STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235723	A. Building B. Wing	07/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harbor Post Acute Center	2060 Health Drive Wyoming, MI 49519

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to notify the physician and/or pharmacy when a medication was unavailable and the resident did not receive it for 4 of 4 residents reviewed (R1, R2, R3, and R4) for medication administration. Findings include: R1 A review of R1's admission Record, dated 6/30/26, revealed R1 was a [AGE] year-old resident that was admitted to the facility on [DATE] with multiple diagnoses that included depression, dysphagia (difficulty swallowing), and anxiety. A review of R1's Minimum Data Set (MDS) (a tool used for assessing a resident's care needs), dated 6/24/26, revealed a Brief Interview for Mental Status (BIMS) (a scale used to determine a resident's cognitive status) score of 10 which revealed R1 was mildly cognitively intact. A review of R1's Medication Administration Record (MAR), dated 6/18/26 to 6/30/26, revealed that R1 did not receive her morning doses of bupropion (a medication for depression), duloxetine (a medication for depression), esomeprazole (a medication for acid reflux), and levothyroxine (a thyroid medication) on 6/19/26. A further review of R1's MAR revealed she did receive the morning doses of her other prescribed medications on that day. A review of R1's electronic medical record (EMR), dated 6/18/26 to 6/30/26, revealed that she was not administered her morning doses of bupropion, duloxetine, esomeprazole, and levothyroxine on 6/19/26 because the medications were not available and the back-up medication machine was not working. In addition, the progress notes revealed the pharmacy was notified. However, R1's progress notes failed to reveal if the physician/healthcare provider had been notified that these medications were not available and/or that R1 did not receive them. During an interview on 6/30/26 at 1:45 PM, R1 stated there was only one time that she had not received her medication since she had been at the facility. She stated she thought that was close to the time she was admitted to the facility. During an interview on 6/30/26 at 1:55 PM, Licensed Practical Nurse (LPN) F stated the medication carts have the residents' medications in them and there was a machine which had the back-up prescription medications in it. LPN F further stated if a medication was not available in the medication cart or the backup machine, then they would notify the pharmacy to see when it would be delivered. She stated she would call the physician/healthcare provider after talking to the pharmacy to let them know that the medication was not available. She stated she would tell them when the pharmacy delivery would be and would ask them if there was another medication that they wanted the resident to have instead of the unavailable medication or if it was ok to just wait until the medication arrived. LPN F stated if the physician/healthcare provider wanted the resident to have the medication prior to the next pharmacy delivery or if the medication was a critical medication that needed to be given within a strict time frame and it would not arrive in time, then she would call the pharmacy back and request a STAT drop (an immediate delivery of the medication by a courier) from the pharmacy. R2 A review of R2's admission Record, dated 6/30/26, revealed R2 was an [AGE] year-old resident admitted to the facility on [DATE] with multiple diagnoses that included diabetes, hypertension (high blood pressure), and hyperlipidemia (high cholesterol). A review of R2's MAR, dated 6/20/26 to 6/30/26, revealed that R2 did not receive her hydrochlorothiazide (a medication for high blood pressure), Mounjaro (a medication for diabetes), pantoprazole (a medication for acid reflux), losartan (a medication for high blood pressure- morning dose), metformin (a medication for (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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