

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>034040</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>3/12/2025</b>
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NAME OF PROVIDER OR SUPPLIER  <b>ELY MANOR</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1200 ELY ST ALLEGAN, MI 49010</b>
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F0000 SS=	INITIAL COMMENTS  Ely Manor was surveyed for an Abbreviated survey on 3/11/25 - 3/12/25.  Intake: MI00150558  Census = 89	F0000		
F0550 SS= D	Resident Rights/Exercise of Rights §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or	F0550	Resident #104 and #105 continue to reside in the facility. Care plans have been reviewed and deemed appropriate. Residents residing in the facility have the potential to be affected by the deficient practice. The Director of Nursing/designee has re-educated staff on the Resident Rights Policy and the Call light Policy. Staff members who have not received education by March 24, 2025 will be removed from the schedule until education has been received. The Director of Nursing/designee will complete an audit of 10 random call lights during and around meal times to ensure resident's needs are met in a timely matter. An audit will be completed once a week for four weeks then once every month for three months to ensure call lights are being answered in a timely matter. Results of the audits will be reported to facility QAPI committee for review and recommendations. This plan of correction will be monitored at the routine Quality Assurance (QAPI) meeting until such a time it is identified by the committee that sustained substantial compliance has been achieved. The Director of Nursing is responsible for attaining and maintaining compliance. Compliance Date: March 24, 2025	3/24/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

03/21/2025

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.

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	<p>her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by:</p> <p>Based on interview and record review, the facility failed to maintain dignity and respond to residents' call lights in a timely manner in 2 (Resident #104 and #105) of 5 residents reviewed for dignity, resulting in feelings of frustration and the potential for overall decline in quality of life.</p> <p>Findings include:</p> <p>Resident #104</p> <p>Review of an "Admission Record" revealed Resident #104 was a male, with pertinent diagnoses which included: depression and type 2 diabetes mellitus (a condition where the body is not able to properly use sugar from the blood).</p> <p>Review of a "Minimum Data Set" (MDS) assessment for Resident #104, with a reference date of 2/25/25 revealed a "Brief Interview for Mental Status" (BIMS) score of 14, out of a total possible score of 15, which indicated Resident #104 was cognitively intact.</p> <p>In an interview on 3/11/25 at 9:24 AM, Resident #104 reported sometimes it takes "forever" for his call light to be answered. Resident #104 reported this was especially true when the facility was serving lunch or dinner, and he wanted something.</p> <p>Resident #105</p> <p>Review of an "Admission Record" revealed Resident #105 was a male, with pertinent</p>				

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	<p>diagnoses which included: urinary tract infection, unsteadiness on feet, and weakness.</p> <p>Review of a "Minimum Data Set" (MDS) assessment for Resident #105, with a reference date of 2/1/25 revealed a "Brief Interview for Mental Status" (BIMS) score of 15, out of a total possible score of 15, which indicated Resident #105 was cognitively intact.</p> <p>In an interview on 3/11/25 at 10:00 AM, Resident #105 reported call light response times varied, but when staff were busy, it takes too long for them to respond. Resident #105 reported sometimes staff didn't get to him soon enough and he urinated in his pants which made him feel terrible that he had to do that.</p> <p>In an interview on 3/12/25 at 9:11 AM, "Certified Nurse Aide" (CNA) "I" reported occasionally residents had complained to her about long call light wait times. CNA "I" reported staff tried to get to the residents as soon as possible but sometimes the residents complained that it took too long.</p> <p>In an interview on 3/12/25 at 9:22 AM, "Activities Assistant" (AA) "H" reported residents have complained to her about long call light wait times.</p> <p>Review of "Resident Council Minutes" dated 10/25/24 revealed, "...residents are waiting longer periods of times to have their call light answered ..."</p> <p>Review of "Resident Council Minutes" dated 11/29/24 revealed, "...residents are having troubles with their call lights being answered ..."</p> <p>Review of "Resident Council Minutes" dated 1/10/25 revealed, "...Aides are turning off call</p>			

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F0565 SS= D	lights without addressing resident issues and saying they will return but either never show up or it takes then 45 minutes to an hour to return ..."  Review of "Resident Council Minutes" dated 2/7/25 revealed, "...Light still being turned off and now (sic) addressing resident issues ..."  Resident/Family Group and Response §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility.	F0565	No residents were identified in this citation. Residents residing in the facility have the potential to be affected by the deficient practice. The Administrator re-educated the Activities Director of the Guest/Resident Council policy and the proper use of grievance/concern forms to be used for concern resolution. The Administrator will audit resident council minutes to ensure guest/resident concerns are resolved in a timely manner and concern forms are completed appropriately. The Administrator will complete the audit monthly for four months to ensure substantial compliance. Results of the audits will be reported to facility QAPI committee for review and recommendations. This plan of correction will be monitored at the routine Quality Assurance (QAPI) meeting until such a time it is identified by the committee that sustained substantial compliance has been achieved. The Administrator is responsible for attaining and maintaining compliance. Compliance Date: March 24, 2025	3/24/2025

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	<p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on interview and record review, the facility failed to demonstrate evidence of prompt action taken to resolve resident council concerns of lengthy call light wait times in 4 of 6 resident council meetings reviewed for concern resolution, resulting in on-going dissatisfaction with call light response and the potential for feelings of frustration.</p> <p>Findings include:</p> <p>In an interview on 3/12/25 at 9:11 AM, "Certified Nurse Aide" (CNA) "I" reported occasionally residents had complained to her about long call light wait times. CNA "I" reported staff tried to get to the residents as soon as possible but sometimes the residents complained that it took too long.</p> <p>In an interview on 3/12/25 at 9:22 AM, "Activities Assistant" (AA) "H" reported residents have complained to her about long call light wait times.</p> <p>Review of "Resident Council Minutes" dated 10/25/24 revealed, " ...residents are waiting longer periods of times to have their call light answered ..."</p> <p>Review of "Resident Council Minutes" dated 11/29/24 revealed, " ...residents are having troubles with their call lights being answered ..."</p> <p>Review of "Resident Council Minutes" dated 1/10/25 revealed, " ...Aides are turning of call lights without addressing resident issues and saying they will return but either never show up or it takes then 45 minutes to an hour to return ..."</p>			

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F0580 SS= D	<p>Review of "Resident Council Minutes" dated 2/7/25 revealed, "...Light still being turned off and now (sic) addressing resident issues ..."</p> <p>In an interview on 3/12/25 at 2:26 PM, "Nursing Home Administrator" (NHA) "A" reported after resident council meetings are held, the activity director types up the meeting minutes and shares the information with the management team. NHA "A" reported prior to the start of the following month resident council meeting, old business was reviewed with the resident council and an update was provided on the work the management team had done to resolve their concerns. NHA "A" reported a formal concern/grievance form was not completed for concerns that arise from the resident council as a whole; only resident-specific concerns were written up on concern/grievance forms. NHA "A" reported maybe they should start putting resident council concerns on concern/grievance forms to keep track of them better.</p> <p>Notify of Changes (Injury/Decline/Room, etc.) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or</p>	F0580	<p>Resident #101 continues to reside in the facility. The resident's care plan has been reviewed and deemed appropriate. Residents residing in the facility have the potential to be affected by the deficient practice.</p> <p>The Director of Nursing/designee has re-educated the licensed nurses of the Notification of change policy. Any licensed nurse who have not received education by March 24, 2025 will be removed from the schedule until education has been received. The Director of Nursing/designee will audit fall documentation to ensure that all appropriate parties have been notified in a timely manner. The Director of Nursing/designee will conduct the audit once a week for four weeks then once every month for three months to ensure</p>	3/24/2025

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	<p>(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by:</p> <p>This citation pertains to intake MI00150558</p> <p>Based on interview and record review, the facility failed to inform the resident's emergency contact of a fall in a timely manner for 1 (Resident #101) of 3 residents reviewed for falls resulting in a delay in the time the emergency contact was made aware of the fall.</p> <p>Findings include:</p> <p>Resident #101</p>		<p>appropriate parties are being notified timely. Results of the audits will be reported to facility QAPI committee for review and recommendations. This plan of correction will be monitored at the routine Quality Assurance (QAPI) meeting until such a time it is identified by the committee that sustained substantial compliance has been achieved. The Director of Nursing is responsible for attaining and maintaining compliance. Compliance Date: March 24, 2025</p>	

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	<p>Review of an "Admission Record" revealed Resident #101 was a male, with pertinent diagnoses which included: aftercare following joint replacement surgery and presence of left artificial knee joint.</p> <p>Review of a "Minimum Data Set" (MDS) assessment for Resident #101, with a reference date of 2/20/25 revealed a "Brief Interview for Mental Status" (BIMS) score of 15, out of a total possible score of 15, which indicated Resident #101 was cognitively intact.</p> <p>Review of Resident #101's "Nurses Note" dated 2/21/25 at 4:39 AM and authored by "Licensed Practical Nurse" (LPN) "F" revealed, "Note Text: Resident observed on the floor next laying on right side with back next to recliner and head facing bed. Walker was next to him. Resident stated "I was getting up to use the bathroom and coulnt (sic) wait and peeded (sic) and slipped in it" Passive and active ROM (range of motion) to all four extremetis (sic) with pain to right side. Resident safely tranfered (sic) by staff to chair. Head to toe assessment completed and neuros implemented. Dressing applied to skin tear of right elbow. Xray ordered for right hip and right knee. Immediate intervention pull ups and contined (sic) to encourage using call light with ambulation (sic). CP (care plan) updated. All appropriate parties notified."</p> <p>Review of Resident #101's "Fall" Report dated 2/21/25 at 3:45 AM revealed, " ...Incident Description Nursing Description: Resident observed on the floor next laying on right side with back next to recliner and head facing bed. Walker was next to him Resident Description: I was getting up to use the bathroom and coulnt (sic) wait and peeded (sic) and slipped in it ...Injuries Observed at Time of Incident Injury Type Injury Location Abrasion ...Right knee</p>			

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	<p>(front) Reddened Skin ...Right trochanter (hip) Skin Tear ...Right elbow ...Agencies/People Notified Agency/Person DON ...Physician ..."</p> <p>In an interview on 3/6/25 at 12:50 PM, "Confidential Informant" (CI) "O" reported Resident #101 fell on 2/21/25 at approximately 3:30 AM. CI "O" reported Resident #101's emergency contact was not made aware of the fall until Resident #101's grandson went to visit the next day and Resident #101 had told him about the fall.</p> <p>In an interview on 3/11/25 at 2:16 PM, Resident #101 reported if something were to happen with him, such as a fall, it was his preference that his family (including emergency contact) would be called. Resident #101 reported the facility had all the information to make the notifications and they knew that was his preference.</p> <p>In an interview on 3/11/25 at 12:53 PM, LPN "F" reported after Resident #101 fell, she went to assess him. LPN "F" reported Resident #101 had said his knee hurt. LPN "F" reported she had also noted that Resident #101's elbow was bleeding, and his knee was red. LPN "F" reported she had called the on-call provider to get x-rays and had also notified the Director of Nursing of the resident fall. LPN "F" reported she had not called Resident #101's emergency contact to notify them of the fall because it was at 3:30 in the morning. LPN "F" reported she had passed off to the next shift that Resident #101's emergency contact needed to be called.</p> <p>In an interview on 3/12/25 at 10:38 AM, "Registered Nurse" (RN) "M" reported she was the nurse who came in on the next shift after Resident #101 fell and relieved LPN "F". RN "M" reported by protocol, the person who was on duty at the time of the fall was the person who was</p>				

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	<p>supposed to notify family of the incident. RN "M" reported she did not contact Resident #101's emergency contact to notify them of the fall because LPN "F" had reported she had made all appropriate notifications.</p> <p>In an interview on 3/11/25 at 4:18 PM, "Nursing Home Administrator" (NHA) "A" reported the emergency contact should be notified right away in the event of a change of condition, including a fall, regardless of the time of day.</p> <p>Review of a "Notification Of Change" policy last revised 2/14/24 revealed, "POLICY The facility must inform the resident, consult with the resident's practitioner, and notify, consistent with his or her authority, the resident representative(s) when there is a change in status. Even when a resident is mentally competent, his or her designated resident representative or family, as appropriate, should be notified of significant changes in the resident's health status unless the resident does not want the notification. INFORMATION A change in status would include the following: An accident involving the resident ...PROCEDURE ...2. Changes in the resident status, including but not limited to, those identified above, or any unusual occurrence, the licensed nurse will notify the resident's representative, unless otherwise dictated by the resident ..."</p>			