| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235652 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 02/19/2026 |
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| The Timbers of Cass County | 55432 Colby St<br>Dowagiac, MI 49047 |

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) |
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| F 0627<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake #2735635Based on interview and record review, the facility failed to provide 30-day notification of discharge and implement appropriate discharge processes for 2 (Resident #100 and Resident #101) of 4 residents reviewed for facility-initiated discharge resulting in a lack of resident education related to care needs, lack of medical supplies needed for care at home, and the unapproved discharge of both residents.Findings include:Resident #100Review of an admission Record revealed Resident #100 was an [AGE] year old male who was originally admitted to the facility on [DATE] with pertinent diagnoses which included: traumatic ischemia of muscle(insufficient blood supply to muscle tissue caused by severe physical injury), fall on same level from slipping, tripping.muscle weakness, need for assistance with personal care, neuromuscular dysfunction of the bladder (nerve damage that disrupts between the brain, spinal cord, and bladder muscles causing underactive bladder function), diabetes mellitus(chronic metabolic disease characterized by high blood sugar levels), and encephalopathy(broad term for any disease, damage, or malfunction of the brain that alters mental state).Review of a Minimum Data Set (MDS) assessment for Resident #100 with a reference date of 1/29/26, revealed a Brief Interview for Mental Status (BIMS) assessment score of 15 /15, which indicated the resident was cognitively intact. Section H revealed Resident #100 had an indwelling urinary catheter (flexible tube inserted into the bladder to continuously drain urine, held in place by a balloon) Section I revealed Resident #100 had an active diagnosis of malnutrition or was at risk for malnutrition.Review of a Care Plan for Resident #100 with a reference date of 8/29/25 revealed the following problems/goals/interventions: 1. Problem: Resident admitted to facility with foley catheter after hospitalization related to diagnosis of urinary retention. Goal: Resident will have toileting needs met without complications.2. Potential for episode(s) of hypo-hyper glycemia (excessively low or high blood sugar levels), r/t DX (diagnosis) of diabetes. Goal: Early recognition of s/s (signs and symptoms) of hypo/hyperglycemia with timely interventions. Approaches: (name of device omitted) blood sugar checks as ordered, administer diabetic medication(s) as ordered, observe for signs of hyperglycemia.observe for signs of hypoglycemia.3. Problem: Resident's ADL (activity of daily living) functional abilities.vary and fluctuate.4. (Resident #100) experiences incontinence of bowel on occasion.Approach: provide incontinence care after each incontinent episode.5. Problem: (Resident #100) is to discharge from the facility. Goal: Resident will be discharged to possible assisted living.obtain needed equipment and supplies.In an interview on 2/18/26 at 11:55am, Resident #100 reported he discharged from the facility on 1/20/26, one day after he met with Nursing Home Administrator (NHA) A who told him he had to leave because he had met all his goals. Resident #100 reported he was upset about leaving because his home was uninhabitable, he had never cared for his urinary catheter before, and he had no food. Resident #100 reported he felt he had no choice, and the facility bribed him by paying for a hotel for 10 days. Resident reported he did not receive<br><br>(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 0627<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | information about his right to appeal his discharge. Resident #100 also reported he was discharged with no glucometer (device for checking his blood sugar level).In an interview on 2/18/26 at 1:50pm, Certified Nursing Assistant (CNA) C reported she was working the day Resident #100 discharged from the facility. CNA C reported she was concerned when she learned Resident #100 was being discharged to a hotel because he sometimes needed help with managing his bowel incontinence and catheter. CNA C reported she spoke with Resident #100 who voiced concern about his lack of food and told her he wished he had some oatmeal and milk he could take with him.In an interview on 2/18/26 at 2:52pm, former Social Worker (SW) J reported Resident #100 was discharged to a hotel but was hesitant about leaving the facility because he knew it was unlikely his home would be repaired enough to be in a livable condition within 10 days. SW J reported the facility pushed Resident #100 to discharge because of his outstanding balance with the organization. SW J reported she was concerned about Resident #100's wellbeing at the hotel due to a lack of transportation options, lack of food, and his need for support with catheter care.In an interview on 2/18/26 at 3:39pm, former Social Services Assistant (SSA) J reported she was pressured by NHA A to get the residents who had high bills out of the facility. SSA J reported part of the discharge process should include ensuring a resident has the medical supplies they need and referrals for other resources, including food if needed. SSA J confirmed Resident #100 was not referred for assistance with obtaining food.In an interview on 2/18/26 at 4:43pm former Social Worker (SW) L reported NHA A pressured Resident #100 to leave the facility on a daily basis due to the resident's outstanding balance and failure to pay. SW L reported Adult Protective Services (APS) deemed Resident #100's home as unsafe and uninhabitable but NHA A continued to pressure the resident to go home. SW L reported she was present when APS caseworker (APS/CW) O showed Resident #100 pictures of the inside of his home and at that time, Resident #100 reported he did not feel safe living in those conditions.In an interview on 2/19/26 at 3:12pm, APS/CW O reported with permission she inspected Resident #100's home and brought him pictures of the condition of the inside of his home. APS/CW O reported upon seeing the pictures Resident #100 confirmed he could not discharge back to his home until it was cleaned out and repaired. APS/CW O reported the home barely had a walking path through the interior, tripping hazards were present everywhere, it needed repairs to the utilities, had no running water, and front door had been kicked open. APS/CW O reported Resident #100 had friends that would help him repair his home, but repairs would likely take months, and Resident #100 frequently waffled on allowing others to help him.In an interview on 2/18/26 at 3:12pm, Durable Power of Attorney (DPOA) H reported she and Resident #100 met with NHA A approximately 2 weeks prior to Resident #100 being discharged , at which time NHA A told her Resident #100 could not afford to stay at the facility. When further queried, DPOA H reported she was not informed Resident #100 had an option to stay at the facility and/or to appeal being discharged . DPOA H expressed concern that Resident #100 was discharged without her knowledge and was not sent with a glucometer. DPOA H reported when the home health nurse made her initial visit 6 days after the discharge, the nurse evaluated him and sent him to the emergency room for further treatment.In an interview on 2/19/26 at 2:17pm, Registered Nurse (RN) R reported prior to discharge residents must be offered training for any nursing care they will complete for themselves. RN R reported the training should be documented in a progress note. RN R also reported any resident who requires blood sugar monitoring should be discharged with a glucometer and that should also be documented.In an interview on 2/19/26 at 2:51pm, RN Q reported Resident #100 relied on staff to complete catheter care and blood sugar checks.Review of a Emergency Department Provider Note for Resident #100, with a reference date of 1/26/26 revealed (Resident #100) is an 86 y.o.(sic) (year old) male patient presenting to emergency department with diarrhea and<br><br>(continued on next page) |

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| F 0627<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | dark stools. States stools have been dark on and off for the past week.does have nearly black stool in brief.does state he recently came from (Skilled Nursing Facility) and was moved to a motel which he has for 10 days. He states he feels like he is having difficulty caring for himself at home.prescribed glucometer with test strips and lancets as he does not have a way to check glucose at home.DPOA called and expressed concerns about safety of discharge. States patient is relying on friends for food.is unable to leave his hotel room due to weakness. Patient is agreeable to permanent placement as he feels he cannot safely care for himself.HISTORY OF PRESENT ILLNESS.states he was referred here today by his home health nurse.Per EMS (Emergency Medical Services), home health care nurse called because he was covered in feces.Issues Requiring Follow Up: Patient has been taking (anticoagulant).dose reduced to 2.5mg (milligrams).Patient would likely benefit from Geri-psych referral.there are some signs of developing cognitive impairment.In an interview on 2/19/26 at 3:51pm, Director of Nursing (DON) B reported she could not locate documentation of Resident #100 receiving catheter care training or a blood glucose monitor prior to being discharged .In an interview, Business Office Manager (BOM) U confirmed Resident #100 owed the facility a substantial amount of money and had refused to apply for Medicaid or make any payments toward the balance. BOM U reported she tried many times to work with Resident #100 to resolve the issue and when she had no success, she asked NHA A to step in and attempt to resolve the situation. BOM U reported NHA A was responsible for issuing a 30-day notice of discharge.In an interview on 2/19/26 at 12:30pm, NHA A reported he had talked with Resident #100 on multiple occasions about his financial balance and about discharging from the facility. NHA A reported Resident #100 refused to apply for Medicaid because he did not want to have a portion of his income go toward his patient pay amount. NHA A reported Resident #100 was discharged to a motel with home health services. NHA A reported Resident #100 never mentioned wanting assistance with resources for food so the facility honored his wishes and did not pursue it.Resident #101Review of an admission Record revealed Resident # 101was a [AGE] year old male who was originally admitted to the facility on [DATE] with pertinent diagnoses which included: malignant neoplasm of colon (disease in which cells in the large intestine's inner lining grow uncontrollably, forming tumors), alcohol dependence with delirium( a sudden, temporary, and usually reversible state of confusion), and perforation(tearing) of the intestine.Review of a Minimum Data Set (MDS) assessment for Resident #101with a reference date of 1/13/26, revealed a Brief Interview for Mental Status (BIMS) assessment score of 5 /15, which indicated the resident was severely cognitively impaired. Section GG revealed Resident #100 was independent for wiping the opening of his ostomy (surgically created opening in the abdomen). Section H revealed Resident #101 had a colostomy (surgical procedure that creates an opening in the abdominal wall, connecting the colon to the outside of the body to divert waste into a replaceable bag).Review of a Care Plan for Resident # 101 with a reference date of 11/24/25 revealed the following problem/goal/approaches: Problem: (Resident #101) has impaired cognition AEB (as evidenced by) BIM's 5 severe impairment. Goal: (Resident #101) will be able to make safe.decisions with staff supervision. Approach: .reorient PRN (as needed), when resident is trying to remember something, do not rush.Review of a Social Services Progress Note for Resident #101 with a reference date of 1/7/26 revealed Resident is discharging tomorrow 1/8/26.Resident is being discharged to home.In an interview on 2/19/26 at 10:45am, DPOA M reported Resident #101 was notified on 1/7/26 that he would need to discharge on [DATE]. DPOA M reported she spoke with NHA A and told him there was no safe place for Resident #101 to go and no one to care for him. DPOA A reported NHA A said he'd look into options for Resident #101 but kept saying he did not want Resident #101 to build up medical debt. DPOA M reported ultimately, she picked Resident #101 up on 1/8/26 because an unknown staff member told her if<br><br>(continued on next page) |

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| F 0627<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Resident #101 was not picked up by midnight, he would be escorted outside the main door with the door locked behind him. DPOA M reported no one at the facility discussed the resident's right for a 30-day notice of discharge or his right to appeal the discharge. DPOA M reported Resident #101 initially said he did not want to discharge but after he was repeatedly approached by staff, who asked when his ride was coming, he agreed. DPOA M reported Resident #101 was not safe in his home, where he currently resides alone. DPOA M reported Resident #101 had never previously cared for his colostomy on his own, had poor short-term memory and reduced mobility following his lengthy hospitalization. DPOA M reported Resident #101 walked with a wheeled walker now that did not fit through the door to his bathroom, and he had fallen several times at home since his discharge. DPOA M reported Resident #101 was discharged with a referral to a local social services organization, but he has not received any homecare yet.In an interview on 2/19/26 at Certified Occupational Therapy Assistant (COTA) V reported Resident #101 should have received training on colostomy care from nursing prior to his discharge. COTA V reported Resident #101 was discharged with a wheeled walker for use in his home but a home evaluation to determine if the resident could safely use the device in his home was not completed. When further queried, COTA V reported with Resident #101's type of insurance, therapy does not have time to do home evaluations. COTA V reported due to Resident #101's cognition, he would need repetition in training to be successful with new tasks. COTA V also reported Resident #101 displayed impulsivity (tendency to act with no consideration of consequences) with unfamiliar tasks.In an interview on 2/19/26 at 3:51pm, DON B reported the facility could not provide any documentation of Resident #101 receiving training for colostomy care prior to his discharge.Review of an electronic communication received from NHA A on 2/18/26 at 9:59am revealed all discharges were voluntary, in reference to the discharge of Resident #100 and Resident #101.In an interview on 2/19/26 at 4:00pm, NHA A reported Resident #101's DPOA said they did not want him to discharge from the facility on 1/8/26 but they ultimately took him to his home. NHA A stated I'm not forcing people out.if they had said they weren't leaving they could have stayed. When queried, NHA A confirmed the facility did not provide Resident #100 or Resident #101 with written notice of discharge or right to appeal document.In a follow-up interview on 2/19/26 at 4:50pm, NHA A confirmed the facility was reluctant to initiate the involuntary discharge process.Review of electronic communications from the governing body on 2/19/26 8:38am, revealed the facility did not submit the required Notice of Involuntary Transfer or Discharge and Facility Initiated Discharge and Appeal Form form (ITD 100) for Resident #100 or Resident #101.Review of a Resident Transfers and Discharge policy with a reference date of 4/2020 revealed Facility -initiated transfer or discharge-Involuntary discharge: A transfer or discharge which the resident objects to; or did not originate though a resident's verbal or written request, and/or is not in alignment with the resident's stated goals for care and preferences.The facility provide written notice in a language the resident or the resident's representative can understand.Written notice will be given at least 30 days before the proposed discharge. |