

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235019	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/27/2025
NAME OF PROVIDER OR SUPPLIER Jackson County Medical Care Facility		STREET ADDRESS, CITY, STATE, ZIP CODE 524 Lansing Ave Jackson, MI 49201	

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 - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>46954</p> <p>Based on observation, interview and record review, the facility failed to ensure residents were treated with dignity and respect for two (R27 and R100) of three residents reviewed for dignity.</p> <p>Findings include:</p> <p>On 1/21/25 at 1:23 PM Licensed Practical Nurse (LPN) U was observed at a medication cart preparing medications which included insulin. Resident #100 (R100) was observed next to the medication cart waiting for her medications to be prepared and administered. Resident #27 (R27) was a few feet away seated in a recliner chair. During medication preparation, LPN U was observed having a personal phone conversation on speaker phone. A few minutes into the conversation, LPN U abruptly stated I gotta go and ended the phone conversation.</p> <p>In an interview 1/24/25 at 1:00 PM, Nursing Unit Manager V stated that staff should not be on their phones in care areas, and especially not while preparing medications.</p> <p>Review of the facilities policy titled Cellphone Use dated 8-20-2012 and reviewed on 9-12-24 stated . personal use of devices must be limited to break periods and only occur off the neighborhoods in designated break areas . cellphone use is never allowed in resident rooms or while providing direct care .</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 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.</p> <p>45038</p> <p>Based on interview, and record review the facility failed to ensure accurate advance directive (legal documents that allow a person to identify decisions about end-of-life care ahead of time) information was in place for one resident (#319) of one resident reviewed for advance directives from a total sample of 35 residents.</p> <p>Findings included:</p> <p>Resident #319 (R319)</p> <p>Review of the medical record revealed R319 was admitted to the facility 01/16/2025 with diagnoses that included end stage renal disease, dependence on renal dialysis, gastro-esophageal reflux, congestive heart failure (CHF), atherosclerotic heart disease (plaque build up in artery wall), hyperlipidemia (high fat content in blood), obstructive sleep apnea, type 2 diabetes, hypothyroidism (low thyroid hormone), morbid obesity, anemia (low number of red blood cells), cancer of kidney, hypertension, and spinal disc degeneration.</p> <p>Review of R319's medical record demonstrated a physician order for advance directives of DNR (Do Not Resuscitate). No facility document entitled DO-NOT-RESUSCITATE ORDER was found in R319's medical record, that was entered 01/21/2025.</p> <p>In an interview on 01/23/25 at 09:08 a.m. Unit Manager (UM) C explained that when a resident is admitted , the social worker would discuss the advance directives with the resident. UM C explained that the social worker would then obtain a resident signature and two witness signatures. UM C explained that then the document entitled DO-NOT-RESUSCITATE ORDER would be sign by the attending physician. UM C explained once the document entitled DO-NOT-RESUSCITATE ODER was completed a physician order would be entered for into the medical record. UM C explained that the completed DO-NOT-RESUSCITATE ORDER document would be scanned into the medical record. UM C confirmed that R319 had a physicians order which stated DNR (Do not Resuscitate), that had been entered 01/21/2025. UM C could not locate the document DO-NOT-RESUSCITATE ORDER in R319's medical record.</p> <p>In an interview on 01/23/2025 at 09:13 a.m. Social Worker (SW) D explained that she was responsible to discuss advance directives with newly admitted residents at the facility. SW D explained that she would assist resident to complete the document entitled DO-NOT-RESUSCITATION ORDER. SW D explained that once the resident signed the document, two witnesses would sign the document, then the document would be signed by the physician. SW D explained that once the document DO-NOT-RESUSCITATE ORDER is completed a physician order would be written and the completed document would be scanned in the resident's medical record. SW D could not locate R319's DO-NOT-RESUSCITATE ORDER document and explained it still must be in the physician folder, located at the nurse's station. SW D could not explain why an DNR order was present in R319's medical record but not the completed DO-NOT-RESUSCITATE ORDER document. SW D then proceeded to the nurse's station and located R319's DO-NOT-RESUSCITATE ORDER document.</p> <p>(continued on next page)</p>

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<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of R319's DO-NOT-RESUSCITATE ORDER document (which was located in the physicians folder) contained R319's signature on 01/21/2025, two witness signatures signed on 01/21/2025, but no physician signature.</p> <p>In an interview on 01/23/2025 at 09:24 a.m. Director of Nursing (DON) B explained that a resident's advance directive is reviewed upon admission with the social worker or physician. DON B explained that a completed document entitled DO-NOT-RESUSCITATE ORDER is completed, which includes the resident's signature, two witness signatures, then a physician signature. DON B explained once the document DO-NOT-RESUSCITATE ORDER is completed then an order for Do not Resuscitate would be written. DON B confirmed that R319 did not have a completed document DO-NOT-RESUSCITATE ORDER in his medical record and should have not had a completed DNR order until the document had been completed. DON B could not explain why the DNR order for R319 had been written prior to the completion of the DO-NOT-RESUSCITATE ORDER document.</p>		

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<p>F 0640</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Encode each resident's assessment data and transmit these data to the State within 7 days of assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27446</p> <p>Based on interview and record review the facility failed to ensure Minimum Data Set (MDS) assessments for three out of 35 residents (Resident #470, 472, & 477) were transmitted to the Centers for Medicare & Medicaid Services (CMS) system timely.</p> <p>Findings Included:</p> <p>Resident #470 (R470):</p> <p>In an interview on 1/23/2025 at 11:35 AM, R472 he had been at the facility 11 days.</p> <p>Review of R470's MDS assessments revealed an entry MDS dated [DATE] was transmitted and accepted, a 5-day MDS was completed on 1/20/2025 but not transmitted, and an admission MDS was ready to be exported on 1/20/2025.</p> <p>As of the review on 1/24/2025 the MDS assessments had not been completed nor transmitted to the CMS system. The 5-day MDS was due for transmission on 1/21/2025.</p> <p>Resident #472 (R472):</p> <p>R472 was admitted to the facility on [DATE].</p> <p>Review of R472's MDS' revealed the entry MDS was due on 1/10/2025 which had not been submitted, but was noted to have a status of Export Ready. Review of the MDS summary revealed the Assessment Reference Date or Target Date (completion date) was 1/10/2025. The actual completion date was noted to be 1/17/2025. Review of the history of the Entry MDS revealed the MDS was never added to a batch of assessment for export and on 1/23/2025 dated of review remained in Export Ready status.</p> <p>Further review of R472's MDS' revealed the 5-day MDS was In Progress and was dated 1/17/2025. On the review date of 1/23/2025 the MDS was noted in red letters ARD: 1/17/2025, 6 Days Overdue, as the MDS had not been transmitted as of 1/23/2025.</p> <p>Continued review of R472's MDS assessments revealed R472 was due to have a comprehensive (full-all care areas are assessed) assessment completed by 1/23/2025. The assessment had not been started as of the review date of 1/23/2025.</p> <p>Resident #477 (R477):</p> <p>Review of R477's admission MDS revealed R477 was admitted to the facility on [DATE]. The assessment was noted to have been completed on 1/23/2025 however, the submit by date was noted to be 2/6/2025 which is incorrect, and should have been submitted on 1/23/2025.</p> <p>(continued on next page)</p>		

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<p>F 0640</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Per the Resident Assessment Instrument (RAI) Version 2.0 Manual, under section 2.2 an admission assessment which is the initial/comprehensive assessment, Must be completed .by the 14th day of the resident's stay.</p>

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<p>F 0645</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>PASARR screening for Mental disorders or Intellectual Disabilities</p> <p>27306</p> <p>Based on interview and record review the facility failed to ensure a Preadmission/Annual Resident Review (PAS/ARR) was completed after the 30 day exemption period and failed to notify the State Agency Health Authority for 1 Residents (#62) of 3 residents reviewed for PAS/ARR.</p> <p>Findings include:</p> <p>Review of the clinical record reflected Resident # 62 (R62) was admitted to the facility with diagnoses that included major depression. Review of R62's PAS/ARR 3877 screening dated 8/24/23 reflected R62 had a mental illness diagnosis and was prescribed an anti-depressant medication. Review of the 3878 dated 8/26/23 reflected R62 was on a 30 day exemption and was expected to be discharged from the facility within the next 30 days. There was no further level I or level II screenings, no indication or documentation that the State Mental Health Authority was aware R62 resided at the facility and no documentation regarding R62 not meeting criteria or needing level II assessment from Community Mental Health.</p> <p>Further review of R62's clinical record reflected R62 had psychotropic medication changes (wellbutrin was ordered on 10/5/24) and a new diagnosis of anxiety was added on 10/07/24.</p> <p>On 01/27/25 at 09:11 AM, during an interview with Case Manager/ Social Service Director X he reported the Social Workers on each unit was responsible for tracking the PAS/ARR were due including 30 day exemptions and they were to notify Case Manager/ Social Service Director X who completes them and was responsible for submitting them to Community Mental Health (CMH). R62's medical record was reviewed with Case Manager/ Social Service Director X who agreed there was no further required documentation related to PAS/ARR. Case Manager/ Social Service Director X then went into the portal for CMH to ensure the PAS/ARR was updated and possibly just not entered into the medical record. Case Manager/ Social Service Director X confirmed there was no information in CMH portal and offered no explanation as to how/why the required documentation was not completed.</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46954</p> <p>Based on observation, interview and record review, the facility failed to formulate comprehensive Care Plans for two (Resident #92 and Resident #370) of 35 reviewed for Care Plans.</p> <p>Findings include:</p> <p>Resident #92 (R92)</p> <p>Review of the medical record reflected R92 was admitted to the facility on [DATE], with diagnoses that included atrial fibrillation (irregular heartbeat). The Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/9/24, reflected R92 scored 7 out of 15 (cognitively impaired) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool).</p> <p>On 1/21/25 at 9:31 AM, R92 was observed in a recliner chair watching television.</p> <p>Review of the Physician Orders revealed R92 had an active order with at start date of 10/42/24 for Eliquis 5 milligrams (a blood thinning medication).</p> <p>Review of R92's Care Plan revealed no Care Plan for the anticoagulant.</p> <p>In an interview on 1/27/25 at 1:59 PM, Director of Nursing (DON) B reviewed the Care Plan for R92 and confirmed that there was no Care Plan for the anticoagulant use for R92. DON B stated that the expectation would be to have a Care Plan in place for the high risk medication.</p> <p>Resident #370 (R370)</p> <p>Review of the medical record reflected R370 was admitted to the facility on [DATE] and readmitted to the facility on [DATE], with diagnoses that included end stage renal disease and dependence on dialysis. The Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 1/18/25, reflected R370 scored 15 out of 15 (cognitively intact) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool).</p> <p>On 1/22/25 at 8:52 AM, R370 was observed in bed watching television. R370 confirmed that she attended outside dialysis appointments and shared her routine for her dialysis days.</p> <p>Review of R370's Care Plan and Physician Order's revealed an absence of any mention of dialysis including when she attended, where she attended, and required assessments.</p> <p>In an interview on 1/24/25 at 8:41 AM, Registered Nurse (RN) W stated that typically dialysis residents had a dialysis Care Plan and Physician Orders however, when asked to located R370's Care Plan and orders, RN W confirmed an absence of both.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 1/24/25 at 12:49 PM, Nursing Unit Manager V stated that residents receiving dialysis services would typically have a dialysis Care Plan and Physician Orders however, it was identified that day that R370 did not have a Care Plan or Physician Orders.</p> <p>In an interview on 1/27/25 at 1:56 PM, Director of Nursing (DON) B stated that dialysis Care Plans and Physician orders were an important part of Care to ensure effective communication and assessments were being completed.</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49272</p> <p>Based on observation, interview and record review the facility failed to provide assistance with activities of daily living (ADL) for one (R12) of five residents reviewed for ADL's, resulting in the potential for unmet needs.</p> <p>Findings include:</p> <p>Review of the clinical record revealed R9 was admitted into the facility on [DATE] with diagnoses that included: congestive heart failure and arthritis. According to the Minimum Data Set (MDS) assessment dated [DATE], R12 scored 9/15 on the Brief Interview for Mental Status exam (which indicated moderately impaired cognition). Section GG (Functional Abilities and Goals) of MDS assessment dated [DATE] indicated resident was dependent (Helper does all of the effort. Resident does none of the effort to complete the activity.) with personal hygiene.</p> <p>Review of the photo taken of resident on admission revealed short facial hair, stubble only, no beard.</p> <p>On 1/22/25 at 9:23 AM, R12 was observed lying in bed on his back. R12 was noted to have a long, full, unkempt beard. When asked on what his preference was he reported that he prefers to be shaved and not to have a beard. R12 stated that he has reported this to staff in the past.</p> <p>On 1/24/25 at 2:22 PM, R12 was observed lying in bed on his back with a full, ungroomed beard. He reported that he still has not been shaved and did not express a preference for who shaved him.</p> <p>On 1/27/25 at 10:36 AM, R12 was observed to still have a long, full, unkempt beard.</p> <p>Review of R12's Kardex (document used by facility staff to communicate the needs of the residents) revealed I am dependent on staff for my AM/HS care/personal hygiene .Use an electric razor for shaving.</p> <p>Review of R12's task log titled Personal Hygiene revealed resident required substantial/maximal assistance to fully dependent for Personal hygiene tasks for the past 30-day span (12/29/24 through 1/27/25).</p> <p>During an interview on 1/27/25 at 10:41 AM, Certified Nursing assistant (CNA) Y was asked on how she would determine a male's preference for shaving. CNA Y reported that she would look at their Kardex or ask the resident if they are coherent. When asked about the facial care for R12 she reported that he prefers to have the beautician shave him and he has an appointment for that sometime this week.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 1/27/25 at 10:46 AM, Unit Manager (UM) V reported that preferences for facial hair for men would be found in the residents Kardex. When asked if she was aware of R12's preference for who shaves him UM V reported that he doesn't have a preference to see the beautician for shaving. She further reported that if it was his preference to be shaved by the beautician it should be indicated in his Kardex as such. UM V reported that the CNA's should be offering to shave him or helping him get set up so that he can shave himself and that she could reach out to R12's nephew if his razor needed to be replaced. UM V reported that she would ensure the resident got shaved.</p> <p>Review of the facilities policy titled Activities of Daily Living (ADL) updated 12/29/23, documented in part The facility must provide care and services in accordance with CMS (Centers of Medicare and Medicaid Services) regulations for the following activities of daily living: hygiene-bathing, dressing, grooming and oral care .</p> <p>Review of the facilities policy titled Shaving Male Residents updated 12/5/20, documented in part Nursing department will pursue and provide such care as the Resident desires and provide comfort to the Resident . Purpose: To provide cleanliness and improve morale and well-being .Offer Resident the opportunity to shave self: if unable, then assist .Use new safety razor or Resident's personal electric razor .</p>		

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<p>F 0685</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Assist a resident in gaining access to vision and hearing services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49272</p> <p>Based on observation, interview and record review the facility failed to provide proper assistive devices to maintain hearing for one (Resident 25) of one reviewed for specialty services, resulting in unmet needs.</p> <p>Findings include:</p> <p>Review of the clinical record revealed R25 was admitted into the facility on [DATE] with diagnoses that included: Alzheimer's disease and major depressive disorder.</p> <p>According to the Minimum Data Set (MDS) assessment dated [DATE] R25 had adequate hearing with hearing aids.</p> <p>A review of R25's Kardex (document used by facility to communicate the needs of the resident) revealed no documentation of hearing aids.</p> <p>On 1/22/25 at 9:33 AM, R25's roommate reported that R25 was missing her hearing aids and had been for an extended period.</p> <p>On 1/22/25 at 9:42 AM, R25 was observed sitting up in recliner with television on without hearing aids in place. R25 was able to answer yes/no questions when spoken to in a loud voice and at a slow pace. R25 confirmed she was missing her hearing aids.</p> <p>On 1/23/25 at 12:18 PM, R25 was observed sitting in recliner with television on. No hearing aids in place.</p> <p>On 1/23/25 at 12:26 PM during an interview with LPN U she reported R25 had thrown away her hearing aids in the past despite interventions put in place and she no longer wears them. LPN U reported that family was aware of R25 not currently having any hearing aids and that resident can hear if you enunciate and speak slowly.</p> <p>On 1/24/25 at 1:07 PM during an interview with Social work director X he reported being aware R25 was missing her hearing aids and that R25's family member had stopped by to see him. He was unsure of an exact date but recalled it was a while ago but not years ago. Social work director X turned away from his desk and attempted to locate a paper in a drawer full of paperwork. He reported that there should be a missing item report for the missing hearing aids. At the end of the interview SW director X reported that he would continue to look for documentation related to R25's missing hearing aids.</p> <p>(continued on next page)</p>		

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<p>F 0685</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>On 1/24/25 at 2:25 PM during an interview with R25's family member Z, in R25's room, she stated that R25 has had two pairs of hearing aids go missing since being in the facility. Family member Z reported that R25 should have her hearing aids to help with conversations and for her to hear the television. Family member Z reported R25 enjoys watching TV but is not able to hear it without her hearing aids. Family member Z stated that the floor staff is aware of the missing hearing aids but was unable to recall specifically who was told or when (reported that it had been at least one year since R25 has had her hearing aids).</p> <p>On 1/27/25 at 9:47 AM during a telephone interview with R25's family member AA, he reported that R25 has not had her hearing aids for at least a year and he felt that she could really use them as she reported feeling isolated. He further reported they have to speak directly into her ear to communicate with her. R25's family member AA stated that a facility social worker is supposed to see her each week as the family had reported R25's report of feeling isolated.</p> <p>On 1/27/25 at 10:51 AM during an interview with unit manager V she reported that the facility is working on getting R25 new hearing aids based on a recent email from Social Work Director X. When quired about why care plan interventions related to hearing aids had been removed she reported she was not aware of the reason why but they had been removed by an MDS (Minimum Data Set) nurse.</p> <p>On 1/27/25 at 2:50 PM during an interview with NHA (nursing home administrator) A she reported that there is a lot of confusion around R25's hearing aids and confirmed she does not currently have hearing aids. NHA A further reported that the facility is working on getting R25 a new pair of hearing aids and they plan to have her seen by a local audiologist as soon as possible.</p> <p>A review of the facilitate policy titled Grievances/Complaints: Resident & Non-Employee documented in part, Investigations will be done promptly, with every effort to complete the investigation and hold outcome meeting with in ten working days .Every action will be taken to resolve grievances within 30 days .</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235019	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/27/2025
NAME OF PROVIDER OR SUPPLIER Jackson County Medical Care Facility		STREET ADDRESS, CITY, STATE, ZIP CODE 524 Lansing Ave Jackson, MI 49201	
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 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34705</p> <p>Based on observation, interview and record review the facility failed to justify continued use of psychotropic medications for one residents (#154) of five residents reviewed.</p> <p>Findings include:</p> <p>Resident #154 (R154)</p> <p>Review of the Face Sheet and Minimum Data Set (MDS) dated [DATE], reflected R154 was a [AGE] year old female admitted to the facility on [DATE], with diagnoses that included hypertension (high blood pressure), heart disease, major depressive disorder, transient ischemic attach (small stroke), cerebral infarction, dementia with anxiety, adjustment disorder with anxiety and depression, and delusional disorders. The MDS reflected R154 had a BIM (assessment tool) score of 9 which indicated her ability to make daily decisions was moderately impaired, and she required partial to moderate physical assist with dressing, hygiene, toileting, bathing and transfers. Continued review of the MDS reflected R154 had not had any behaviors including delusions, hallucinations, physical or verbal.</p> <p>R154 was observed throughout the survey dates of 1/21-1/24 to be pleasant, up daily for meals and socially engaging with staff, other residents and visitors.</p> <p>Review of R154's Physician's Orders, dated 9/26/24 though current, for antipsychotic Seroquel 75 mg daily at bedtime for delusions. Continued review reflected R154 had physician order for antidepressant Effexor 225 mg daily for depression with order start date 8/1/24 to current.</p> <p>Review of the Medication and Treatment Administration Record, dated 12/1/24 through 1/27/25, reflected, Is the resident experiencing any concerns with mood/mental health or any behaviors this shift? If yes, please document what s/sx resident is presenting in behavior PN/ note section? every shift for Mood and behavior monitoring. The documents reflected a response of, No for both months on every shift.</p> <p>Review of the Psychiatric consult, dated 9/13/24, reflected R154 was on Effexor 225 mg daily and Seroquel 100 mg daily. Continued review reflected physician completed chart review discussed case with facility staff who reported R154 psychiatric condition had remained unchanged. Continued review reflected R154 had record of depressive symptoms that were not distressful to R154. Consult reflected R154 appeared happy, smiled throughout exam and denied depression or anxiety. Note reflected, Documentation reviewed for this visit includes: current medication list, any recent changes to psychiatric medications, recent labs and diagnostic testing results/behavior tracking tool which were all considered as a part of the plan of care. Based on the data obtained and discussions with patient and staff, this provider concludes: a change in medication was considered but will not be implemented/recommended as current plan is most effective at present time. (Seroquel was reduced 13 days later on 9/26/24.) Continued review reflected, Continue to monitor for anxiety agitation, aggression and document. Encourage relaxation techniques and distraction. Promote non-pharmacological method to assist with processing frustration and adjustment challenges .</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235019	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/27/2025
NAME OF PROVIDER OR SUPPLIER Jackson County Medical Care Facility		STREET ADDRESS, CITY, STATE, ZIP CODE 524 Lansing Ave Jackson, MI 49201	
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 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Review of the Psychiatric Consult, dated 12/23/24, reflected R154 was on Effexor 225 mg daily and Seroquel 75 mg daily. Consult reflected provider reviewed chart and discussed R154 and reported R154 psychiatric condition had remained unchanged. Continued review reflected R154 had record of depressive symptoms that were not distressful. The Consult reflected no dose reduction was recommended.</p> <p>Review of the Behavior Well Being assessments, dated 1/25/24, 4/2/24, 6/17/24, 9/24/24, 10/23/24 and 12/12/24, for R154, reflected section labeled, Behavior Incident Huddle Review with response, There have been no incident huddle reviews this past quarter. Continued review of the assessment dated [DATE] reflected R154 had irritability, agitation, and hallucinations and delusional thinking at times.</p> <p>Review of the Behavior Tracking, dated 9/24/24 through 12/31/24, reflected R154 had seven documented behaviors three months that included wandering or refusal of care.(Reviewed by psychiatric services as not be distressing to R154). Review of the facility Behavior log, dated 1/1/25 through current reflected R154 had 4 documented behaviors that including wandering, yelling and/or screaming.</p> <p>Review of the Electronic Medical Record, dated 9/19/24 through current, reflected R154 had five falls including with injury.</p> <p>Review of R154 Psychosocial Note, dated 1/22/2025 at 1:01 p.m., reflected, Quarterly Note: [named R154] overall mood is stable with her current psychotropic medication regiment .She reports no concerns with her appetite, sleep appetite or activity participation. [named R154] has been pleasant and cooperative with her care partners and reports she is receiving good care and treatment .</p> <p>During a telephone interview on 1/24/25 at 3:45 PM, Social Worker (SW) BB reported, would expect Certified Nurse Aids to document behaviors in facility Electronic Medical Record under tasks and Nurses and Social Workers to document in Progress Notes. SW BB reported facility completed Behavior Well Being assessments quarterly. SW BB reported R154 had behaviors that included delusions/hallucinations, refusal of care, irritation and agitation. SW BB reported behaviors documented in tasks and progress notes were reviewed quarterly. SW BB reported recalled R154 had behaviors after September Gradual Dose Reduction(GDR) but unsure if documented in R154 medical record but should have been. SW BB reported would review R154 medical record upon return to the facility, prior to survey exit, for supporting documentation.</p> <p>A request was made for clinical documentation for the continued use of Seroquel 75 mg without a gradual dose reduction. Documentation was not received prior to the survey exit.</p>		