

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235003	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/09/2024
NAME OF PROVIDER OR SUPPLIER Manistee County Medical Care Facility		STREET ADDRESS, CITY, STATE, ZIP CODE 1505 E Parkdale Avenue Manistee, MI 49660	

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)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>35103</p> <p>Based on interview and record review, the facility failed to ensure the provision of dignified care and services for five Confidential Residents (C1, C2, C3, C4, and C5)) out of 13 residents reviewed for dignity. This deficient practice resulted in feelings of intimidation, frustration, and fear of retaliation from facility staff. Findings include:</p> <p>Confidential Resident C2</p> <p>Review of C2's Minimum Data Set (MDS) assessment, dated 9/23/24, revealed a Brief Interview for Mental Status (BIMS) score of 13 of 15, reflective of intact cognition.</p> <p>During an interview on 10/07/24 at 12:29 p.m., Confidential Resident C2 was asked about the provision of dignified and respectful care and services by facility staff. C2 initially spoke in a whisper and said she did not want to discuss it, but then motioned this Surveyor closer and said there was one staff member that did not like her and did not treat her properly. When asked who the staff member was, C2 noted it was Staff T, who had refused to clean up a beverage C2 had spilled at lunch. C2 said she had spilled a lunch beverage, and it was all over the floor. Staff T entered the room and did not clean/pick up the spilled beverage. C2 said they had yelled for Staff T to come back, but Staff T never returned to the room, and the beverage remained on the floor for approximately an hour.</p> <p>During an interview on 10/7/24 at approximately 12:35 p.m., Staff U entered C2's room, and C2 asked Staff U to confirmed what they had just reported to this Surveyor. Staff U said they had heard C2 yelling for Staff T and came to the room to investigate what was going on. Staff U confirmed C2 had a beverage spilled on the floor and it had not been cleaned up by Staff T. Staff U said they had come into C2's room and had to finish cleaning up the floor. Staff U said the spilled had remained on C2's floor for over an hour. Staff U said she was aware of resident complaints regarding how Staff T treated some of the residents.</p> <p>Review of Staff T's personnel file on 10/08/24 at 12:10 p.m., revealed no disciplinary action present in their personnel file for the last year.</p> <p>Confidential Resident C4</p> <p>Review of C4's Minimum Data Set (MDS) assessment, dated 8/5/24, revealed a Brief Interview for Mental Status (BIMS) score of 12 of 15, reflective of moderate cognitive impairment.</p> <p>(continued on next page)</p>

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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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 10/07/24 at 2:34 p.m., Confidential Resident C4 was asked if they had any concerns related to respectful and dignified care. C4 said that Staff V had taken them to the bathroom and had not adequately cleaned up the feces that was present in her perineal area. C4 said Staff T had found the feces and showed her the amount of stool that was left in and on her body. C4 stated, I went to the office, and I told the office staff about it. I got really sick. When she (Staff V) come in here and [they] work on you, you have to take [them] if there is nobody else . C4 said the office staff were supposed to talk to Staff V about the lack of care and said she did not want Staff V caring for her any more.</p> <p>During an interview on 10/08/24 at 10:47 a.m., the Director of Nursing (DON) was asked if there was an investigation file for allegations made by C4 that Staff V did not provide toileting hygiene properly for the Resident. The DON stated, I don't have anything on [C4]. I know [they] did not like [Staff V]. When asked if Staff V was able to provide care for C4 currently, the DON stated, I don't have [Staff V] in that section. No, I don't. I can't have continuity all the time. I don't want [Staff V] in that section. When asked if other Residents had complained about [Staff V's] undignified and disrespectful treatment, the DON stated, Yes, other residents like C1. When asked if C1 was the only one to complain about Staff V, the DON stated, No, C5 also complained about [Staff V]. When asked if there was any other resident, the DON stated, C3 on 8/12/24. When asked documentation of the Confidential Resident complaints about Staff V's care would be found in their personnel file, the DON acknowledged that no written documentation of those resident allegations/complaints would be found in Staff V's personnel file. The DON said she had completed interviews with Staff V, but they were not documented as evidence of the allegations. The DON confirmed that Staff V had been re-assigned to a different area with different residents. The DON acknowledged [Staff V] did have a pattern of behavior and people were feeling a little uneasy around her. When asked if they have received staff reports that Staff V was not performing her duties properly, the DON stated, I get multiple complaints a day from staff - some I take to heart, some I don't. I have received a complaint from one of my complainers . I do agree that I have heard [Staff W] curse before. Do I know that Staff W swore at C5? I believe C5 (that Staff W swore at him). The DON acknowledged she had previously heard Staff W swear while working in the facility.</p> <p>Review of C5's Minimum Data Set (MDS) assessment, dated 8/5/24, revealed a Brief Interview for Mental Status (BIMS) score of 13 of 15, reflective of intact cognition.</p> <p>Confidential Resident C3</p> <p>Review of C3s Minimum Data Set (MDS) assessment, dated 9/16/24, revealed a Brief Interview for Mental Status (BIMS) score of 12 of 15, moderate cognitive impairment.</p> <p>During an interview on 10/08/24 at 9:12 a.m., Confident Resident C3 was asked if she had ever been treated in an undignified or disrespectful manner by facility staff. C3 said she was in the facility for a short time period and had a couple of disagreements with facility staff. C3 said she had brought it up to the DON, and everything was settled, and the Staff member in question no longer provided care to her. C3 said she did not remember the Staff members name, but when several names were mentioned, C3 confirmed it was Staff V. C3 stated, The first time, before [they] did anything else, [they] would walk over to my window and shut my blinds. I told [them] to open the blinds. I told them I was the patient, and you are going to open those blinds, and [they] left (without opening the blinds). I guess they (administration) gave her hell. [Staff V] got hall bent out of shape. I didn't want Staff V here. [Staff V] doesn't come and take care of me anymore.</p> <p>(continued on next page)</p>		

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Confident Resident C1</p> <p>Review of C21s Minimum Data Set (MDS) assessment, dated 9/23/24, revealed a Brief Interview for Mental Status (BIMS) score of 15 of 15, reflective of intact cognition.</p> <p>During an interview on 10/08/24 at 3:11 p.m., C1 stated, [Staff V] was very disrespectful to both myself, and my wife. How was she disrespectful? If I couldn't turn on my side, she would yell at me and say, 'You can do it', and she would not turn me . Staff V would leave me on urine stained, wet pads . I complained to [The DON] about it. I probably (first) complained about three to four months (ago). When asked what the DON did in response to the complaints, C1 stated, I am not sure what [the DON] did, because nothing changed. [The DON] did not give me any feedback. I told [the DON] the same things I told you . [Staff V's] lack of hygienic care for me was the most troublesome to me . I was laying in my own pee. [Staff V] had an air of superiority, like [they were] better than me. That is how I felt anyway. I would say about a month after the initial complaint about [Staff V] I complained to [the DON] again. I told her the same issues were going on. She says, 'That it is hard to hire good people.' [The DON] said she would take care of it. She initially banned [Staff V] from the hallway, but now she is allowed in my room if she has at least one aide with her. I am still not comfortable with having Staff V in my room. I agreed to it because they are short-staffed, but I don't feel comfortable about it . I think administration has not dealt with these individuals appropriately, and I think people are afraid to speak up. Staff are very intimidated here .</p> <p>During a telephone interview on 10/08/24 at 3:46 p.m., Family Member (FM) F of C1 was asked about the provision of respectful and dignified care by facility staff. FM F stated, One day the green (privacy) curtain was shut, and I arrived earlier than expected. I waited to tell [Staff V] that I was here. I heard her say, to C1, 'I don't care what you want. I am going to do what I want to do.' C1 wanted the nurse to come and look at his bottom before [Staff V] covered it up . I told [Staff V] that was so inappropriate. I asked [them] why [they] didn't get the nurse. [Staff V] said I will get her when I want to. I [FM F] went and got the nurse and she acted like I was the problem. I said to [Staff V], why do I have problems with you, when I have no problems with anyone else here. [Staff V] rolled her eyes and made an obvious smirk to the nurse. The nurse was saying it needed to be treated right away. [Staff V] wanted to get c1 dressed right away - and what [Staff V] was doing was ripping the skin and it was bleeding. Even though [C1] was repeated saying 'Please, please get the nurse before you put anything on me, because there is something wrong, it is hurting so bad.' [Staff V] said 'You are not in charge here'.</p> <p>During a continued telephone interview on 10/08/24 at 3:51 p.m., FM F stated, Another time I had trouble, C1 was saying [Staff V] was leaving wet (urine soaked) pads on [their] bed. I put my hand under the blanket, and the mat was soaked. It was wet . I told the nurse I was going to make C1's bed. The nurse took everything off the bed and remade the bed. The nurse told [Staff V] what was going on and [Staff V] started acting like she was going to make the bed. After the nurse left, [Staff V] turned and said, 'it is all taken care of now isn't it. Now you don't have anything to say about it' . When [Staff V] was by themselves, they were ornery. I stayed away from [them] as much as I could . C1 just reported it to [the DON]. I thought everything would be taken care of because [Staff V] seemed to be having trouble with other people at the same time. It is up to the facility to take care of this. We are not in charge of anything here.</p> <p>(continued on next page)</p>		

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the Resident Rights Policy, reviewed 07/24, revealed the following, in part: .The resident has the right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility . The resident has a right to be treated with respect and dignity .</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49310</p> <p>This deficiency pertains to Intake MI00147245 and MI147343</p> <p>Based on interview and record review, the facility failed to notify the state agency timely of reportable occurrences for one Residents (R199) of two residents reviewed for abuse. Findings include:</p> <p>Resident #199</p> <p>On 9/26/24 at 1:00 a.m., Resident #199 (R199) was found unresponsive in his wheelchair. A nurse's progress note dated 9/26/24 at 1:44 a.m. documented R199 had been resting in his wheelchair until 1:00 a.m. when staff approached R199 about going to bed. Documentation in nurse progress notes indicate R199's arms and legs were flaccid, and the resident had a blank gaze when staff performed sternal rubbing.</p> <p>R199 was transferred to the Emergency Department (ED) on 9/26/24 at 1:35 a.m. where a urine drug screen (UDS) was performed. The results of the UDS were positive for cocaine. The ED physician documented, in part: .I reviewed the nursing home note and also his medication list. Nothing can account for the cocaine in his urine .A confirmation test quantitatively was sent out .</p> <p>In a hospital Discharge Summary dated 9/27/24, the physician documented the UDS was repeated and returned positive results for the presence of cocaine. The Discharge Summary documented pharmacy involvement to verify potential cross-reactions with medications, but there were none found. R199 returned to the facility on [DATE].</p> <p>On 10/2/24, R199's attending physician documented, in part: . I am aware of the call that they made last week that he was obtunded [diminished response to stimuli, often due to a state of reduced consciousness]. He was sent to the hospital and this is attending I followed this case there [sic]. It was found that his urine tested positive in the preliminary testing for cocaine. I spoke with the hospitalist and [R199] had been rechecked and again tested positive. Just now we found out that the confirmatory test was positive for the metabolite of cocaine benzoylecgonine which in my research is the main metabolite for cocaine, can persist in the urine for 5 days and is usually how ingestion is diagnosed , he has very few if any false positives, but I did read where he [sic]could be from some sort of teas from Latin America. Cocaine must have been ingested somehow. In my clinical practice we find this fairly commonly due to adulterated marijuana .</p> <p>During a phone interview with the Durable Power of Attorney (DPOA) and Family Member (FM) N on 10/7/24 at 2:13 p.m., FM N said she was notified by the hospital about the cocaine identified in R199's UDS. FM N conveyed R199 had never used illicit drugs.</p> <p>The Director of Nursing (DON) was interviewed on 10/8/24 at 8:45 a.m. The DON said she and the Administrator (NHA) were made aware R199 tested positive for cocaine when R199 was readmitted to the facility on [DATE]. The DON confirmed a facility-reported incident was not filed with the state agency until 10/2/24.</p>		

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<p>F 0659</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care by qualified persons according to each resident's written plan of care.</p> <p>35103</p> <p>Based on interview and record review, the facility failed to ensure invasive blood sugar (glucometer) testing and insulin injections were administered by licensed nursing staff for one Resident (R19) out of 13 residents reviewed for qualified staffing. This deficient practice resulted in Certified Nurse Aide (CNA) B providing care outside the scope of practice when they administered insulin via injection and completed invasive blood glucose monitoring for R19. Findings include:</p> <p>During an interview on 10/08/24 at 9:22 a.m., R19 said [CNA B] came into their room and gave them two insulin shots. R19 stated, [CNA B] gave me the insulin . [CNA B] came in and gave it (insulin) to me on one side . and then came in later and gave it to me on the other side. This happened in May or June. It is almost like a bad dream . I knew it wasn't right .</p> <p>Review of R19's Physician Order Summary, as of 10/9/24, revealed the following orders to be administered by licensed nursing staff, in part:</p> <p>Humalog Injection Solution 100 Unit/ML (milliliter) (Insulin Lispro) Inject as per sliding scale; if 0-100 = 0 units; 101-150 = 5 units; 151-400 = 10 units, subcutaneously three times a day for DM (diabetes mellitus).</p> <p>Lantus Subcutaneous Solution 100 Unit/ML (Insulin Glargine) Inject 20 unit subcutaneously one time a day for DM.</p> <p>Review or R19's Care Plan Interventions revealed the following, in part: Accu-Chek's and insulin as ordered by physician. Date Initiated: 02/02/2024 . Administer medications as ordered by physician . Date Initiated: 02/02/2024.</p> <p>During an interview on 10/08/24 at 9:56 a.m., the Director of Nursing (DON) reported, The Date of Infraction was 8/12/24. This is the RN's (RN A's) corrective action. He received a written warning. It is pretty severe to have a CNA giving medication (insulin). The DON confirmed [CNA B] was spoken to about the administration of insulin to [R19]. Discipline documentation for both CNA B and RN A were requested at that time from the DON. The DON said they would have to look in CNA B's personnel file.</p> <p>Review of RN A's personnel filed on 10/08/24 at 11:36 a.m., revealed the following, in part:</p> <p>1. 8/12/24 Corrective Action Notice, with all duplicate pages attached, received directly from the DON was not found in RN A's personnel file. Review of the Corrective Action Notice, dated 8/12/24 for [RN A], revealed the following Section 2: [RN A] gave insulin to [CNA B] to give to Resident in room (Room Number). Work Rules #1 - Conduct harmful to the reputation and purpose of [Facility Name]. #9 - Unprofessional conduct while in the workplace or while on [Facility Name] work.</p> <p>Review of CNA B's Disciplinary Action in Personnel File revealed only one disciplinary action documentation found in CNA B's personnel file. No documentation was present regarding administration of insulin, or completion of an invasive blood sugar (glucometer) check by CNA B without a nursing license.</p> <p>(continued on next page)</p>		

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<p>F 0659</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a telephone interview on 10/9/24 at 4:50 a.m., RN A acknowledged he had given CNA B the tasks of blood sugar monitoring, and insulin injection for R19. RN A stated, I didn't pressure her (CNA B), I asked her, and it was completely 100% my idea . [CNA B] did the [blood glucose monitoring] reading . [The DON] took my statement. It was my final written warning . RN A said it (CNA B giving insulin and blood sugar test) happened on a weekend: a Saturday. [RN A] . asked [CNA B] to perform the [blood sugar monitoring] and administer insulin two times to R19. RN A said he knew it was a mistake, and they should have asked another nurse in the building to perform those tasks if [RN A] was not going to enter R19's room. RN A confirmed they had documented on the Medication Administration Record (MAR), that [RN A] had administered the insulin two times on that Saturday. RN A stated, I knew it was wrong. I thought to myself, 'What was I thinking.' I should not have asked CNA B to do that.</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34568</p> <p>Based on observation, interview, and record review, the facility failed to provide the necessary standards of care and services for diabetes management in one Resident (Resident #37) of one resident reviewed for diabetic management. This deficient practice resulted in the potential for diabetic related complications including organ damage, stroke, and death.</p> <p>Findings include:</p> <p>Resident #37 (R37)</p> <p>Review of R37's electronic medical record (EMR) revealed admission to the facility on [DATE] with diagnoses including Type 2 diabetes mellitus. R37's 8/19/24 Minimum Data Set (MDS) assessment revealed a Brief Interview for Mental Status (BIMS) score of 2, indicative of severe cognitive impairment. R37 was also noted to have received seven insulin injections in Section N of the 8/19/24 MDS assessment.</p> <p>Review of R37's Medication Administration Record (MAR) revealed the following:</p> <p>Basaglar Tempo Pen Subcutaneous Solution Pen-injector 100 Unit/ML (milliliters) (Insulin Glargine) Inject 20 unit subcutaneously one time a day for DM (diabetes mellitus)</p> <p>HumaLOG Injection Solution 100 UNIT/ML (Insulin Lispro) Inject 5 unit subcutaneously with meals related to type 2 diabetes mellitus without complications plus sliding scale insulin</p> <p>HumaLOG Injection Solution 100 UNIT/ML (Insulin Lispro) Inject as per sliding scale:</p> <p>if 150-200 = 2 units;</p> <p>201-250 = 4 units;</p> <p>251-300 = 6 units;</p> <p>301-350 = 8 units;</p> <p>351-400 = 10 units;</p> <p>401-500 = call DR (doctor);</p> <p>subcutaneously three times a day for DM</p> <p>Review of R37's MAR revealed no orders, including frequency or method, to monitor blood glucose levels or an order for Glucagon Emergency Kit.</p> <p>Review of R37's Blood Sugar Summary from 7/1/24 through 10/8/24 revealed R37 was being monitored for blood sugar values three times a day and ranging from 63-334.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview was conducted with Registered Nurse (RN) L on 10/9/24 at 9:40 a.m. RN L confirmed R37 was diagnosed with type 2 diabetes with orders for insulin. RN L stated that the Glucagon Emergency Kit was a standing order and would notify the physician after the event if Glucagon was used for R37.</p> <p>Review of R37's Standing Orders dated 2/14/24 revealed no order for the use of Glucagon.</p> <p>An interview was conducted with the Director of Nursing (DON) on 10/9/24 at 9:55 a.m. The DON confirmed that R37 did not have physician orders for blood glucose monitoring despite being tested daily. The DON also confirmed that Glucagon is not part of the facility's standing order and R37 should have access to Glucagon if needed.</p> <p>Review of the facility's Hypoglycemia Management policy dated 9/24 revealed, .Compliance Guidelines . Diabetic residents will have their blood sugar tested per the physician's orders and at the residents' request . If the blood glucose reading is 70 mg/dL or below, the nurse will utilize the '15'15 Rule' per the American Diabetes Association. The 15-15 rule: The nurse will provide 15 grams of carbohydrate to resident to raise blood glucose and complete a follow up blood glucose test in 15 minutes .Per American Diabetes Association examples of 15 grams of carbohydrates may be: 4 ounces of juice or regular soda, 1 tablespoon of sugar, honey, or corn syrup, Glucose tablets, Gel tube .</p> <p>The facility's policy did not indicate the use of Glucagon.</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>49310</p> <p>Based on observation, interview, and record review, the facility failed to provide appropriate support surfaces for residents with wounds, develop care plan interventions for pressure-reducing support surfaces, accurately document the stage of a pressure injury, and provide ongoing weekly skin assessments for one (Residents R43) of four residents reviewed for pressure injury, resulting in the potential for worsening pressure ulcers.</p> <p>Findings include:</p> <p>Resident #43</p> <p>On 10/7/24 at 12:20 p.m., Resident #43 (R43) said she hurt, and indicated the pain was in her gluteal area. R43 was sitting in a recliner with no visible chair cushion on the recliner. The mattress on R43's bed was a standard facility mattress. R43 was unable to answer questions regarding potential skin impairment.</p> <p>R43 had a quarterly Minimum Data Set (MDS) assessment completed on 7/22/24. The MDS documented R43 was dependent on staff for Activities of Daily Living (ADL), including dependence on staff for bed mobility, turning and repositioning.</p> <p>Physician's orders for R43 included treatment orders for a Stage 4 (Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer) pressure injury to the sacrum.</p> <p>Progress notes in the medical record dated 9/14/24, 9/23/24, 9/27/24, 9/28/24, 9/29/24, and 9/30/24 documented a Stage 4 pressure injury to R43's sacrum.</p> <p>Wound Evaluation Forms dated 9/10/24 and 10/7/24 documented the pressure injury on the sacrum as a Stage 3 (Full-thickness loss of skin, in which subcutaneous fat may be visible in the ulcer and granulation tissue with the presence of slough and/or eschar that does not obscure the depth of tissue loss). The wound evaluation forms documented the pressure injury as developing in the facility.</p> <p>Skin assessment records revealed no documented skin assessments for R43 from 9/4/24 to 10/2/24. The skin assessment of 9/4/24 reflected no skin impairment. The skin assessment of 10/2/24 documented, in part: .[R43] is frequently offered fluids and assisted with position changes when [R43] allows, however [R43] frequently refuses these position changes. Interventions remain in place to mitigate these risks and are reflected in her plan of care. These interventions include pressure reducing devices to [R43] bed and chair as well as frequent rounding to include assisting and offering position changes .</p> <p>A review of R43's care plan did not reveal interventions for pressure reducing devices to the bed or chair. The care plan did not document refusals of position changes or contain interventions to alleviate pressure if R43 refused to be turned or repositioned.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The Director of Nursing (DON) was interviewed on 10/8/24 at 2:00 p.m. The DON confirmed there were no skin assessments completed for R43 between 9/4/24 and 10/2/24. The DON said skin assessments are expected to be completed at least weekly. The DON reviewed the care plan and confirmed there were no care plan interventions for support surfaces. When asked why R43 did not have a therapeutic support surface such as a low air loss mattress on the bed, the DON replied, She should have one.</p> <p>The policy Skin Assessments dated 7/2024 read, in part: .A full body, or head to toe skin assessment will be completed by the licensed nurse and documented in the electronic health record (EHR) on admission/readmission and weekly thereafter .</p> <p>The policy Standards of Care dated 7/2024 read, in part: .It is the policy of (name of facility) to use facility standards of care in developing resident-directed, individualized care plans .with resident-specific approaches .Standards of care promote consistent quality and the provision of clear, concise direction for staff providing care .</p>

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34568</p> <p>Based on observation, interview, and record review, the facility failed to implement interventions to address range of motion (ROM) for one resident (Resident #11) of two residents reviewed for limited range of motion. This deficient practice resulted in the potential for extreme pain, discomfort, and worsening of positions. Findings include:</p> <p>Review of R11's Electronic Medical Record (EMR) revealed an admitted [DATE] and diagnoses including cerebral palsy, epilepsy, anoxic brain damage, and anxiety disorder. Review of R11's 8/19/24 Quarterly Minimum Data Set (MDS) assessment revealed they were unable to complete the Brief Interview for Mental Status (BIMS) score and was marked with severely impaired cognition. In Section O of the 8/19/24 MDS, R11 was noted to have received zero days of treatment for therapy services and restorative nursing program services.</p> <p>On 10/7/24 at approximately 3:00 p.m., R11 was observed sitting in her bed watching television. R11's bed was noted to be elevated at the head. R11 was nonverbal during this interaction but was observed with her head leaning down and towards the right with her right ear resting on her shoulders. There were no assistive devices in place.</p> <p>On 10/8/24 at 9:53 a.m., R11 was observed sleeping in her bed. The head of R11's bed was elevated with her head slumped down onto her right shoulder.</p> <p>On 10/8/24 at 10:17 a.m., R11 was observed after being changed by two staff members. R11 was placed in the same position, with the head of her bed elevated and her head slumped down onto her right shoulder. An interview was conducted with Certified Nurse Aide (CNA) P who stated that R11's head positioning had been this way for quite some time. CNA P stated that R11's neck will become excoriated and red due to the position of her head on her shoulder. An observation was made of R11's neck which showed a pinkish red excoriation mark starting underneath R11's chin and ending at the base of her neck on the right side. CNA P stated that nursing will put cream on her neck to help with pain and healing. CNA P confirmed that after changing R11 she did not turn or reposition her into a new position.</p> <p>On 10/8/24 at approximately 10:40 a.m., an interview was conducted with Director of Rehabilitation (DOR) Q in R11's room. DOR Q observed R11's head positioning and confirmed that R11's head going down and touching her right shoulder has gotten significantly worse since admission. DOR Q confirmed that R11 had not been screened by therapy for her positioning and was not made aware of the excoriation on her neck.</p> <p>Review of R11's Care Plan revealed the following, (R11) is at risk for skin breakdown related to incontinence and contractures, need for total care from staff for transfers/skincare/repositioning, incontinence, and history of skin issues .Interventions: Assist with repositioning and incontinence care at least every two hours. Reposition side-to-side .</p> <p>(continued on next page)</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview was conducted with the Director of Nursing on 10/9/24 at 10:16 a.m. The DON confirmed that R11's head positioning has gotten worse and confirmed that a therapy screen should have been conducted.</p> <p>Review of the facility's Standards of Care policy reviewed 7/24 revealed the following, .A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene .CNA - Standards of Care: .Turn/reposition residents who cannot turn/reposition themselves, every two (2) hours and as needed. Support body alignment with pillows, wedges, ordered splints, etc. Chair bound residents, once (1x) every hour .Stop and watch tool will be utilized to communicate changes in condition of residents to the nurses .If the concern is not addressed by the nurse and the problem persists then report this finding to DON/ADON (Assistant Director of Nursing) . Responding to decline in ADL (activities of daily living) skills as a change in medical condition, Evaluating reasons for decline in ADL skills .</p>

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<p>F 0732</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>49302</p> <p>Post nurse staffing information every day.</p> <p>Based on interview and record review, the facility failed to complete, post, and retain the required daily nurse staffing information. This deficient practice resulted in the inability of residents and visitors to determine the number of staff available to provide resident care and had the potential to affect all 45 residents in the facility.</p> <p>Findings include:</p> <p>A review of the Daily Nursing Staff sheets from July - August, provided by the Director of Nursing (DON), revealed no postings were completed for the following dates:</p> <p>July (2024) 1, 3-7, 9, 11-14, 16-21, 23-25, 27-29, 31; and</p> <p>August (2024) 2-19, 21, 22, 24-26, 28, 31; and</p> <p>September (2024) 1, 2, 6-8, 10-16, 18, 19, 21-30.</p> <p>It was noted staffing sheets were not completed, posted, or retained on 73 of 92 days reviewed.</p> <p>On 10/9/24 at 10:37 AM, an interview was conducted with Nursing Administrative Assistant/Scheduler R who verified she was in responsible for completing and retaining the daily nursing staff postings. Scheduler R stated she worked on a part-time basis and only completes the required daily nurse staffing information on the days she works. When asked if the task was delegated to a different employee on the days she was not scheduled to work, Scheduler R verified it was not.</p> <p>On 10/9/24 at 10:53 AM, an interview was conducted with the DON regarding her expectations related to completion and retention of daily nurse staffing information. The DON stated, My expectation is that they should be completed daily. It's a regulation.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>35103</p> <p>Based on observation, interview, and record review, the facility failed to ensure all medications and biologicals were stored in locked compartments accessible only by authorized personnel in one medication room, of one medication storage room reviewed during the medication storage task. This deficient practice resulted in the potential for medication diversion when the medication room door was propped open without supervision and the medication refrigerator was unlocked and utilized for staff food items. Findings include:</p> <p>During an observation on 10/09/24 at 7:27 a.m. the second floor medication storage room was found propped wide open and unattended by any facility staff. This Surveyor walked into the medication storage room without supervision. Registered Nurse (RN) S, upon seeing this Surveyor walked into the second floor medication room. RN S acknowledged the medication room door was not supposed to be left open, unattended, and stated, I already shut this door once. When the unlocked, medication refrigerator was opened, three small plastic, storage containers with food, an aluminum foiled wrapped sandwich, and a protein drink were observed in the medication refrigerator with the back-up resident medication requiring refrigeration. RN S stated, That is not supposed to be here. I will get that out of here right now. RN S removed all of the food items from the medication storage room refrigerator and placed them on top of her purse/bag on the medication storage room counter next to the refrigerator. RN S closed the medication room door upon exit from the medication storage room with this Surveyor.</p> <p>During an observation on 10/09/24 at 7:55 a.m., the medication room door was found again propped open and unsupervised to the second floor medication room. This Surveyor entered the second floor medication room, unsupervised through the open, unsecured door. Unlocked, unsecured medication observed included discarded medication for Resident (R199) found in a cardboard box with one pharmacy prepared packed of medications. All medication stored in the medication refrigerator was unlocked and unsecured.</p> <p>During an interview on 10/09/24 at 7:58 a.m., the Director of Nursing (DON) was asked to observed the second floor medication room door that was propped open with no staff supervision. The DON said the nurse around the corner was supervising the open medication room. When the DON looked for the nurse and confirmed the nurse was not within view of the open medication room door, the DON confirmed the medication room door should not be left open unattended. The DON shut the second floor medication room door on 10/09/24 at 8:00 a.m.</p> <p>During an interview on 10/9/24 at 8:00 a.m., when asked if it was acceptable for staff to place their lunch food items in the medication room refrigerator for storage, the DON looked at this Surveyor in apparent disbelief and stated, No, it is not acceptable for staff to put their lunch in the medication refrigerator.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the Medication and Nursig Storage Rooms policy, on 10/9/24 at 10:00 a.m., revealed the following, in part: . It is the policy of [Facility Name] to ensure medications housed on our premises will be stored in the medication rooms according to the manufacturer's recommendations and sufficient to ensure proper sanitation, temperature, light, ventilation, moisture control, segregation, security and expiration . 1. General Guidelines:</p> <p>a. Drugs and biologicals will be stored in locked compartments (i.e., medication carts, cabinets, drawers, refrigerators, medication rooms) under proper temperature controls.</p> <p>b. Only authorized personnel will have access to the keys to locked compartments.</p> <p>c. During a medication pass, medications must be under the direct observation of the person administering medications or locked in the medication storage area/cart .</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>49310</p> <p>Based on observation, interview and record review, the facility failed to adhere to Enhanced Barrier Precautions and follow infection control standards of practice in 2 of 2 residents (Resident #43 and Resident #12) review for infection control, resulting in the potential for the spread of infection.</p> <p>Findings include:</p> <p>Resident #43</p> <p>Signage was posted outside the door to R43's room that read, in part, .Enhanced Barrier Precautions [EBP] . Put on PPE [Personal Protective Equipment] before entering for high contact care: 1. Hand Hygiene 2. Gown 3. Gloves .</p> <p>On 10/9/24 at 9:50 a.m., the Wound Nurse (Registered Nurse (RN) M) was observed completing treatments and dressing changes to R43's pressure injuries. The sacral wound was observed to be a Stage 3 pressure injury without a dressing. A stage 2 pressure injury was observed on the right buttock lateral to the superior gluteal fold. RN M wore gloves but did not wear a gown throughout the dressing change procedure in accordance with EBP instructions.</p> <p>Resident #12</p> <p>Resident #12 (R12) had a stage 3 pressure injury on the right gluteus. EBP signage posted outside the door to R12's room instructed staff to wear gowns and gloves for high-contact care.</p> <p>On 10/9/24 at 10:17 a.m., RN M was observed completing a dressing change to R12's pressure injury. RN M did not wear a gown throughout the dressing change procedure.</p> <p>RN M was interviewed on 10/9/24 at 10:38 a.m. RN M was asked regarding EBP. RN M said Enhanced Barrier Precautions are for catheters, wounds, or the immunocompromised. RN M said EBP consists of wearing gowns and gloves, and confirmed dressing changes were considered high contact care. When asked why a gown was not worn during treatments and dressing change procedures, RN M said, I know should have had a gown on. I thought about that when I was done.</p> <p>The policy Enhanced Barrier Precautions dated 3/28/24 read, in part: .Enhanced barrier precautions' refer to the use of gown and gloves for use during high-contact resident care activities .4. High-contact resident care activities include .h. Wound care .</p>		