and new skin disruption dated 9/8/2023. Goal: Resident will not develop any new areas of skin disruption, target date 2/5/2026. Record reviewed interventions: the last skin impairment intervention added to the care plan was dated 12/9/2024, over a year prior. In an interview and record review on 12/12/2025 at 9:37 AM with the Director of Nursing (DON) reviewed all Resident #2's care plans with the state surveyor. Record review of skin impairment care plan, last revision 2023, no added interventions with new development of skin pressure/injury. Intervention of Air mattress added 12/9/2024. DON stated that Resident #2 has now developed stage II to the sacrum, wound nurse calling it a skin tear. The DON reviewed medical record and care plan intervention. The DON stated that staff did start to only get the residents up for a limited number of hours daily like 6 hours, but it's not on the care plan either. There is a physician order for strict turning every 2 hours is on the treatment record but not on the care plan either. Record review of the facility 'Comprehensive Care Plans' policy dated 11/11/2025 revealed it is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with residents rights, that include measurable objectives and timeframes to meet a resident's medical, nursing and mental and psychosocial needs and all services that are identified in the resident's comprehensive assessment and meet professional standards of quality. Professional standards of quality means that care and all services are provided according to accepted standards of clinical practice. Standards may apply to care provided by particular clinical discipline or in a specific (continued on next page)

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	235641	A. Building B. Wing	12/12/2025

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	clinical situation or setting . The comprehensive care plan will be reviewed and revised by the interdisciplinary team .

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	235641	A. Building B. Wing	12/12/2025

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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 prevent the development of Stage II pressure ulcer for one resident (Resident #2) of 1 resident reviewed for pressure ulcer/injury, resulting in Resident #2 developing a facility-acquired Stage II pressure ulcer. Findings include: Resident #2 (R2):Interview and observation on 12/09/2025 at 10:31 AM of Resident #2 (R2) refused to respond to questions but was triggered as a wound infection on the CMS 802 form, so I will need further review. R2 was observed with a blanket pulled over her head and not receptive to conversation from surveyor. Record review of the facility provided CMS 802 form dated 12/9/2025 identified Resident #2 (R2) as not having any pressure ulcer but was identified as having a wound infection. Record review of Resident #2 Minimum Data Set (MDS) quarterly 11/7/2025 revealed an elderly female with moderately impaired cognitive abilities with decisions poor, requiring cues and supervision. Section GG- Functional abilities of dependent with eating, oral hygiene, toileting, bath/showers, dressing, and personal hygiene. Resident non-weight baring, mechanical lift assist for mobility. Bowel bladder functions with indwelling catheter and colostomy. Medical diagnosis included: Medically complex conditions, anemia, seizure disorder, and bipolar disorder. Section M- Skin conditions noted no unhealed pressure ulcers/injuries. In an interview on 12/09/2025 at 2:19 PM with a family member stated that Resident #2 (R2) has a new pressure area in the crack of her butt, with redness on the lower butt area. The family member was told that they are going to try Silvadene to dry the skin and get it to heal. The resident had a pressure ulcer when she first came to the facility and they should be aware of that, so she is concerned with a new area or re-opening of a skin injury/wound. They should be doing better. Record review of Resident #2's March 21, 2025 'Skin & Wound Evaluation' form noted a skin tear, category 1- epidermis and dermis are pulled in one layer from supporting structures. In-house acquired new wound measurements: length 1.6cm X width 0.5cm X depth 0.1cm. Photo of wound reviewed and noted at the coccyx/sacrum region, old scar tissue noted in photo to the area. Record review of Resident #2's physician progress note dated 3/21/2025 noted only a wound to the resident left heel. On 3/21/2025 there were no nursing progress notes that identified that the sacrum wound occurred, measurements, treatments or notification of physician/responsible party. Record review of Resident #2's 'Skin Impairment' care plan noted that there were no new interventions for treatment or prevention of sacrum wound development. On 3/25/2025 at 1:49PM 'Skin/Wound Note' by the Infection Control Preventionist/Wound care nurse F noted: Sacrum has resolved and no longer being followed. Record review of Resident #2's physician progress note dated 7/18/2025 at 8:51PM noted open wound of lower back pelvis without penetration into retroperitoneum. On 7/18/2025 there were no nursing progress note that identified that the sacrum wound re-occurred, measurements, treatments or notification of physician/responsible party. Record review of Resident #2's July 22, 2025 'Skin & Wound Evaluation' form noted a skin tear, category 1- epidermis and dermis are pulled in one layer from supporting structures. In-house acquired new wound measurements: length 2.5cm X width 0.8cm X depth 0.2cm. Larger than the previous March wound. Photo of wound reviewed and noted at the coccyx/sacrum region, the wound is open with a beefy red base to the wound. Record review of Resident #2's 'Skin Impairment' care plan noted that there were no new interventions for treatment or prevention of sacrum wound development in the month of March 2025. Record review of Resident #2's 'Skin/Wound Note' dated 7/22/2025 at 2:07PM documented by the Infection Control Preventionist/Wound care nurse F noted: Old wound on Sacrum reopened, NP (Nurse Practioner) notified and currently being monitored. Record review of Resident #2's Nurse Practioner note dated 7/22/2025 at 6:12PM noted: Pressure ulcer Stage II to coccyx- not improving measuring deeper and larger in width. Wound treatment: Coccyx clean with saline, apply Collagen sheet- Endoform and Allevyn Dressing, change every 2 days and as needed on time a day for wound. Strict turning schedule; Must be every 2 hours. Record review of Resident #2's 'Skin Impairment' care plan noted that there were no new interventions for treatment or prevention of (continued on next page)

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	235641	A. Building B. Wing	12/12/2025

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	sacrum wound development in the month of July 2025. Record review of Resident #2's Nurse Practioner note dated 8/26/2025 at 2:40PM noted: Pressure ulcer Stage II to coccyx- unchanged. Nursing only putting on dry gauze on wound and saying they can't find the ordered treatment dressings even though they are in the wound cart that is fully accessible to them. Nursing noncompliance with dressing changes. Wound treatment: Coccyx clean with saline, apply collagen sheet- Endoform and Allevyn foam dressing, change every 2 days and as needed one time a day for wound. Record review of Resident #2's Nurse Practioner note dated 9/16/2025 at 2:08PM noted pressure ulcer Stage II to coccyx- closed. Record review of Resident #2's Nurse Practioner note dated 9/30/2025 at 10:00 AM noted wound to sacrum reopened and worsened= patient up in wheelchair throughout the day which is a benefit to her physical function, but she may need to be alternated between WC and bed multiple times throughout the day as able to relieve pressure points and get air to her skin. Wound treatment: Cleanse with soap and water, dry completely, Calcium Alginate (debride enzyme) with silver to wound bed, do not cover. Apply calmoseptine to buttocks every day shift for wound treatment. Record review of Resident #2's Nurse Practioner note dated 11/11/2025 at 10:0AM noted: Open wound to sacrum, improving since (urinary) catheter placement, measuring smaller, 100% granulation, surrounding skin intact and not moist, wound culture positive for MRSA (Methicillin Resistant Staph Arius), start on Bactrim for 7 days. Bactrim DS oral tablet 800-160mg give 1 tablet by mouth two times a day for MRSA in wound for 10 days until 11/21/2025. Coccyx wound stalled and still with odor. Record review of Resident #2's Nurse Practitioner note dated 12/2/2025 at 10:52AM noted: Open wound to sacrum not improving this week , turn schedule in place but patient not being turned according to schedule, indwelling catheter placed in mid-October to help with moisture and acidity exposure related to urinary incontinence, wound is measuring three times in length, again with bloody drainage, 100% gran tissue, surrounding skin hyperpigmentation is improving, but skin is moist . Coccyx wound was cultured on 11/6/2025 and positive for MRSA, resident completed 10 days Bactrim (antibiotic). New order: Linezolid (antibiotic) 600mg tablet take one tab by mouth twice daily for 7 days for wound infection. Record review of Resident #2's Nurse Practitioner note dated 12/9/2025 at 10:00AM noted: open wound to sacrum improving, patient is now being turned according to schedule, indwelling catheter placed in mid-October to help with moisture and acidity exposure related to urinary incontinence, wound is measuring smaller, no drainage, 100% gran tissue, surrounding skin hyperpigmentation, moist and starting to break down. Start metronidazole (Flagyl-antibiotic) 500mg tablet take one tablet daily for 5 days for fungal skin infection. Record review of the facility 'Pressure Injury Prevention and Management' policy dated 12/12/2025 revealed the facility is committed to the prevention of avoidable pressure injuries, unless clinically unavoidable, and to provide treatment and services to heal the pressure ulcer/injury, prevent infection and the development of additional pressure ulcers/injuries. 'Pressure Ulcer/Injury' refers to localized damage to the skin and/or underlying soft tissue usually over a bony prominence or related to a medical or other device. Avoidable means that the resident developed a pressure ulcer/injury and that the facility did not do one or more of the following: evaluate the resident's clinical condition and risk factors; define and implement interventions that are consistent with resident needs, resident goals, and professional standards of practice; monitor and evaluate the impact of the interventions; or revise the interventions as appropriate . Modification of Interventions: Interventions on a resident's plan of care will be modified as needed. Considerations for needed modifications include new onset or recurrent pressure injury development, lack of progression towards healing . Observation and interview on 12/12/2025 at 8:36 AM of Resident #2 (R2) sacrum pressure/injury with Registered Nurse I and Certified Nurse assistant (CNA) I. R2 was observed to be lying in bed and was positioned flat on the back. Observation of Foley Catheter with a right leg strap in place dated 11/27/25, right abdomen colostomy intact. R2 was repositioned rolled onto the left side by CNA I. Observed an estimated 8 inch by 8-inch heart shaped foam boarder dressing to the sacrum/coccyx area dated 12/11/2025. The sacrum/coccyx dressing peeled back, and wound packing fell out of the wound. Observation of the (continued on next page)

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	235641	A. Building B. Wing	12/12/2025

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	wound was estimated to be 2cm in length x 1cm wide, depth was visible with a beefy red base of the wound. Observation of surrounding skin was noted with red area fungal in appearance with irregular boarders. Record review of Resident #2 (R2) nursing care plans pages 1-16 revealed Resident #2 had an actual skin impairment upon admission and is at risk for reopening and new skin disruption dated 9/8/2023. Goal: Resident will not develop any new areas of skin disruption, target date 2/5/2026. Record reviewed interventions: the last skin impairment intervention added to the care plan was dated 12/9/2024, over a year prior. In an interview and record review on 12/12/2025 at 9:37 AM with the Director of Nursing (DON) reviewed all Resident #2's care plans with the state surveyor. Record review of skin impairment care plan, last revision 2023, no added interventions with new development of skin pressure/injury. Intervention of Air mattress added 12/9/2024. DON stated that Resident #2 has now developed stage II to the sacrum, wound nurse calling it a skin tear. The DON reviewed medical record and care plan intervention. The DON stated that staff did start to only get the residents up for a limited number of hours daily like 6 hours, but it's not on the care plan either. There is a physician order for strict turning every 2 hours is on the treatment record but not on the care plan either. Record review of the facility 'Comprehensive Care Plans' policy dated 11/11/2025 revealed it is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with residents rights, that include measurable objectives and timeframes to meet a resident's medical, nursing and mental and psychosocial needs and all services that are identified in the resident's comprehensive assessment and meet professional standards of quality. Professional standards of quality means that care and all services are provided according to accepted standards of clinical practice. Standards may apply to care provided by particular clinical discipline or in a specific clinical situation or setting . The comprehensive care plan will be reviewed and revised by the interdisciplinary team .

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	235641	A. Building B. Wing	12/12/2025

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. Based on observation, interview and record review, the facility failed to ensure that the enteral tube feeding (TF) solution was labeled with the resident's name, date, and rate of infusion for one resident (Resident #6) of 1 sampled resident. Findings include: Resident #6:Observation and interview on 12/09/2025 at 9:24 AM during the screening process at the beginning of the survey of Resident #6 was observed to be lying in bed. Observation of the bedside revealed an empty bottle/container and tubing of Glucerna 1.5 cal. solution with no resident name, rate, time, date or duration of infusion of feeding material. Observation of the Hospice Registered Nurse M providing care in the room to Resident #6. RN M stated that hospice does not hang feeding tube solution. The state surveyor had the hospice RN M observe the feeding tube bottle and tubing for a name, date, rate. RN M stated Yes, it is empty, and it does not tell you who's it is or how long or rate to run it. Observation and interview on 12/09/2025 at 9:26 AM with Registered Nurse (RN) F were brought into Resident #6's room to observe the Glucerna 1.5cal, feeding tube solution hanging at bedside that was empty. RN F reviewed the feeding tube bottle with no date, to time, no resident name, no rate of infusion, and the bottle is empty. Registered Nurse F stated that the feeding tube solution is hung by the night shift and runs all night long. Record review of Resident #6's 'Medication Administration Record (MAR)/Treatment Administration Record (TAR)' for the month of December 2025 revealed that on 12/8/2025 in the evening: Glucerna 1.5 cal. oral liquid (Nutritional Supplement) give 150 ml via PEG-tube in the evening for dysphagia continuous via pump, run from 7:00PM to 5:00AM water to run concurrently with enteral feeding at 100ml/hr. was signed out by a night shift nurse. Record review of the facility 'Medication Administration via Enteral Tube' dated 12/10/2025 revealed it is the policy of the facility to ensure the safe and effective administration of medications via enteral feeding tubes by utilizing best practice guidelines. Procedure: b.) Ensure residents' name, date, dosing, are present on the waster bag and tube feeding bottle. Record review of the facility 'Care and Treatment of Feeding Tubes' policy dated 12/10/2025 revealed it is the policy of this facility to utilize feeding tubes in accordance with current clinical standard of practice, with interventions to prevent complications to the extent possible. 1.) Feeding tubes will be utilized according to physician orders, which typically include: the kind of feeding and its caloric value, volume, duration, mechanism of administration, and frequency of flush.

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	235641	A. Building B. Wing	12/12/2025

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. Based on observation, interview and record review, the facility failed to assess and monitor a post-dialysis pressure dressing for 1 resident (Resident #3) of 1 sampled resident, resulting in Resident #3 to be observed with a pressure dressing to the fistula access sites with no date on the dressing or documented nursing assessment. Findings include: Resident #3:In an observation and interview on 12/09/2025 at 9:01 AM with Resident #3 was seated up in a wheelchair in her room. Resident #3 stated that she goes to hemodialysis, on Monday, Wednesday, and Fridays. The state surveyor observed two pressure dressings to left upper arm, with 4x4 gauze folded and applied with tape, no dates noted on the dressings. Resident #3 stated that I take the dressings off, and if it starts to bleed again i go to the nursing station and tell them. The nurses put a dressing on the area. I also Go to the wound clinic for my left ankle wound. I got the wound at a previous nursing home. it's better now, getting smaller, less painful. Observation and interview on 12/09/2025 at 11:45 AM with Resident #3 were still seated up in her room in WC able to propel self, eating red peppers snacks in a baggie, denied any needs. Observation of the residents Left upper arm dialysis dressing now with a piece of tape with date 12/8/2025 with initials, back dated to the dressing site to the day of dialysis treatment which was on Monday 12/8/2025. The state surveyor tracked down the nurse initials and brought in Licensed Practical Nurse/ Infection Control/ Wound Care Nurse F into resident room to observe the dialysis dressing site, LPN F appeared flustered and stated that she forgot the date. LPN F reviewed Resident #3's nursing progress notes dated 12/8/2025 and stated that the nurse should have assessed the dressing site from dialysis and dated the dressing for 12/8/2025. The nurse was to take a clean piece of tape and write the date on and apply it to the dialysis pressure dressing. There were no nursing progress notes documented for the day. Record review of Resident #3's dialysis communication form dated 12/8/2025 at 12:00PM post dialysis notes by Registered Nurse (RN) G documented shunt location/status: left upper arm. Bruit/thrill present: yes. Bleeding: no. General condition of resident: good- Norco given for pain. Vital signs: BP:144/65, Pulse: 53, Resp. 18, Temp: 97.4, Pain:7 SPO2 96% room air. There was no assessment or documentation of the left upper arm pressure dressings placed by the dialysis center. Record review of Resident #3's Nursing progress notes revealed that there were no documented notes on 12/8/2025 for the entire day. There were no notes or assessments related to the dialysis pressure dressings noted. Record review of Registered Nurse (RN) F's 'Licensed Nurse Orientation/Annual Competency Checklist' dated 5/21/2025 had no skills related to dialysis pre/post therapy assessments or dialysis pressure dressing monitoring post treatment.

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	235641	A. Building B. Wing	12/12/2025

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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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. Based on interview and record review, the facility failed to ensure that the Infection Control Preventionist Licensed Practical Nurse F completed an annual nursing skills competency evaluation for 1 of 2 nurses reviewed. Findings include:Staffing review task: In an interview and records review on 12/11/2025 at 10:57 AM with the Human resource staff member N revealed that there were 4 Registered Nurses, seven Licensed Practical Nurses, and 24 Certified Nursing Assistants available for scheduling. The Staff member N prepared and submitted the PBJ (Payroll Based Journal) quarterly. The facility had a full time Director of Nursing. Record review on 12/11/2025 during the staffing task of the survey of professional licensed nurses' annual competencies/skills checklist for the year 202 was not completed for Licensed Practical Nurse (LPN)/Infection Control Preventionist/Wound Care nurse F. Human resource staff member N stated She did not have an annual competency check list for 2025 for LPN F and did not know why she does not have one. The former Director of Nursing (DON) did not do it. LPN/ICP was hired in August 2023 and should done one. Record review of LPN/IPC employee file by Human resource staff and state surveyor looked through the employee file, binders and piles of papers in office. No annual competency for 2025 was located. On 12/12/2025 at 9:48 AM the Director of Nursing (DON) presented the state surveyor with a 'Licensed Nurse Orientation/Annual Competency Checklist' form dated 12/11/2025 for Licensed Practical Nurse (LPN)/Infection Control Preventionist/Wound Care nurse F. The state surveyor asked Why did LPN/ICP/Wound care not have an annual competency evaluation for 2025 until the state agency inquired? THE DON stated that LPN/ICP/Wound care nurse F also worked the resident care floor as nurse when needed. The DON stated the LPN F did not have 2025 annual skills/competency and did not know why. THE DON stated that she was the MDS assessment nurse until November of 2025 and had recently become the DON. The DON stated that No one said anything to her about it, and that LPN F should have known as she was a part of the management team and it should have been done. The DON stated that she did sign off on the new annual competency checklist dated 12/11/2025. The DON when asked about performing all of the required skills on the checklist form in one day replied that we did most of skills/procedures she thinks.

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	12/12/2025

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 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. Based on observation, interview and record review, the facility failed to identify targeted behaviors, medication classifications, and the duration of therapy on the informed consents for 3 residents (R5, R6, R22) of 5 sampled residents. Findings include: Resident #5:Record review of Resident #5's Minimum Data Set (MDS) date 11/30/2025 revealed an elderly resident who was his own responsible party. Review of section I: active medical diagnosis included: debility, heart failure, diabetes, anxiety, depression, bipolar and post-traumatic stress disorder. Section N: Medications identified that the resident received antipsychotic, antidepressant, and anticonvulsant medications. Record review of Resident #5's 'Medication Administration Record' (MAR) for December 2025 revealed medications administered of aripiprazole (Abilify) antipsychotic medication 2mg tablet by mouth in the evening for mood stabilizer. Escitalopram (Lexapro) antidepressant medication 10mg tablet by mouth one time a day for depression. In an interview and record review on 12/11/2025 at 9:07 AM with Social Worker (SW) H regarding Resident #5's medications. Social worker H revealed Resident #5 was on Lexapro 20mg every day for depression, Abilify 2mg at night for mood stabilizer, and Tramadol 50mg twice daily for pain. On 12/11/2025 at 9:17 AM with the SW H of Resident #5's physician orders and interview revealed that the facility had Resident #5 Sign his consent on September 12, 2025. Record review of the 'Psychoactive Medication Informed Consent' form dated 9/12/25 did not identify which medication was for depression and which medication was used for mood stabilizer. The form did not identify clinically significant side effects potentially associated with the medication's classification. The consent form expected benefits from the medication intervention included was blank. There were no targeted behaviors identified. Record review of medications Abilify (antipsychotic) and Lexapro (antidepressant) consent dated 9/12/2025 did not identify triggered behaviors to be treated, identify which classification of medication and significant side effects associated with the medications was being consented too. Record review of Resident #5's behavior 30-day monitoring task from 11/12/2025 through 12/12/2025 identified triggered behaviors of repeats movement, and grabbing. Resident #6:Record review of Resident #56s Minimum Data Set (MDS) date 10/2/2025 revealed an elderly resident who was his own responsible party. Review of Section I: active medical diagnosis included: progressive neurological condition, coronary artery disease, hypertension, peripheral vascular disease, diabetes, cerebrovascular accident/stroke, seizure disorder, anxiety, depression, and psychotic disorder. Section N: Medications identified that the resident received antipsychotic and antidepressant medications. Record review of Resident #6's 'Medication Administration Record' (MAR) for December 2025 revealed medications administered of risperidone antipsychotic medication 0.5mg tablet via peg-tube in the evening for depression. mirtazapine (Remeron) antidepressant medication 15mg tablet by via peg-tube in the evening for depression. In an interview and record review on 12/11/2025 at 9:20 AM with Social Worker (SW) H regarding Resident #6's medications Risperidone 0.5mg for depression in the evening, Remeron 15mg in evening for depression and appetite. Record review of 'Psychoactive Medication Informed Consent' form dated 11/22/2024 revealed medications of duloxetine (Cymbalta) antidepressant, risperidone antipsychotic, and mirtazapine (Remeron) antidepressant medications were listed on the consent. Record review of the consent form was completed by the Director of Nursing (DON) and signed the consent and did not identify the targeted behaviors of treatment. The form did not identify clinically significant side effects potentially associated with the medication's classifications. The consent form expected benefits from the medication intervention statement was blank. There were no targeted behaviors identified. Record review of Resident #6's behavior 30-day monitoring task from 11/12/2025 through 12/12/2025 identified triggered behaviors of repeats movement, pushing and grabbing. Resident #22:Record review of Resident #22's Minimum Data Set (MDS) date 9/18/2025 revealed an elderly resident who was his own responsible party. Review of section I: active medical diagnosis included: non-traumatic brain dysfunction, cancer, anemia, atrial fibrillation, coronary artery disease, (continued on next page)

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	235641	A. Building B. Wing	12/12/2025

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	hypertension, non-Alzheimer's dementia, anxiety, and depression. Section N: medications identified that the resident received antipsychotic, antianxiety, and antidepressant. Record review of Resident #22's 'Medication Administration Record' (MAR) for December 2025 revealed medications administered olanzapine (Zyprexa) antipsychotic medication 5mg tablet by mouth on time a day for major depressive disorder recurrent with psychotic symptoms. Trazodone antidepressant medication 50mg tablet by mouth in the evening for insomnia. Venlafaxine (Effexor) antidepressant medication 75mg capsule by mouth in the morning for depression. Buspirone (Buspar) antianxiety medication 10mg tablet by mouth two times a day for anxiety. Clonazepam antianxiety medication 0.5mg tablet by mouth three times a day for anxiety disorder. In an interview and record review on 12/11/2025 at 12:32PM with Social Worker (SW) H regarding Resident #22's medications. Social worker H reviewed Resident #22 'Psychoactive Medication Informed Consent' form dated 9/12/25 identified mirtazapine (Remeron) antidepressant, olanzapine (Zyprexa) antipsychotic, clonazepam benzodiazepine, trazadone antidepressant was listed on the consent. did not identify which medication was for depression and which medication was used for mood stabilizer. The form did not identify clinically significant side effects potentially associated with the medication's classification. The consent form expected benefits from the medication intervention included was blank. There were no targeted behaviors identified. Record review of medications Abilify (antipsychotic) and Lexapro (antidepressant) consent dated 9/12/2025 did not identify triggered behaviors to be treated, identify which classification of medication and significant side effects associated with the medications was being consented too. Black box warnings for antipsychotic medications were not identified on the consent. Record review of Resident #22's behavior 30-day monitoring task from 11/12/2025 through 12/12/2025 identified triggered behaviors of frequent crying, yelling and swearing, and rejection of care. Record review of the facility 'Use of Psychotropic Medications' policy dated 12/11/2025 revealed that prior to initiating or increasing a psychotropic medication, the resident, family, and/or resident representative must be informed of the benefits, risks, and alternatives for the medication, including any black box warnings for antipsychotic medications, in advance of initiation or increase.