STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235006	A. Building B. Wing	04/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Munson Healthcare Otsego Memorial Hospital Ltcu	825 North Center Street Gaylord, MI 49735

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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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake: 2614163Based on interview and record review, the facility failed to implement fall preventions for one Resident (R6) of two residents reviewed for falls. This deficient practice resulted in a fractured 5th digit for R6 when a fall mat and bed alarm were not in place and functioning. Findings include:Review of R6's Electronic Medical Record (EMR) revealed admission to the facility on [DATE] with diagnoses including dementia. R6's 8/15/25 Minimum Data Set (MDS) assessment revealed she was unable to complete the Brief Interview for Mental Status (BIMS) score and was noted by staff to have severely impaired cognition.Review of the facility's reported fall incident for R6 dated 8/17/26 read, in part, On 8/17/26 at 10:10 PM, (R6) was found on the right side of her bed on her left side. Resident unaware of what happened. Resident noted with a hematoma to left forehead. Resident noted with ASA regimen (a daily prescription or recommendation of acetylsalicylic acid to reduce blood clot formation) in place and was sent to the Emergency Department (ED) for evaluation. While in the ED, (R6) noted with pain in her left hand. Xray completed and an indeterminate fracture of the left 5th digit was noted.Investigation.During investigation it was stated that Registered Nurse (RN) I had put (R6) to bed. After the fall it was noted that the fall mat was on the wrong side of the bed, and the bed alarm was not turned on. (R6's) fall care plan was reviewed, floor mat and bed alarm are on care plan to be in place at night when in bed.On 4/1/26 at 10:22 AM an interview was conducted with RN I. RN I stated she remembered the night with R6 stating R6's bed was not pushed up against the window like it normally was, but she thought she placed the fall mat on the correct side of the bed, not realizing it was the wrong side. RN I confirmed she did not turn R6's bed alarm on because she forgot.Review of R6's Care Plans read, in part, (R6) is a risk for falls r/t (related to) gait/balance problems, unaware of safety needs and dementia.interventions: anti-fatigue mat is to be placed next to bed (left side) to prevent injury if (R6) should fall/roll out of bed.(R6) uses a bed alarm. Ensure the devices is in place and functioning properly. Bed alarm mat to be used at all times while in bed.During the onsite survey, past noncompliance (PNC) was cited after the facility implemented actions to correct the noncompliance which included:R6's Care Plan was reviewed and interventions updated to prevent further occurrence of fall-related injuries.Staff re-educated related to assuring care planned interventions are followed following care, and notification to nursing leadership when interventions are no longer appropriate and when new interventions are needed.Facility residents have had fall care plans reviewed to ensure appropriate and meaningful interventions are in place. Any identified equipment needs and assistive devices have been obtained and are in place. No further residents were noted with a fall-related injury in the last 30 days.Director of Nursing or designee completed observation and audits twice weekly for four weeks then weekly for four weeks and then monthly at the discretion of the facility Quality Assurance Performance Improvement Committee (QAPI) to ensure continued compliance.Audits reviewed with the Administrator as completed and presented by the Administrator to the monthly facility QAPI Committee.The facility was able to demonstrate monitoring of the corrective action and maintained compliance.

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 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 prepare food in accordance with professional standards for food service safety, resulting in the potential to spread food borne illness among all residents that consume food from the kitchen. Findings include:On 03/31/2026 at 2:45 PM the three-compartment sink was noted to not be properly air gapped and soap was bubbling up out of the floor drain. Kitchen staff had just emptied out the first compartment (wash) of the sink upon arrival. During this observation cook H, stated that happens all of the time, with other staff in the room agreeing with her. On 03/31/2026 at 3:00 PM observed the vegetable wash sink had an air-break and not an air gap between the food compartment drain-line and the floor drain.On 04/01/2026 at 10:05 AM in the Clean Storage Room observed the Symphony Plus ice machine drain extended down into the floor drain without an air gap.According to the 2022 FDA Food Code Section 5-402.11 Backflow Prevention. (A) Except as specified in (B), (C), and (D) of this section, a direct connection may not exist between the SEWAGE system and a drain originating from EQUIPMENT in which FOOD, portable EQUIPMENT, or UTENSILS are placed. P On 03/31/2026 at 2:49 PM observed the floor and drain lines under the three-compartment sink and metal utensil storage rack were soiled with grease, grime and debris. According to the 2022 FDA Food Code Section 6-501.12 Cleaning, Frequency and Restrictions. (A) PHYSICAL FACILITIES shall be cleaned as often as necessary to keep them clean.On 03/31/2026 at 2:48 PM observed the insulation that was wrapping water lines running behind the storage shelving units to the left of the three-compartment sink, damaged, with clean utensils being stored on the shelving unit a couple inches away from the damaged insulation that covered the pipes.4-903.11 Equipment, Utensils, Linens, and Single-Service and Single-Use Articles. (A) Except as specified in (D) of this section, cleaned EQUIPMENT and UTENSILS, laundered LINENS, and SINGLE-SERVICE and SINGLE-USE ARTICLES shall be stored: (1) In a clean, dry location; (2) Where they are not exposed to splash, dust, or other contamination

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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. Based on interview and record review, the facility failed to:Implement an infection prevention and control program (IPCP) that included infection identification and surveillance to prevent the transmission of infectious organisms to all 24 residents in the facilityTrack and correlate a contagious and infectious organism for one Resident (R25) of five residents reviewed for infection prevention and control.Findings include:Resident #25 (R25) was transferred from the hospital to the facility on 2/14/26 with Clostridium difficile infection (CDI - a highly contagious bacterial infection that can be life-threatening). Infection control documentation for February 2026 and March 2026 were requested and reviewed on 4/1/26.The infection control program documents for February 2026 did not include the CDI of R25. The Infection mapping, line listings, logs, and documentation excluded the CDI.Several residents diagnosed with symptomatic infections were on the infection line listing but were not reflected in facility mapping or data analysis documentation.There was no infection documentation provided for the month of March 2026.During entrance conference on 3/30/26 at 1:03 PM, the Nursing Home Administrator (NHA) said the Infection Preventionist (IP) would not be available during the survey. The NHA said questions about the IPCP should be directed to Registered Nurse (RN) B or the NHA.RN B was interviewed on 4/1/26 at 1:12 PM. RN B was asked to review the infection control information for February 2026. RN B was asked the reason the CDI of R25 was not included for tracking, trending, and correlation of symptoms of infection. RN B said she did not know the reason the CDI wasn't included in the infection records. RN B reviewed the February 2026 information and confirmed the CDI for R25 was not documented in infection control information.RN B was asked how the facility monitored the CDI infection and how the facility was correlating other residents with gastrointestinal symptoms. RN B said she did not know how the facility was tracking or monitoring for CDI.When asked where the symptom monitoring information and infection documentation was located for the month of March 2026, RN B said, If it's not in here [infection control binder], we don't have it. RN B confirmed there was no infection control documentation for identifying or monitoring infections for the month of March 2026. RN B confirmed there were residents in the facility with symptomatic infections in March 2026.The NHA was interviewed on 4/1/26 at 1:19 PM. The NHA was queried regarding the exclusion of the CDI of R25 from the February 2026 infection control program documentation. The NHA reviewed the electronic documentation and said, I don't have it - it isn't here.The NHA confirmed there was missing documentation for infections in the infection control program documentation including the month of March 2026. The NHA said the IP was working to catch up on the infection control program. The NHA said, We have a lot of work to do [with the infection control program]. The NHA agreed that the IPCP wasn't in place.The policy Infection Prevention and Control Program dated as revised 7/21/25 read, in part: . 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. A system of surveillance is utilized for prevention, identifying, reporting, investigation, and controlling infections and communicable diseases for all residents.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed toEnsure a discharge summary included a reconciliation of pre-discharge medications with the resident's post-discharge medications, and;Issue written notification of transfer for two Residents (R32 and R30) of four residents reviewed for closed records.Findings include:Resident #32 (R32)R32 was discharged from the facility with home health care services on 2/27/26.A Discharge summary dated [DATE] was reviewed on 4/1/26. Section B number 14 of the discharge summary included the prompt Drug Therapy Required. The documented response read: Meds called into [name of drugstore pharmacy redacted].Section B number 14a of the discharge summary contained a selection box (a user interface element that allows users to select one or more options from a predefined list) that read: See Physician's Order Listing. The selection box was blank. There was no Physician's Order Listing included with the discharge summary.Section F of the Discharge Summary contained sections for the resident and/or resident representative signatures which were blank despite a date entry of 2/27/2026.Social Worker A was interviewed on 4/1/26 at 10:05 AM. Social Worker A said residents received the Discharge Summary when they are discharged from the facility. When asked about a list of medications or medication reconciliation, Social Worker A said all information regarding medications was contained in the Discharge Summary. When asked about the medication reconciliation or a list of discharge medications for R32, Social Worker A reviewed the electronic medical record (EMR) of R32 and said there was no documented indication, a list of discharge medications was provided to R32, or that a medication reconciliation had been completed.When asked if R32 and/or the resident representative of R32 had signed the discharge summary, Social Worker A said it was in the miscellaneous tab in the EMR of R32. Social Worker A reviewed the referenced portion of R32's EMR and verified a signed copy of the discharge summary was not in the EMR of R32.Social Worker A said the signed discharge summary may not have been uploaded into the EMR yet and said she would look for it. No discharge summary containing the resident and/or resident representative signature was provided by the end of survey.The policy Notice of Transfer and/or Discharge dated as revised 7/21/25 read, in part: .Anticipated Discharges. 3. The following items are addressed during the discharge conference: a. Discharge instructions are completed and reviewed b. Reconciliation of all pre-discharge medications with post-discharge medications.Resident #30 (R30)R30 was transferred from the facility to the hospital Emergency Department on 3/12/26.The EMR of R30 did not contain documentation indicating written notification of transfer was provided to R30 or the resident representative of R30.During an interview on 4/1/26 at 10:27 AM, Social Worker A was asked for the written notification of transfer that was provided to R30 and/or the resident representative of R30. Social Worker A said, We don't do that - all we've ever sent is the bed hold information.The policy Notice of Transfer and/or Discharge dated as revised 7/21/25 read, in part: .The facility will provide the resident, and/or resident's representative with the appropriate notice of transfer/discharge according to state and federal requirements. The resident and/or representative will be notified of the transfer/discharge and provided with the following information: 1. The reason for the transfer or discharge. 2. The effective date of the transfer or discharge. 3. The location to which the resident is being transferred or discharged . 4. The name, address, and telephone number of the state long-term care (LTC) ombudsman.6. The name, address, and telephone number of the state health department agency that has been designated to handle appeals of transfers and discharge notices.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure Medication Regimen Reviews (MRR) were addressed by the attending physician for three Residents (R16, R3, & R4) of five residents reviewed for MRR and unnecessary medications. Findings include:Resident #16 (R16) A Minimum Data Set (MDS) assessment dated [DATE] documented R16 was readmitted to the facility on [DATE] following a hospitalization. The MDS disclosed R16 had severely impaired cognition and displayed verbal and physical behaviors. The electronic medical record (EMR) of R16 documented a diagnosis of dementia with behavioral disturbance, and a physician's order for twice daily administrations of divalproex (a medication that reduces mood swings, impulsiveness and agitation). A pharmacist's monthly medication regimen review (MRR) dated 12/16/25 read, in part: See Report – GDR [Gradual Dose Reduction] and clarification requests. The pharmacist's report referenced in the MRR on 12/16/25 was not located in the EMR of R16. An MRR dated 1/14/26 read, in part: See Reports – GDR request. The pharmacist's report referenced in the MRR on 1/14/26 was not located in the EMR of R16. On 3/31/26 at approximately 2:00 PM, Social Worker A was asked to provide the pharmacist's reports to the physician and the physician's response to the pharmacist's recommendations for the MRRs conducted for R16 on 12/16/25 and 1/14/26. On 3/31/26 at 2:50 PM, Social Worker A provided an undated pharmacist's report addressed to R16's physician. The report read, in part: .Note to Attending Physician/Prescriber. Resident is currently due for a GDR evaluation on her divalproex. Please evaluate [R16's name redacted] to determine if she is ready for a reduction at this time. If you feel that no GDR should be attempted, please document your reasoning for clinical contraindication at the bottom of this form or in your next progress note. The undated pharmacist's report contained check boxes to agree or disagree with the recommendation. The disagree box was checked and the physician signed and dated the form on 1/22/26. The physician did not document clinical reasoning for declining the pharmacist's recommendation on the form. A review of the EMR of R16, including physician progress notes, which also did not reveal documentation from the physician regarding the rationale for rejecting the pharmacist's recommendation. The Nursing Home Administrator (NHA) was interviewed on 3/31/26 at 3:31 PM. The NHA was asked if the pharmacist's report for R16 that was signed by the physician on 1/22/26 was for the MRR conducted on 12/16/25 or 1/14/26. The NHA reviewed facility documents and the EMR of R16 and said he was unable to determine the date. The NHA was asked the location of the other MRR report. The NHA said he was unable to locate the additional MRR report. When asked if the physician documented the clinical rationale for declining the pharmacist's recommendation, the NHA said he and Social Worker A would look for the information. On 3/31/26 at 3:41 PM, Social Worker A reported they were unable to locate physician documentation (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	regarding the reason for declining the pharmacist's recommendation for GDR of the divalproex. Social Worker A said the additional MRR report could not be located. Resident #3 (R3) An MDS dated [DATE] documented R3 was admitted to the facility on [DATE] with a primary medical condition of rheumatoid arthritis (a disease of the joints that can affect the organs). The MDS reflected R3 had moderately impaired cognition. The EMR of R3 documented a diagnosis of osteoporosis (a bone disease resulting in weak and fragile bones). A pharmacist's monthly MRR dated 10/15/25 read, in part: .Medication change recommendations. See Report – med addition request. The pharmacist's report for the MRR on 10/15/25 was not located in the EMR of R3. On 4/1/26 at 9:01 AM, Social Worker A provided an undated pharmacist's report addressed to R3's physician. The report read: Resident is taking alendronate [a medication to strengthen bones and reduce the risk of fractures] 70 mg [milligrams] q [every] week. Could consideration be given to adding a calcium/vitamin D supplement to her regimen to augment? . The physician wrote declined on the pharmacist's report and signed and dated the report on 10/23/25. There was no rationale written on the report or in the EMR of R3 indicating the rationale for declination of the pharmacist's recommendation. Social Worker A was queried on 4/1/26 at 9:06 AM regarding physician documentation regarding the reason for declining the pharmacist's recommendation. Social Worker A said, There is no documentation by the doctor. I don't know why he didn't take the recommendation. During an interview with the NHA on 4/1/26 at 1:32 PM, the NHA confirmed the missing pharmacist reports and lack of physician documentation on pharmacist recommendations were a concern. Resident R4 On 3/31/26 at 1:12 p.m., review of R4's MDS assessment, dated 2/18/26, revealed R4 was admitted to the facility on [DATE], with current active diagnoses that included the following, in part: Non-Alzheimer's dementia and anxiety disorder. The MDS assessment also revealed R4 received an antipsychotic medication on a routine basis and noted no gradual dose reduction (GDR) had been completed, with Contraindicated documented as No. R4 scored 12 of 15 on the Brief Interview for Mental Status (BIMS), reflective of moderately impaired cognition. On 3/31/26 at 1:58 p.m., review of R4's monthly MRRs revealed a 11/19/25 pharmacy recommendation for a GDR of an antipsychotic medication. The Note to Attending Physician/Prescriber was requested from Social Worker A, and provided on 3/31/26 at 2:50 p.m. Review of the Note to Attending Physician/Prescriber on 3/31/26 at 2:50 p.m., revealed the following, in part: .Resident is currently due for a GDR evaluation on [their] risperidone (antipsychotic medication) 1mg (milligram) qd (daily) for hallucinations. Please evaluate [R4] to determine if she is ready for a reduction at this time. If you feel that no GDR should be attempted, please document your reasoning for clinical contraindication at the bottom of this form or in your next progress note. The (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Physician/Prescriber Response area for physician notation included Decline see form with a signature that appeared to be a circle with a line drawn through it, similar to a zero, dated 12/5/25. During an interview on 4/1/25 at 8:15 a.m., when asked for any documentation showing the physicians declination rationale for R4's antipsychotic GDR, Social Worker A stated, I cannot find one (GDR declination rationale). No physician rationale was provided for the 11/19/25 GDR request declination. Review of the [Pharmacy Name] Skilled Nursing Facility Policy and Procedure Manual, received from the facility on 3/31/26 at 2:09 p.m., revealed the following, in part: Medication Regimen Review policy: The consultant pharmacist will review the drug regimen of all the residents at least monthly and report any observed irregularities in drug use and other drug therapy recommendations to the director of nursing and attending physician . The prescriber's response will be recorded on a copy of the MRR report that shall remain in the facility or in the individual resident's clinical record. Recommendations are acted upon and documented by the facility staff or prescriber .Physician accepts and acts upon suggestion or rejects and provides an explanation for disagreeing . Nursing and physician responses to the consultant pharmacist's observations and recommendations should be recorded in the resident's clinical record or on the consultant's written report and filed in the facility for at least two (2) years.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide hospice documentation for two Residents (R2, and R22) out of two residents reviewed for hospice care services. This deficient practice resulted in incomplete documentation for services that were provided by hospice. Findings include: R2 Review of R2's Electronic Medical Record (EMR) revealed admission to the facility on 1/29/26 with diagnoses including congestive heart failure (CHF). R2's Minimum Data Set (MDS) assessment dated [DATE] revealed she scored a 15/15 on the Brief Interview for Mental Status (BIMS) score, indicative of cognitively intact status. The MDS assessment also documented R2's participation in Hospice care. Review of R2's Physician Orders read, in part, May sign on to hospice agency of choice .Order: Active .Start Date: 3/2/2026 Review of R2's Care Plans read, in part, (R2) has a terminal prognosis r/t (related to) heart disease. (R2) is on [Hospice Company Name] and will remain long term in facility .Interventions: Work cooperatively with hospice team to ensure (R2)'s spiritual, emotional, intellectual, physicial and social needs are met . On 3/31/26 at 12:00 PM, Review of R2's EMR revealed no documentation including visit notes, cares, or services provided by hospice during the course of her care starting on 3/2/26. The facility was unable to provide further documentation before the end of the survey on 4/1/26. Resident R22 Review of R22's MDS assessment, dated 1/30/26, revealed the Resident was admitted to the facility on [DATE], with active diagnoses that included the following, in part: coronary artery disease (CAD), vascular dementia, hemiplegia (paralysis of left side), chronic obstructive pulmonary disease (COPD), peripheral vascular disease (PVD) and encounter for palliative care. R22 scored 9 of 15 on the Brief Interview for Mental Status (BIMS) reflective of moderately impaired cognition. The MDS assessment also documented R22's participation in Hospice care. On 3/31/26 at 8:49 a.m., review of R22's electronic medical record (EMR) revealed a Hospice Election Statement, dated 10/13/2025. On 3/31/2026 at 11:28 a.m., review of R22's EMR revealed a [Hospice Agency] Hospice Care Plan created 10/14/25. Review of the MISC (miscellaneous) tab in the [Hospice Agency] binder found no Hospice visit notes pertaining to the care and services provided to R22 by the Hospice Agency during the course of his care since October of 2025. During an interview on 3/31/26 at 11:37 a.m., Clinical Care Coordinator (CCC) B was asked for documentation of Hospice visit notes for R22. CCC B said the daily Hospice visit notes should be in the miscellaneous tab in R22's EMR. When R22's miscellaneous tab was reviewed with CCC B they (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	confirmed no visit notes completed by the Hospice Agency were found in R22's EMR. CCC B stated, When I get stuff from Hospice, I put it in the scanning bin. I am not sure of where the papers with the Hospice visit notes are. During an interview on 3/31/26 at 11:42 a.m., Social Worker (SW) A was asked for R22's Hospice visit notes detailing care and services provided to the Resident. SW A stated, They (Hospice visit notes) would not be scanned in. [Hospice Agency] signs the log and the notes are uploaded. We haven't uploaded any daily visit notes for hospice yet. They are going to have to start filling out daily visit notes . They will have to do daily collaboration sheets like [another Hospice Agency] does. During an interview on 3/31/26 at 11:58 a.m., a copy of the Hospice Policy was requested from SW A. Review of the Hospice Care policy, provided on 4/1/26 at approximately 11:30 a.m., revealed the following, in part: .The facility will initiate and maintain a medical record on each hospice resident. Hospice staff will document progress information on hospice forms, leaving a copy of such notes with the facility. The facility will retain these notes as a part of the resident's permanent record .