STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235011	A. Building B. Wing	11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Iosco CO Medical Care Facility	1201 Harris Ave Tawas City, MI 48763

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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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22927 Based on observation, interview and record review, the facility failed to issue a beneficiary notice (ABN/Nomnic) for one resident (Resident #155) of three residents reviewed for beneficiary notices to eligible resident/representative in writing of the items and services which are/are not covered under Medicaid or by the facility's per diem rate, including the cost of those items and services, resulting in the potential for financial hardship when changing to hospice services. Findings include: The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. Resident #155: Beneficiary Notification An interview and record review was conducted on 11/18/24 at 02:42 PM with Social Work Designee G to review the ABN/NOMNIC forms issued to residents. Review of Resident #155's ABN/NOMNIC notification forms revealed them to be unsigned by the resident or representative. Social work designee G revealed that Resident #155 admitted on [DATE] and then switched to hospice services on 9/13/2024 but stayed in the facility. Review of the ABN/NOMNIC forms were not signed/not issued at the time of the care level switch. Social work designee G did not know why the forms were not signed. and referred the writer to the billing office manager. Social work designee G revealed that she had documented notes, but that the notes did not state why the forms were not signed. An interview and record review on 11/19/24 at 01:03 PM with [NAME] staff H revealed that she types up the ABN/NOMNIC forms but does not get them signed. [NAME] staff H revealed that the forms were not signed because of the family choice of hospice. Resident #155 went right to hospice services here within the facility and there was no window of time to get the forms signed. On 11/19/24 at 12:11 PM this writer Requested the facility ABN/NOMIC policy. No ABN/NOMIC policy was received. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 11/20/24 at 12:09 PM with the Nursing Home Administrator (NHA) revealed that the facility had no ABN/NOMNIC policy. The NHA stated that she did type up a policy, but it will not be ready for 2 more weeks.

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22347 Based on observation, interview and record review, the facility failed to update care plans for 2 residents (Resident's #19 and #50) of a sample of 16 resident's reviewed for care plans, resulting in delayed nursing interventions, showers not given and proper wound care given for a pressure ulcer not done. Findings Include: Resident #19: Review of the face Sheet, diagnosis sheet, orders, nurse's notes and physician progress note's dated 9/24 through 11/24, revealed Resident #19 was [AGE] years-old, had a guardian in place, admitted to the facility on [DATE], dependent on staff for all Activities of Daily Living/ADL's, and resided on the Woodlands unit (locked Dementia unit). The resident's diagnosis included, cognitive impairment, severe depression, Dementia, Parkinsonism, pressure ulcer stage II on coccyx, heart disease, stroke with weakness of left side, Aphasia (difficulty with communication) and Dysphagia (swallowing impairment). Review of the facility Brief Interview for Mental Status (BIMS) dated 11/7/24, revealed the resident had a BIMS of 2, severe cognitive decline. Review of the facility nursing progress note dated 11/12/24, stated This nurse (Wound Nurse K) assessed what was documented as a stage II pressure ulcer on resident's coccyx. Upon assessment resident was noted to have an area of blanchable erythema (reddened) measuring 4.0cm (L) x 4.0cm (W). In the center of the erythema is an area of MASD (macerated) measuring 2.2cm (L) x 1.0. (W) x 0.1cm (D). The area presented as white, wrinkled macerated skin. ROHO cushion (pressure reduction cushion) placed in wheelchair. Review of the physician order dated 11/12/24, stated Cleanse MASD (macerated area) on coccyx with wound wash, pat dry, and cover with Optifoam 3 x 3 Q (every) 3 days and PRN (as needed) if soiled. Observation of wound care was done on 11/19/24 at 2:50 p.m. During the dressing change, Resident #19 had a stage II pressure ulcer to his lower coccyx area that was red on the outside and a light pink to white in the center. Review done on 11/18/24, of the resident's facility potential for impairment to skin integrity r/t (related) limited mobility related to CVA (stroke) care plan dated 4/3/24, revealed no actual pressure ulcer care plan was in place nor any up-dates of an actual pressure ulcer was found. During an interview done on 11/19/24 at 3:03 p.m., Rehab Manager D said a communication between nursing and rehab, is what generates a care plan or a care plan change and she had none for the resident regarding pressure ulcer or preventive skin management. (continued on next page)

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview done on 11/19/24 at 12:03 p.m., Shower Aide/Nursing Assistant J revealed the facility had no longer used shower sheets to document any reddened areas or unusual skin concerns (pressure ulcers) noted during a shower. When the previous Director of Nursing discontinued the shower sheets, nothing was put in their place for communication to nursing of abnormal skin areas on resident's. Shower Aide J stated, We no longer have shower sheets; no communication of any abnormal skin areas was being told to nursing for skin assessment to be done. 22927 Resident #50: An observation and interview on 11/18/24 at 12:03 PM with Resident #50 revealed that her call light takes a long time to get someone to her room to assist her to the bathroom and with her bathing. Record review of Resident #50's Progress notes from admittance date of 10/29/2024 through 11/19/2024 revealed an elderly female admitted with post-surgical hip repair for rehab services. Record review of Resident #50's care plan for: Activity of Daily Living (ADL) self-care deficit related to deconditioning from recent hospitalization for right hip fracture with closed reduction (repair). Interventions included: Toileting- assist of 2 staff members to use toilet, Transfers- assist of 2 staff members with pivot transfer and front wheeled walker (FWW). Bathing- assist of one staff member participation with bathing. Record review of Resident #50's Kardex (resident care guide) noted assist of one staff member with bathing. There was no indication of what days to bathe and if the resident preferred showers or bed baths. An interview on 11/19/24 at 12:03 PM with Certified Nurse Assistant (CNA) J shower assistant revealed that resident showers are to be twice a week. CNA J stated that she does get pulled to the floor and may miss some showers. Resident #50 in room [ROOM NUMBER] was a Tuesdays and Fridays shower. CNA J reviewed Shower task and admitted Resident #50 as 10/29/2024 and the resident has been at the facility 21 days and has 3 documented showers. CNA J explained that if a resident is washed up in the bathroom, CNA's can document in the progress note, but it disappears after 24 hours. CNA's use to have paper shower sheets, but those went away this year, So CNA's no longer have written document just the disappearing progress note. It doesn't stay there very long.

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22927 Based on observation, interview and record review, the facility failed to provide Activities of Daily Living (ADL), including bathing/showering for one resident (Resident #50) of 13 residents reviewed for ADL's, resulting in missed bathing/showers and the potential for feelings of embarrassment. Findings include: Resident #50: The clinical record of Resident #50's OBRA admission assessment dated [DATE] revealed under section GG: Functional abilities- substantial/maximal assist, helper does more than half the effort for task: toileting, shower/bathing, personal hygiene. Record review of Resident #50's Progress notes from the admittance date of 10/29/2024 through 11/19/2024 revealed an elderly female admitted with post-surgical hip repair for rehab services. Record review of Resident #50's care plan for: Activity of Daily Living (ADL) self-care deficit related to deconditioning from recent hospitalization for right hip fracture with closed reduction (repair). Interventions included: Toileting- assist of 2 staff members to use toilet, Transfers- assist of 2 staff members with pivot transfer and front wheeled walker (FWW). Bathing- assist of one staff member participation with bathing. Record review of Resident #50's Kardex (resident care guide) noted assist of one staff member with bathing. There was no indication of what days to bathe and if the resident preferred showers or bed baths. An interview on 11/19/24 at 12:03 PM with Certified Nurse Assistant (CNA) J shower assistant revealed that resident showers are to be twice a week. CNA J stated that she does get pulled to the floor and may miss some showers. Resident #50 in room [ROOM NUMBER] was a Tuesdays and Fridays shower. CNA J reviewed Shower task and admitted Resident #50 as 10/29/2024 and the resident has been at the facility 21 days and has 3 documented showers. CNA J explained that if a resident is washed up in the bathroom, CNA's can document in the progress note, but it disappears after 24 hours. CNA's use to have paper shower sheets, but those went away this year, So CNA's no longer have written document just the disappearing progress note. It doesn't stay there very long. Record review of Resident #50's Shower Task documentation for a 30-day look back revealed Question #3: Bathing support provided how resident takes full-body bath/shower, sponge bath, and transfers in/out of tub/shower: there were only three dates of showers given in the 30 days look back period. 10/30/2024, 11/4/2024 and 11/11/2024.

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22347 Based on observation, interview and record review, the facility 1) Failed to prevent and implement preventive measures to avoid a pressure ulcer and 2) Failed to timely identify a pressure ulcer, for 1 resident (Resident #19) of 3 residents reviewed for pressure ulcers, resulting in a Stage II pressure ulcer on the coccyx, pain, increased potential for infection, antibiotic usage and hospitalization . Findings Include: Resident #19: Observation of wound care was done on 11/19/24 at 2:50 p.m. During the dressing change, Resident #19 complained of discomfort and pain when the pressure ulcer was cleaned and dressed. The resident had a Stage II pressure ulcer to his lower coccyx area that was red on the outside and a light pink to white in the center. At this time the dressing was coming off due to loose stool. When the nurse cleaned him up, he complained of pain. Review of the face Sheet, diagnosis sheet, orders, nurse's notes and physician progress note's dated 9/24 through 11/24, revealed Resident #19 was [AGE] years-old, had a guardian in place, admitted to the facility on [DATE], dependent on staff for all Activities of Daily Living/ADL's, and resided on the Woodlands unit (locked Dementia unit). The resident's diagnoses included, cognitive impairment, severe depression, Dementia, Parkinsonism, pressure ulcer stage II on coccyx, heart disease, stroke with weakness of left side, Aphasia (difficulty with communication) and Dysphagia (swallowing impairment). Review of the facility Brief Interview for Mental Status (BIMS) dated 11/7/24, revealed the resident had a BIMS of 2, severe cognitive decline. During an interview done on 11/19/24 at 10:23 a.m., Wound Nurse, RN K stated On 11/12/24, this pressure ulcer was identified. I saw a reddened area about a week ago (no documentation was found of area). It's (a wheelchair cushion) something he should of had prior (before the development of a pressure ulcer), it (the pressure ulcer) could have been prevented. Review of the facility nursing progress note dated 11/12/24, stated This nurse (Wound Nurse K) assessed what was documented as a Stage II pressure ulcer on resident's coccyx. Upon assessment resident was noted to have an area of blanchable erythema (reddened) measuring 4.0cm (L) x 4.0cm (W). In the center of the erythema is an area of MASD (macerated) measuring 2.2cm (L) x 1.0. (W) x 0.1cm (D). The area presented as white, wrinkled macerated skin. ROHO cushion (pressure reduction cushion) placed in wheelchair. Review of the physician order dated 11/12/24, stated Cleanse MASD (maserated area) on coccyx with wound wash, pat dry, and cover with Optifoam 3 x 3 Q (every) 3 days and PRN (as needed) if soiled. Review of facility nursing progress note dated 11/14/24, stated Resident noted to have a Stage II pressure ulcer to coccyx area. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the physician progress note dated 11/14/24, stated Patient is seen for newly acquired Stage II pressure ulceration to the coccyx. Review of the facility Skin/Wound assessment dated [DATE], 1 of 3 pages, had no documentation of a coccyx wound; just a scabbed area on the top of the resident's head. No facility Skin/Wound assessment dated [DATE] or 11/13/24, regarding the resident's pressure ulcer, was given to this surveyor upon request. Review of the facility nursing progress note dated 11/14/24, stated Action: Treatment is to cleanse wound (coccyx pressure ulcer) with wound wash and cover with Optifoam BID (twice a day) and PRN (as needed). Response: Resident noted to have poor diet. Air mattress and Roho cushion in w/c (wheelchair) have been put into place for pressure relief. Staff to lay resident down after meals, reposition often and be prompt with brief changes. The first time an air mattress was documented as being used for the resident, after development of the pressure ulcer. During an interview done on 11/20/24 at 8:07 a.m., the MDS Coordinator, RN E stated On 11/9/24 there was an order for an open area, the Stage II pressure ulcer was identified on 11/9/24, an order given for a dressing and a skin assessment was done. It also should have been put in the wound binder for the wound nurse (on 11/9/24). The care plan was up-dated on 11/12/24, but no documentation of it being an actual care plan (no care plan for actual pressure ulcer was done, only potential). I think they should of put actual impairment (skin impairment care plan) on the 9th (11/9/24), the care plan was not up-dated until today (11/20/24), I just did it. This surveyor requested MDS Coordinator E get the wound binder; no documentation of any pressure ulcer for the resident of concern was found. Review of the resident's facility potential for impairment to skin integrity r/t (related) limited mobility related to CVA (stroke) care plan dated 4/3/24, revealed a Roho cushion intervention was added onto this care plan on 11/12/24. No actual pressure ulcer care was found. During an interview done on 11/19/24 at 3:03 p.m., Rehab Manager D revealed she had no communication from therapy to nursing or from nursing to therapy regarding a pressure reduction cushion for the resident's wheelchair. Rehab Manager D said a communication between nursing and rehab, is what generates a care plan or a care plan change. Review of the facility Therapy Communication forms dated 9/16/24 and 10/22/24 (only two available upon request), revealed no documentation of an air mattress or of a cushion for the wheelchair, preventive measures. The facility note dated 11/14/24, was the first documentation of an air mattress and Roho cushion (pressure reduction cushion) being used for the resident. Review of physician order dated 9/9/24, stated Skilled PT tx (treatment) includes: W/C (wheelchair) Management/Training (includes placing a pressure reduction cushion put on the wheelchair if resident at risk for skin breakdown). No documentation of any type of wheelchair cushion was found prior to 11/14/24 on the potential for wound/skin pressure ulcer care plan dated 4/3/24. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview done on 11/19/24 at 12:03 p.m., Shower Aide/Nursing Assistant J revealed the facility had no longer used shower sheets to document any reddened areas or unusual skin concerns (pressure ulcers) noted during a shower. When the previous Director of Nursing discontinued the shower sheets, nothing was put in their place for communication to nursing of abnormal skin areas on resident's. Shower Aide J stated, We no longer have shower sheets; no communication of any abnormal skin areas was being told to nursing for skin assessment to be done. The resident's pressure ulcer was not identified until it was staged as a stage II pressure ulcer. Review of the facility Nurse's education and meeting dated 10/25/24, revealed slides going over pressure ulcer preventive measures and wound care. This surveyor requested a pressure ulcer preventive policy during the survey (11/18/24 to 11/20/24), none was received.

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F 0689 Level of Harm - Minimal harm or potential for 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** 22927 Based on observation, interview and record review, the facility failed to maintain supervision of two residents (Resident #19 and Resident #37), of two residents reviewed for falls, resulting in Resident #19 and Resident #37 to have recurrent/repeated falls causing Resident #37 to have a head injury, pain and transfer to the emergency room and the potential for continuous falls and injuries. Findings include: Resident #37: Record review of Resident #37's Minimum Data Set (MDS) assessment dated [DATE] revealed an elderly male with medical diagnosis included: Cancer, hypertension, Gastroesophageal reflux disease, benign prostatic hyperplasia, arthritis, dementia, anxiety, depression and glaucoma. Section I: Health conditions- noted falls of two or more since prior assessment. Observation on 11/19/24 at 08:05 AM with Licensed Practical Nurse (LPN) L during medication administration in the secured dementia unit of Resident #37 revealed left upper brow facial bruising with a small laceration. LPN L stated that Resident #37 had sustained a fall over the weekend and went out to the hospital for treatment. LPN L revealed that Resident #37 was on Ativan (Antianxiety medication) cream three times daily was out of stock per the pharmacy, so Resident #37 was ordered Ativan 1mg oral three times daily. LPN L stated that the oral Ativan snowed (sleepy/lethargic). Observation of Resident #37's medication pass revealed the resident took oral medication crushed in pudding. Record review of Resident #37 incident reports from August 2024 through November 2024 revealed: On 8/2/2024 at 2:20 PM Resident #37 misjudged sitting in recliner and sat on floor. Predisposing factors included: confusion, impaired memory, wandering, ambulating without assist, and poor safety awareness. No injuries noted. Record review of Resident #37's incident report dated 8/25/2024 at 7:10 PM revealed that the resident was in the common area and tried to sit on the small end table between the two recliner chairs. The resident misjudged the distance and sat on the floor in front of the table. Predisposing factors included: poor safety awareness. No injuries noted. In a record review of Resident #37's incident report dated 8/31/2024 at 7:50 AM Resident #37 was found by staff sitting on the floor in resident's room. Resident #37 complained of hip and knee pain with pain score of 6 expressed by facial expression, ridged, fist clenched, knees pulled up, pulling or pushing away, striking out and unable to console. Record review of Resident #37's incident report dated 9/12/2024 at 6:10 PM when staff heard loud noise and approached the dining area Resident #37 was on his buttocks next to dining chair. Predisposing factors included: confusion and ambulating without assist. No injuries noted. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #37's incident report dated 9/29/2024 at 9:50 AM Resident #37 was found on the floor in resident room on hands and knees with blankets between legs attempting to get up. Predisposing factors included: confusion, impaired memory, improper footwear, and poor safety awareness. No injuries noted. Record review of Resident #37's incident report dated 11/17/2024 at 2:15 AM Resident was found on floor with large golf ball size hematoma to left side of forehead with scant amount of blood. Resident tired and groggy still and mumbled incoherent responses when asked what happened. Resident had removed his socks. Resident sent to emergency room for evaluation. Predisposing factors included: confusion, impaired memory, drowsy, improper footwear, ambulating without assist, wanderer and poor safety awareness. Facility fall investigation noted that the resident #37 was incontinent/wet. Medications given in the previous 8 hours included: Anti-anxiety, cardiovascular, and anti-psychotic medications. Investigation noted that the Resident #37 was receiving Ativan 1 mg tablet due to pharmacy unable to prepare the gel/cream formula. Record review of Resident #37's 'Neurological Record' dated 11/17/2024 instructions: Complete form and describe any neurological problems on the reverse. Perform initial, then every 15 minutes, then every hour times 4 hours, then every 8 hours times 24 hours. The Neurological record stopped documenting neurological checks after six hours. In an interview and record review on 11/20/24 at 08:34 AM, Registered Nurse (RN) M reviewed the Medication Administration Record of Resident #37, who was receiving cream Ativan 1mg topical and on 11/14/2024 the order was discontinued. Resident #37 was started on Ativan 1 mg tablet oral. RN M revealed that Resident #37 had a history of falls, and he does have 4 falls in the last 2 months. There should have been a continued neurological assessment for 24 hours with the 11/17/2024 fall with head injury. Record review of Resident #37's hospital emergency room evaluation discharge instructions included diagnosis of: head injury, scalp hematoma, traumatic brain injury. Resident #37 was returned to the facility. Record review of fall program policy on 11/20/24 09:39 AM with Registered Nurse (RN) M revealed that the policy 'Catch a Falling Star Program' dated 1/23/2024 revealed that the facility was committed to the reduction of falls among residents using a systematic, multidisciplinary team approach. This program serves as an alert to all staff, including clinical and non-clinical staff. The yellow sticker star is a signal to all staff to be observant and to intervene if resident is displaying any unsafe behaviors. Record review of facility 'Fall Prevention & Follow-up' policy dated 12/21/2023 revealed each resident will be assessed for the risk of falls. Appropriate interventions are identified, care planned and follow up done to monitor effectiveness. Residents are assessed for fall risk upon admission, quarterly, with any significant change and with each fall. (4.) Post fall assessment may include: c) Neuro checks (head injury or unwitnessed fall). (5.) If head injury or unwitnessed fall: initiate neurological checks: initial, then every 15 minutes for 1 hour (5 assessments), every 1 hour for 4 hours (4 assessments) and every 8 hours for 24 hours (3 assessments). 22347 Resident #19: (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the face Sheet, diagnosis sheet, orders, nurse's notes and physician progress note's dated 9/24 through 11/24, revealed Resident #19 was [AGE] years-old, had a guardian in place, admitted to the facility on [DATE], dependent on staff for all Activities of Daily Living/ADL's, and resided on the Woodlands unit (locked Dementia unit). The resident's diagnosis included, cognitive impairment, severe depression, Dementia, Parkinsonism, pressure ulcer stage II on coccyx, heart disease, stroke with weakness of left side, Aphasia (difficulty with communication) and Dysphagia (swallowing impairment). Review of the facility Brief Interview for Mental Status (BIMS) dated 11/7/24, revealed the resident had a BIMS of 2, severe cognitive decline. Review of the physician order dated 10/16/24, revealed Resident #19 was ordered Ativan (for anxiety) oral tablet 0.5 mg, Give 1 tablet by mouth three times a day. This medication is scheduled as a regularly scheduled med to be given 3 times per day. Review of the physician order dated 9/24/24, revealed Resident #19 was ordered Ativan oral tablet 0.5 mg, give 1 tablet by mouth every 6 hours as needed for agitation. The resident was getting a total of 1.5 mg of Ativan daily regularly scheduled, with the likelihood for getting a total of 2.0 mg Ativan as needed with no stop date (every 14 day's this medication is required to be re-ordered with explanation or stopped. This would be a total (both as needed and regularly scheduled) of 3.5 mg a day of Ativan given per order. Review of the resident's facility fall's dated 5/10/24 through 11/20/24, revealed he had fallen a total of x 7 times. Resident #19's Falls: 1. On 5/10/24 2. On 5/31/24 3. On 7/7/24 4. On 7/10/24 5. On 7/25/24 6. On 11/15/24 7. On 11/20/24 Review of the resident's Anti-Anxiety care plan dated 9/30/24, stated I am taking Anti-anxiety meds which are associated with an increased risk of confusion, amnesia, loss of balance, and cognitive impairment that looks like dementia, falls, broken hips and legs. Review of the resident's Falls care plan dated 4/2/24, stated Anticipate and meet my needs, visualize resident while in dining room at all time. The resident fell in the dining room on . (continued on next page)

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	235011	A. Building B. Wing	11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Iosco CO Medical Care Facility	1201 Harris Ave Tawas City, MI 48763

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview done on 11/19/24 at approximately 2:00 p.m., Medical Director C said he ordered Resident #19's Ativan, he was aware of the dose. During an interview done on 11/20/24 at 11:18 a.m., the Director of Nursing and this surveyor reviewed Resident #19's orders, and the Ativan order had not been changed and no note from Physician C was found to justify the continuing of Ativan PRN/as needed. The Director of Nursing changed the order and stated it was not changed until today (11/20/24). We will be having a manager on that unit, that will help out. Review of the facility Fall Prevention & Follow-up policy dated 12/21/23, revealed all fall investigations will include interviews with resident's and staff, vital signs, pain, injuries occurred, fall assessment, medication review (includes Ativan), psychiatric and cognitive factors, history of other fall, and causative factors. This information generates care plan interventions and safety precautions.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22927 Based on observation, interview and record review, the facility failed to ensure that one resident (Resident #19) remain free from unnecessary medications (Ativan) and to obtain consent for antidepressant use for one resident (Resident #26) of two residents reviewed for Ativan usage, resulting in Resident #19 receiving Ativan medication as needed with no stop date and Resident #26 receiving antidepressant medications with no consent. Findings include: Record review of the facility 'Psychotropic Medications' policy dated 12/21/2023 revealed residents receiving ant-psychotic medications with black box warnings will be provided with education regarding the significant risk of serious or even life-threatening adverse effects of the medication. A signed informed consent will be obtained for all ant-psychotic medications use in the facility. The attending physician or psychiatrist will provide an individualized risk vs benefits analysis for each resident receiving anti-psychotic medications. Specific conditions listed: Mood disorders (e.g., mania, bipolar disorder, depression) All residents receiving newly prescribed psychotropic medications PRN (as needed) will be evaluated by provider within 14 days to evaluate need to continuation, or discontinuation of medication. Record review of the 'Nursing 2017 Drug Handbook' page 1454-1455, Identified Trazadone Hydrochloride therapeutic classification: antidepressant. Resident #26: Record review of Resident #26's physician orders on 11/20/24 at 07:55 AM revealed medications of Prozac and Trazadone were ordered on 10/29/2024. Record review of Resident #26's October 2024 Medication Administration Record (MAR) revealed that anti-depressant medications of Prozac and Trazadone were administered starting on 10/29/2024. In an interview on 11/20/24 at 08:05 AM, social service designee G revealed that Resident #26 admitted on [DATE] from hospital, referral paperwork comes prior to resident arrival. Resident #26 Started Prozac and Trazadone (antidepressants) on 10/29/2024 was administered and the written consent was obtained November 13th. Social services designee G stated that she asks the nurses to get consents signed before the first dose is administered. An interview and record review on 11/20/24 at 08:11 AM with the interim Director of Nursing (DON) M revealed that the nurses get the consent prior to administering the medications. It's in the policy to get a consent. Record review of the Psychotropic medication policy was reviewed. 22347 Resident #19: (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the face Sheet, diagnosis sheet, orders, nurse's notes and physician progress note's dated 9/24 through 11/24, revealed Resident #19 was [AGE] years-old, had a guardian in place, admitted to the facility on [DATE], dependent on staff for all Activities of Daily Living/ADL's, and resided on the Woodlands unit (locked Dementia unit). The resident's diagnosis included, cognitive impairment, severe depression, Dementia, Parkinsonism, pressure ulcer stage II on coccyx, heart disease, stroke with weakness of left side, Aphasia (difficulty with communication) and Dysphagia (swallowing impairment). Review of the facility Brief Interview for Mental Status (BIMS) dated 11/7/24, revealed the resident had a BIMS of 2, severe cognitive decline. Review of the physician order dated 10/16/24, revealed Resident #19 was ordered Ativan (for anxiety) oral tablet 0.5 mg, Give 1 tablet by mouth three times a day. This medication is scheduled as a regularly scheduled med to be given 3 times per day. Review of the physician order dated 9/24/24, revealed Resident #19 was ordered Ativan oral tablet 0.5 mg, give 1 tablet by mouth every 6 hours as needed for agitation. The resident was getting a total of 1.5 mg of Ativan daily regularly scheduled, with the likelihood for getting a total of 2.0 mg Ativan as needed with no stop date (every 14 day's this medication is required to be re-ordered with explanation or stopped. This would be a total (both as needed and regularly scheduled) of 3.5 mg a day of Ativan given per order. Review of Resident #19's Medication Administration Sheet dated 11/24, revealed he had received the Ativan three times a day regularly scheduled and a total of x 20 Ativan doses as ordered on 9/24/24, as needed. Review of the resident's facility fall's dated 5/10/24 through 11/20/24, revealed he had a total of x 7 falls. Review of the resident's Anti-Anxiety care plan dated 9/30/24, stated I am taking Anti-anxiety meds which are associated with an increased risk of confusion, amnesia, loss of balance, and cognitive impairment that looks like dementia, falls, broken hips and legs. During an interview done on 11/19/24 at approximately 2:00 p.m., Medical Director C said he ordered Resident #19's Ativan, he was aware of the dose. During an interview done on 11/20/24 at 11:18 a.m., the Director of Nursing and this surveyor reviewed Resident #19's orders, and the Ativan order had not been changed and no note from Physician C was found to justify the continuing of Ativan PRN/as needed. The Director of Nursing changed the order and stated it was not changed until today (11/20/24). Record review of the facility 'Psychotropic Medications' policy dated 12/21/23, revealed the physician will provide an individualized risk vs benefits analysis for each resident receiving anti-psychotic medications (including Ativan). Residents receiving newly prescribed psychotropic medications PRN (as needed) will be evaluated by provider within 14 days to evaluate need to continuation, or discontinuation of medication.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22927 Based on observation, interview and record review, the facility failed to follow policies and procedures for medication labeling and storage in 3 of 3 medication carts reviewed, resulting in opened and undated multi-dose medications, and an unclean and sanitary medication cart with the potential of administration of ineffective medications and the spread of infection. Findings include: Observation and interview on 11/18/24 at 08:59 AM of the East/West unit medication cart with Licensed Practical Nurse (LPN) N revealed that her morning medication pass was completed. Observation of the top drawer of the medication cart revealed a clear plastic medication dose cup with Pre-setup probiotics capsules sitting in the drawer with no label. LPN N stated that the probiotics are kept in the refrigerator in the medication room and that she put the 6 capsules in the cup so she would not have to go back to the med room to retrieve a capsule. Observation and interview on 11/18/24 at 09:48 AM with Registered Nurse (RN) O of the North sub-acute unit medication cart revealed multiple medications that were opened with no open or expiration dates noted. RN O revealed that Medications need to be dated when opened, so that the medication does not over run the expected date of opening. Observations revealed: Resident #15- Breo Ellipta 100mcg/25mcq multi-dose powder inhaler not dated on box or bottle of when opened or when expires. Fluticasone propionate 50mcg nasal spray opened and not dated on the box or bottle. Albuterol sulfate 2.5mg/3ml multi-dose vial for nebulizer noted 23 vials left in box with no date on foil packet wrap or on the box. New admission resident in room [ROOM NUMBER]-Rocklantan 0.02%/0.005% ophthalmic solution eye drops in 2.5ml bottle and box not dated. Brimonidine tartrate 0.2% eye drop not dated on bottle or box. Resident #156- Albuterol sulfate 2.5 mg/3 ml multi-dose vials for nebulizer noted 21 vials left in box no date on foil packet wrap or box. Resident #26- Albuterol HFA 90 mcg inhaler opened not dated on inhaler or box. Resident #20- Fluticasone Propionate 50mcg nasal spray not dated on bottle or box. Resident #13- Timolol Maleate 0.5% eye drop opened used with no date on bottle or box. Observation and interview on 11/18/24 at 10:45 AM of the secured dementia unit medication cart with Licensed Practical Nurse (LPN) P revealed: (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #21- Potassium chloride 20 meq powder packets in box with individual packets with no open date on the box. Resident #37- Latanoprost 0.005% eye drops for Glaucoma, labeled with pharmacy label to discard six weeks after opening, opened 11/6/2024, no discard or use by date on bottle or box. Timolol maleate 0.5% eye drop expires tomorrow. Observation of the medication cart 1st drawer revealed paper debris and a loose tan round tablet found in the bottom of the medication cart drawer. Observation of the narcotic secured drawer revealed four small white pieces of a tablet found in the back of the drawer. LPN P stated that the night shift clean the medication carts, and the Registered Nurse/staff educator is to review medication carts also. Record review of the facility 'Medication storage' policy dated 10/2/2024 revealed the facility will store medications and biological's in a manner which maintains the integrity of the medications and ensures the safety of the residents. The medication carts are to be kept clean and free of clutter. Record review of the pharmacy services 'General Dose Preparation and Medication Administration' dated 4/30/2024 revealed the policy set forth the procedures relating to general dose preparation and medication administration. Facility staff should also refer to facility policy regarding medication administration and should comply with applicable law and the State Operations Manual (SOM) when administering medications. Procedure: (2.10) Facility staff should enter the date opened on the label of medications with shortened expiration dates. (2.10.1) Facility staff may enter the expiration date based on date opened on the label of the medications with shortened expiration dates. Observation and record review of the medication refrigerator temperature logs observed on 11/19/2024 and on 11/20/2024 revealed there to be two medication refrigerators located within main nursing unit station and another in the main hallway toward the outside of the dementia care units. Record review of medication refrigerator temperature logs for 6 months from May 2024 through November 2024 revealed that the May 2024 log had a month and year but no location. June 2024 medication Refrigerator temperature logs could not be found. July 2024 Refrigerator temperature log had a date but no location. There were no August 2024 medication Refrigerator temperature logs could not be found.