STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235026	A. Building B. Wing	03/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gogebic Medical Care Facility	402 North Street Wakefield, MI 49968

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)
F 0688 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35103 Based on observation, interview, and record review, the facility failed to provide treatment, services, and equipment to maintain and/or prevent avoidable reduction in Range of Motion (ROM) for one Resident (R76) of one resident reviewed for mobility. This deficient practice resulted in harm with incorrect application of a back brace and worsening of R76's L1 (spinal) compression fracture. Findings include: All times noted are Eastern Standard Time (EST) unless otherwise noted. During an interview on 2/25/25 at 3:34 p.m., when asked about any care concerns while residing in the facility, R76 stated, I was sent to a specialty (neurosurgery) appointment on Wednesday, 2/21/25 and they told me that my back has gotten worse because I have not been wearing the back brace correctly. I didn't know how to place the brace on . They (facility staff) should have known how to put the back brace on correctly. R76 said the therapist didn't know the back brace was applied incorrectly either. R76 stated, Now I may have to spend another three months in the nursing home because the brace was incorrectly applied. During an observation at this same time, R76 was wearing a black body brace, that surrounded her abdominal/back area as she reclined on the bed. Two black straps attached the front of the brace to the back over each shoulder. The top of the front body section appeared to be pushed up with no space present between R76's breasts and the top front of the brace. R76's Family Member (FM) E was present in the room at the time of the interview/observation, and confirmed the information provided by R76. Review of R76's Minimum Data Set (MDS) assessment, dated 1/27/25, revealed an admitted [DATE], with active diagnoses that included the following, in part: fractures and other multiple traumas, seizure disorder, anxiety, and collapsed vertebra. R76 scored 15 of 15 on the Brief Interview for Mental Status (BIMS), reflective of intact cognition. (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 0688 Level of Harm - Actual harm Residents Affected - Few	Review of R76's 1/16/25 hospital admission documentation revealed the following, in part: . recently diagnosed with L1 vertebral compression fracture in the emergency room . discharged home with pain control, who then re-presented to the ED (emergency department) with ongoing severe back pain on 1/16/25 and was admitted to the inpatient medical/surgical unit for intractable pain due to L1 vertebral compression fracture . Active Problems: . L1 Vertebral Compression Frx (fracture), Intractable Back pain. Recent fall . L1 vertebral compression fracture with retropulsion (fracture moves backwards into spinal canal), Neurosurgery was contacted when [R76] was evaluated here in the emergency room earlier. Recommended TLSO (thoracic-lumbar-sacral brace used to limit motion in the thoracic, lumbar and sacral regions of the spine) to be worn whenever [R76] was not lying down . should have on whenever [R76] was sitting up in bed, sitting in a chair, or up and ambulating . Review of R76's Physician Orders documented on the February 2025 MAR (Medication Administration Record)/TAR (Treatment Administration Record) between 2/1/25 and 2/26/25, revealed no physician order was present related to the use of R76's TLSO back brace. Review of a Neurosurgery Clinic Appointment: 2/21/2025 for Diagnosis: L1 Compression fracture, revealed the following report details completed by [Practitioner G]: Progress: Patient fracture has significantly worsened from 50% height loss to about 90% height loss, most likely due to brace not being placed or worn appropriately. Will need to continue to monitor for changes and/or worsening symptoms. Patient brace will need to continue for a minimum of 3 months from todays appt. (appointment). PLAN: Restrictions: No bending, twisting, pulling, no lifting > (greater than) 5 lbs. (pounds). Brace needs to be on at all times when head is greater than 30 degrees. Referral to Physical therapy gait, balance and mobility only . Reviewed with patient that if symptoms change, worsen, or new symptoms develop to call the clinic to be seen sooner. Patient also educated on red flag symptoms and if they develop patient should be seen through the ED and not wait for an appointment. During a telephone interview on 2/26/25 at 10:15 a.m., Medical Assistant (MA) H ,from the Neurosurgery Clinic appointment attended by R76 on 2/21/25, acknowledged being present during the appointment. MA H stated, .From what I recall the brace (TLSO back brace) was loose. I don't know if it was [R76] or the nursing staff (that applied the brace). It was not on as tight as it should have been. MA H said patients are usually instructed on how to apply the brace. R76 had not received the brace from the Neurosurgery Clinic, and MA H was unsure who had instructed R76 on how to put it on . MA H stated, Typically it is the responsibility (of the facility) to make sure that the brace was fitted properly. MA H said he would not have placed the responsibility of making sure the brace fit properly onto R76 as their back injury was recent. During a telephone interview on 2/26/25 at 2:03 p.m., Occupational Therapist (OT) B said R76 came to the facility with the back brace which was provided at the hospital. OT B stated, She has kind of a large abdominal area so it would ride right up on her . because of how [R76] was shaped it was hard to get it tight . when [R76] was sent to the Neurosurgery Clinic (on 2/21/25) they wanted it tightened more . (there are) pictures (taken at the Neurosurgery Clinic) in the closet to make sure it was tighter. During a repeat in-person interview on 3/4/25 at 12:00 p.m., when asked if OT B had provided education on R76's back brace to nursing staff and CNAs, OT B stated, No, I did not. When asked if any documentation of R76's refusal to all staff to assist with the back brace had been found OT B stated, I looked for the documentation, but I did not find it. OT B said they understood this Surveyors concerns related to the lack of education and assistance to R76 with a back brace provide to aid in healing the Resident's L1 compression fracture. (continued on next page)

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F 0688 Level of Harm - Actual harm Residents Affected - Few	During a second interview on 2/27/25 at 8:42 a.m., R76 was asked about staff assistance with the correct application of the TLSO back brace. R76 stated, When I first came to the facility, I put the (back) brace on. I thought it was on right. R76 stated she was not educated on use or application of the back brace in the hospital, nor did OT B (in the nursing home facility) come up and tell her how the brace should be used when [R76] arrived at the facility on 1/21/25. R76 stated, No, they were not helping me (with the back brace) before I went to [the Neurosurgery Clinic] . OT or PT (physical therapy) never came in and said I was wearing the brace incorrectly. During an interview on 2/27/25 at 8:45 a.m., when asked about the provision of assistance to R76 in putting on the back brace, Licensed Practical Nurse (LPN) M stated, We (nursing staff) were not instructed (how to apply/adjust the back brace). There was no education on how to apply it. R76's Family Member (FM)/Restorative Certified Nurse Aide (CNA) T, who went to the Neurosurgery appointment (on 2/21/25) with R76, provided pictures from the doctor on how to put the brace on. CNA T stated, R76 was not even provided education on the brace (when she received it at the hospital) . I was not instructed to assist [R76] with the brace or how to adjust the brace . During an interview on 2/27/25 at 8:50 a.m., when asked if they had provided assistant to R76 in application of the back brace , CNA U said she did not help the resident with any adjustment of the back brace prior to the appointment (between 1/21/25 and 2/21/25) at the Neurosurgery Clinic on 2/21/25. CNA U said no education had been provided to CNA staff, by the facility, regarding R76's back brace, and CNA U was unaware that any assistance with the brace was required for R76. Review of R76's Nurse Notes from admission 1/21/25 through 2/26/25, revealed the following documentation related to R76's back brace and level of assistance required: 1/21/25 - DRESSING . requires staff assist to don brace and fasten. RESIDENT NEEDS: assist with fasteners . 1/21/25 - UPPER BODY DRESS substantial/maximal assistance. 1/22/25 - UPPER BODY DRESS substantial/maximal assistance. 1/23/25 - UPPER BODY DRESS setup or clean-up assistance. 1/25/25 - DRESSING Requires one aide assist for dressing . RESIDENT NEEDS: requires staff assist for brace fastening. Evaluation: Dressing ability is unchanged. 1/26/25 - UPPER BODY DRESS partial/moderate assistance . 1/27/25 - UPPER BODY DRESS supervision or touching assistance. 2/8/25 - UPPER BODY DRESS substantial/maximal assistance assist with brace. 2/21/25 - PHYSICIAN VISIT (specialty clinic) .PT - gait, balance, mobility only. Restrictions: no bending, twisting, pushing, pulling, no lifting >75 # (75 pounds) . Brace on at all times when HOB>30 degrees . Review of the type-written physician instructions from the 2/21/25 Neurosurgery Clinic appointment clearly documented .no lifting > 5 lbs. (continued on next page)

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F 0688 Level of Harm - Actual harm Residents Affected - Few	Review of the ADL (Activities of Daily Living) policy, last approved 3/2024, revealed the following, in part; It is the policy of this facility to provide ADL cares to residents to ensure all ADL needs are met on a daily basis. 1. Each Resident's physical functioning will be assessed in accordance with the facility's assessment procedures . 3. The level of assistance needed for any ADL activity will be included on the Resident's plan of care . 8. The care plan interventions will be monitored on an ongoing basis for effectiveness and will be reviewed or revised as necessary . Residents that refuse ADL care, verbalize discomfort or concerns during care must be documented in the residents' medical record and reported to the nurse. Review of R76's Care Plans, received 2/26/25 at approximately 3:13 p.m., related to the TLSO back brace included the following: Title: Activities of Daily Living. Problem: Potential for ADL deficit, Potential for falls/injury. Potential for altered skin integrity, Potential for discomfort. Related to: Discomfort due to recent fall resulting in an L1 wedge compression fx (fracture) .decreased independent mobility, use of back brace . Other Areas of Concern: Potential for Altered Skin Integrity: . Monitor under back brace . The two mentions of R76's back brace were the only information related to the required back brace in all of R76's care plans. No instructions for use, assessment for correct usage, when the brace was to be worn, or level of assistance necessary for application of the back brace were present in R76's care plans. No physician order was present in R76's physician order summary. Review of R76's CNA closet sheet, retrieved on 2/27/25 at 8:42 a.m., revealed a listing of care instructions to the CNA's regarding the following care areas: alarms, ambulation, positioning, eating, transfers, devices (such as braces), toileting, briefs, and bathing. The Devices - Braces and Splints boxes were unchecked, indicating R76 did not have any brace or splint that was used. Review of the CNA Assignment Card, dated 2/3/25 at 11:28 a.m., provided no guidance in the level of assistance or proper application of R76's back brace. The exact references to R76's back brace (2 mentions) found in the care plans were also found on the CNA Assignment Card. No additional instructions regarding the back brace were present. During an interview on 2/27/25 at 10:41 a.m., a copy of the manufacturer's instructions for use for the TLSO back brace worn by Resident R76 since their 1/21/25 admission to the facility was requested. A copy of the manufacturer's instructions for the [Name Brand] TLSO back brace was provided electronically to this Surveyor on 2/27/25 at 12:15 p.m., downloaded from www.Manualslib.com manuals search engine via the internet. The DON acknowledged the manufacturer instructions for the back brace were retrieved electronically and had not been available for staff review and/or use prior to that day. (continued on next page)

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F 0688 Level of Harm - Actual harm Residents Affected - Few	Review of the [Name Brand] TLSO instructions, copyright 2018, revealed the following, in part; .Warnings: Carefully read use/care instructions and warnings prior to use. If increased pain, swelling, sensation changes, or any adverse reactions are experienced while using this product immediately consult your medical professional . The instructions included modifications for use including methods of trimming, heat forming, placement and proper application. During an interview on 2/27/25 at 11:21 a.m., Restorative Aide (CNA) T, also FM of R76 was asked about R76's back brace. CNA T said R76 came to the facility with the back brace from the acute care hospital, without instructions. CNA T stated, When she was in the ER, and she first broke her back . they put the brace on [R76]. I was there and they didn't tell us, they didn't tell her how to use the brace (back brace). Three days later [R76] could not get out of bed, and she was back in the hospital. They never showed her or me how to use the brace. Toward the end of January, she came to the facility. Nobody (in the facility) knew how to use the brace . To be honest I didn't know how to use it. When I went to [the Neurosurgery Clinic on 2/21/25], we were in with the doctor. and I asked about the purpose of this brace if it (was) loose. [Practitioner] G said it was not being worn right. I asked her to physically show me how this brace was supposed to be. I came back here, and I showed the nurse . If you would have seen [R76] with the brace it just looked loose. The more I kept looking at it, I asked what good is this if it is not supporting her back? [Practitioner G] told me and [R76] the brace was not being worn properly. I didn't know how to adjust the brace before we went to [the specialty clinic]. You would have thought the hospital would have shown me and [R76] and sent directions here. I don't work on the hall. I work in therapy. I don't think anybody knew what to do with the brace. I even showed therapy . We didn't come (to the facility) with any instructions. I feel bad that things got worse (deterioration of L1 compression fracture). There was no educational session (for facility staff) related to the back brace (before we went to the specialty clinic on 2/21/25). During an interview on 2/27/25 at 2:09 p.m., the Director of Nursing (DON) was asked to provide any documentation regarding training of staff as it pertained to R76's care and assistance with the back brace. Asked for all or any information that shows the facility was educated and prepared to care for and provide assistance to R76 with the back brace upon admission. During an comprehensive interview on 2/28/25 at 8:50 a.m., the DON was asked to review R76's Nurse Notes specific to admission on 1/21/25 where UPPER BODY DRESS showed substantial/maximal assist. The DON reviewed the Nurse Notes and said that information was part of supplemental section GG charting for R76's MDS assessment, specific to ADLS. The DON agreed R76 would have required maximal assistance with the TLSO back brace. After review of R76's Kardex (CNA care guide), the DON confirmed the back brace was not included on the Kardex. The DON acknowledged R76's back brace instructions/interventions were not present on the At a Glance form in the resident's closet, the CNA care plan in the resident's closet, R76's care plan, physician orders, or the TAR (treatment administration record). The DON agreed the back brace should have had a physician order that was placed on the TAR upon R76's admission. The DON also agreed there should have been more details related to use of the back brace in R76's care plans. The DON stated, I think we depended upon therapy a little too much . We were relying on therapy to provide us with that input. (continued on next page)

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F 0688 Level of Harm - Actual harm Residents Affected - Few	The DON also confirmed a Mitigating Risk form had been completed following the 2/21/25 specialty appointment, related to R76's improper usage of the back brace, although no documentation was found in the medical record of R76's refusal of assistance with the back brace, or failure to wear the brace properly. The Mitigating Risk form was received electronically on 2/26/25 at 3:12 p.m., unsigned and undated. The DON expressed understanding of this Surveyors concern with reliability of the Mitigating Risk form. The DON also acknowledged facility nursing staff, including CNAs did not receive education regarding the correct use of R76's back brace and were unaware of the level of assistance required for therapeutic use of the TLSO back brace in treatment of R76's L1 compression fracture.

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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** 41978 Based on observation, interview and record review, the facility failed to provide adequate supervision for one Resident (R42) of one resident reviewed unsafe wandering, resulting in R42 entering a second-floor stairwell unattended and the potential for falls and injury. Findings include: All times recorded in Eastern Standard Time (EST), unless otherwise noted. Review of the Minimum Data Set (MDS) assessment, dated 12/3/2024, revealed R42 was admitted to the facility on [DATE] with diagnoses including Alzheimer's Disease, osteoarthritis and macular degeneration. The MDS indicated R42 had severe cognitive impairment, was independent with wheelchair use and required supervision/touching assistance (helper provides verbal cures or touching/steadying assistance) for walking. During a telephone interview on 2/25/2025 at 3:36 p.m., Family Member (FM) O was asked if R42 had experienced any falls or unsafe wandering while residing in the facility. FM O reported she was alerted by facility staff of an incident when R42 entered a stairwell on the second floor unattended. FM O stated she was informed R42 was found on the second flight of stairs leading to the first floor entrance. FM O reported the event occurred within the past six months. FM O stated she was unsure how R42 was able to get into the stairwell without staff noticing. On 2/27/2025 at 12:05 p.m., R42 was observed seated in a wheelchair at a table in the Comfort Zone Unit dining area. Further observation revealed a position change alarm attached to the back of R42's wheelchair seat. The green activation light was observed lit up on the alarm, indicating the alarm was functioning. During an interview at the time of this observation, Certified Nursing Assistant (CNA) P reported R42 required standby assistance for walking and engaged in a walking activity with staff after meals. When asked if R42 exhibited exit seeking behavior, CNA P stated Oh, yeah. He has a wander guard [bracelet monitor that sounds an alarm when near doors equipped with sensors]. CNA P proceeded to point to a wander guard monitor bracelet attached to the wheelchair frame under R42's seat. When asked if R42 was wearing a wander guard bracelet on his body, CNA P confirmed R42 was not physically wearing a wander guard bracelet. CNA P confirmed R42 was able to walk independently but required supervision to ensure safety. Review of an incident report, provided by the Director of Nursing (DON) and dated 8/10/2024 at 2:56 p.m. Central Daylight Time (CDT), revealed the following: Date of Incident: 8/10/2024. Time of Incident: 11:20 [a.m. CDT]. Incident Type: Elopement attempt . Location: [NAME] emergency stairwell . resident was walking down the stairs . west fire exit door alarm sounded, resident's w/c [wheelchair] sensor pad [position change alarm] did not sound. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of the incident report revealed prior to being found in the stairwell, R42 was last observed by CNA Q seated in the Comfort Zone Unit dayroom at 10:00 a.m. CDT. According to the report, R42 was found by Licensed Practical Nurse (LPN) R in the west emergency stairwell at 11:20 p.m. CDT at which time R42 reported I need to get to the pharmacy before it closes. Review of R42's electronic medical record (EMR) revealed the following nursing note: 8/10/2024 [2:40 p.m. CDT] . Resident was observed walking down the stair well in the west hall exit. Wheelchair was on the [second] floor landing and resident was almost [two] flights down hanging onto both handrails . New sensor pad applied to [wheelchair]. During an interview on 2/27/2025 at 8:55 a.m., CNA Q recalled R42 being found in the west hall stairwell on 8/10/2024. CNA Q reported, prior to the incident, she last observed R42 seated in the Comfort Zone Unit dayroom. CNA Q stated she and another CNA left the dayroom to provide care to another resident and a third CNA assigned to the unit was off the unit on break. CNA Q reported she saw R42 walk by the door of the room she (CNA Q) was in and down the hall toward the unalarmed doors leading to the nurse's station and the west hall. CNA Q stated she was unaware R42 exited the unit and was found in the west emergency stairwell until staff brought R42 back to the Comfort Zone Unit dayroom around lunchtime. When asked if R42 was at risk for unsafe wandering, CNA Q stated R42 always hung out near the nurse's station and did at times state he was going home. During an interview on 2/28/25 at 9:41 a.m., the DON confirmed R42 exhibited exit seeking behaviors. The DON reported R42 resided on the second floor of the facility and often was found gazing out of windows looking for his car. The DON stated R42 was provided with a wander guard bracelet due to a history of R42 travelling unassisted to the ground floor (main entrance/exit floor) without staff knowledge. The DON agreed there was a risk of falls and injury related to R42 entering the stairwell without staff assistance but denied a risk of unsafe wandering due to the wander guard sensors placed at the main entrance/exit to the facility. The DON stated she was unaware the wander guard bracelet was attached to R42's wheelchair and not physically worn by R42, and acknowledged the wander guard sensors would not alarm if R42 physically walked out without the wheelchair. When asked how staff were made aware of residents at risk for unsafe wandering and elopement, the DON stated there was a binder listing residents names and photographs located at the first floor nurse's station, but not at the front desk or the second floor nurse's station, where R42 resided. The DON reported if R42 was observed to be near an exit door, staff should redirect the resident back to the Comfort Zone Unit. Review of R42's care plan revealed the following: 8/30/2022 . Potential for Elopement related to altered thought process. Manifested by . May inadvertently exit the unit, possibly with others . resident's whereabouts will be known at all times, assure that photo of resident is current and available to all staff . approach resident from the front slowly and calmly, gently guide back to a safe area, redirect conversation when resident speaks of going home, bring back into facility when found wandering outdoors unattended, assure wander guard is on resident' w/c . Review of the facility policy titled, Elopement - Wander Guard Transmitter, effective 3/2024, revealed the following: (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Residents that are assessed to be at risk for wandering or elopement shall have a wander guard transmitter applied to an extremity . Resident's care plan will be updated to include wander guard use and documented in [EMR] . Review of the facility policy titled, Elopement Procedure, effective 6/2024, revealed the following: Before admission, resident will be screened by the Nurse Manager/Social Services Designee to identify if they have a history of wandering. These identified residents shall have specific interventions to address wandering of [sic] elopement in their care plans. Depending on the severity of their condition and the availability of beds, residents assessed with risk for elopement may be transferred to the facility's special needs unit (Comfort Zone) for increased supervision and therapeutic activity.

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F 0693 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49310 All times are in Eastern Daylight Time (EDT) unless otherwise noted. Based on interview and record review, the facility failed to replace a feeding tube in accordance with professional standards of practice for one Resident (#1) of two residents reviewed for enteral nutrition, which resulted in Immediate Jeopardy when Resident #1 subsequently suffered aspiration pneumonia requiring admission to the Intensive Care Unit (ICU) and ultimately resulted in Resident #1 being placed on comfort care measures. The Immediate Jeopardy (IJ) began on 1/11/25 when Registered Nurse (RN) J inserted a urinary catheter with 30 cc (cubic centimeter) balloon into the gastrostomy site of Resident #1 (R1) to use as a feeding tube. After the urinary catheter was placed, R1 experienced blood-tinged vomiting, an oxygen saturation (SPO2) level of 82%, and a decreased heart rate of 42 beats per minute. R1 was noted to be cool and clammy with a hardened abdomen. R1 was transferred to the hospital on 1/11/25 where x-ray examination confirmed the urinary catheter balloon was inflated in R1's esophagus. The Administrator (NHA) was notified of the Immediate Jeopardy on 2/27/25 at 4:00 PM. This surveyor confirmed by interview and record review that the immediacy was removed on 2/28/25 at 2:17 PM, however, noncompliance remained at the potential for more than minimal harm due to sustained compliance which has not been verified by the State Agency (SA). Findings include: According to the EMR, R1 was transferred to the Emergency Department (ED) on 1/11/25 and was admitted to the ICU with aspiration pneumonia (an infection that occurs after a large amount of food or liquid is breathed into the lungs) after RN J inserted a urinary catheter in his gastrostomy site. A radiology examination in the hospital on 1/12/25 at 12:38 AM CT revealed the balloon portion of the urinary catheter was inflated within R1's esophagus. R1 was placed on comfort measures and returned to the facility on [DATE]. A telehealth provider document dated 1/11/25 at 6:19 PM CT documented the provider was notified by RN J regarding R1 vomiting and coughing up copious amounts of white foam. RN J conveyed to the provider that R1 had a G-tube, and congestion was heard throughout R1's lung fields. RN J requested provider instruction regarding when to re-start R1's tube feeding. According to the documentation by the provider on 1/11/25 at 6:19 PM CT, the provider called RN J and was told by RN J that R1 had a Foley (urinary catheter held in place by a balloon) chronically. The provider documentation did not indicate RN J had informed the provider that a new Foley catheter had been inserted prior to R1 experiencing the symptoms of concern. The provider ordered Zofran (a medication to treat vomiting) and Duoneb (a combination medication to relax the airway and improve breathing). The provider ordered the tube feeding to be withheld for four hours and to obtain R1's vital signs every four hours for 24 hours. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gogebic Medical Care Facility	402 North Street Wakefield, MI 49968

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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 0693 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Telehealth provider documentation dated 1/11/25 at 9:30 PM CT documented RN J again contacted the provider to report R1 had blood-tinged emesis and was cool and clammy with a hardened abdomen. The provider documented in part: .This provider returned call to facility and talked to [RN J], and [RN J] states patient had pulled his G-tube out so replaced it and now noted that white milky pink type of fluid now patient is cool and clammy abdomen is hard. This provider inquired if an abdominal x-ray was done after replacing the feeding tube and [RN J] states they cannot do x-rays at the facility and will need to send patient out to ED [Emergency Department]. This provider discussed with [RN J] patient really needs to have x-ray done to make sure that the tube feedings in correct place and also since his oxygen saturation is 82% on room air please [sic] patient on oxygen and send patient to ED . The provider ordered R1 transferred to the ED via ambulance for vomiting and gastrostomy complication. The provider further documented, Patient presents with ongoing emesis and earlier had removed his G-tube and it was replaced by the nurse and now his abdomen hard: emesis secondary to G-tube malfunction. A Hospitalist note dated 1/12/25 documented, in part: .G tube replaced yesterday, and later he appeared to aspirate after vomiting. He was hypoxic on EMS arrival and in ER, required 6 L [oxygen] per NC [nasal cannula - a tube used to deliver oxygen]. He was later switch to oxymask [mask used to provide a broad range of oxygen concentrations] as he was breathing through his mouth . Reviewed pt hx [history] with SNF [Skilled Nursing Facility] nurse. Prior tube was noted to be leaking, so new tube was placed. He received approximately 50 ml of feeding and was noted to vomit and possibly aspirate . G tube was noted to be displaced, reviewed imaging with radiologist who reevaluated placement on CT [scan] and distal end of tube was in esophagus with balloon inflated in distal esophagus with tip facing superiorly [aimed towards the head]. Confirmed with x ray with gastrografin [contrast agent used for x-rays] via tube per radiology recommendation. Tube was initially withdrawn and reimaged. General surgery was consulted and replaced foley tube that was present with MIC-KEY tube [a low-profile gastrostomy feeding tube] . A hospital discharge summary dated 1/13/25 reiterated a foley catheter was placed in R1's gastrostomy site at the facility and R1 began vomiting and became short of breath with presumed aspiration after vomiting. The summary documented, in part: .Given the patients age and comorbidities, as well as acute illness with hypoxia and respiratory distress .discussion was held with the patent's brother who is [R1's] active POA (Power of Attorney) regarding plan and goals of care. [R1's brother's name redacted] opted to keep [R1]comfortable . [R1] has intermittently taken Ativan and morphine via IV to help with comfort and dyspnea which have been effective . A nurse's note entry on 1/12/25 at 2:44 PM CT documented a discussion between a facility nurse and a nurse from the hospital. The nurse's note documented R1 was expected to return to the facility on [DATE] and was being placed on comfort measures. R1 returned to the facility on comfort measures on 1/13/25 with a MIC-KEY in place. An untimed re-admission progress note dated 1/13/25 documented, in part: .Patient was readmitted to [name of facility redacted] 2nd floor Nurses station on 1/13/25 from [name of hospital redacted] at 4:05 PM [CT] via [name of ambulance transport redacted] following a 3-day stay related to aspiration pneumonia and complications of gastrostomy Tube. Rehabilitation Potential is poor related to monitoring of G-tube and pneumonitis [inflammation of the lungs] status . (continued on next page)

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F 0693 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A nurse's note by RN J dated 1/16/25 at 8:54 PM CT documented as late entry for 1/11/25, read in part: . fluid coming from around g-tube site. Tube feeding was stopped. Existing tube was removed without difficulty . New g-tube/catheter was inserted .balloon inflated .Tube feeding was again restarted. Re-entered room to observe resident vomiting a white/pink opaque liquid .Telehealth was contacted . Returned to room, placement was verified via auscultation, Zofran was administered .Within 5 minutes, nursing assistant was calling for nurse, upon entering room, resident was vomiting same white/pink opaque liquid. Suctioning immediately started. SpO2 [oxygen saturation] at 82% RA [room air]. O2 [oxygen] applied via nasal cannula at 2 L [liters] and telehealth was contacted again, orders obtained to transfer resident to local ED to eval (evaluate) and imaging for proper g-tube placement . R1's EMR did not contain documentation by RN J on 1/11/25 of the circumstances surrounding the feeding tube concerns that resulted in R1 being transferred to the hospital on 1/11/25. Review of consecutive nurses' notes on 1/11/25 revealed an entry dated 1/11/25 at 5:09 PM CT documenting R1's feeding tube was flushed with 540 ml (milliliters) of water, 117.5 ml of liquid medications were provided through the feeding tube, and tube feeding was being administered at 55 ml per hour. The next nurse's note on 1/11/25 at 6:29 PM CT documented a PRN (as needed) medication was administered through the feeding tube. The following progress note at 8:10 PM CT documented Duoneb had been withheld. Subsequent nurses' note entries on 1/11/25 included R1's vital signs and notation R1 was transferred to the ED on 1/11/25 at 10:05 PM for hypoxia (low oxygen level), persistent emesis, low heart rate, and congestion throughout the lung fields. A nurse's note entered on 1/11/25 at 10:28 PM documented R1 had a pulse of 42 (beats per minute), a respiratory rate of 24 (breaths per minute), and an oxygen saturation of 82% on room air, for which supplemental oxygen at two liters per minute was administered. On 2/25/25 at 3:18 PM, R1 was observed lying in bed with labored, rapid respirations. R1 had audible rhonchi (gurgling sounds) with inhalation and expiration. A tube feeding pump was next to R1's bed without tube feeding connected. Review of R1's Electronic Medical Record (EMR) revealed admission to the facility 1/22/99 with a primary diagnosis of cerebral palsy. The EMR documented R1 was unable to consume foods or fluids orally and required enteral feeding for nutrition and hydration through a gastrostomy tube (G-tube, a tube placed through the abdominal wall into the stomach for delivery of food, fluid, and medications). A quarterly Minimum Data Set (MDS) assessment dated [DATE] documented R1 was nonverbal and had short-term and long-term memory impairment. A Brief Interview for Mental Status (BIMS) could not be completed due to R1 never being understood. The MDS coded R1 as being dependent on staff for all activities of daily living. RN J was interviewed on 2/26/25 at 10:14 PM. RN J said R1 pulled his feeding tube out on 1/11/25 at approximately 4:30 PM CT so RN J replaced the tube with a 16 French foley catheter (catheter with diameter of 5.3 millimeters) with a 30-cc balloon. RN J said placement of the tube was verified through auscultation (listening with a stethoscope) using air injected from a piston syringe into the tube. When asked if residual was checked, RN J said it was but could not recall the amount of residual. RN J said after the tube was inserted, medications were administered and R1's tube feeding was started. (continued on next page)

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F 0693 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	RN J said about an hour after starting tube feeding, R1 was observed with a foam-like substance coming from the mouth. RN J alleged R1 was suctioned, the tube feeding was stopped, and the telehealth provider was notified. RN J said instruction was received by the provider to administer Zofran and Duoneb to R1, and to check placement of the tube after four hours and if all was good to restart the tube feeding. RN J said the Zofran was administered through the tube. RN J said about an hour after administering the medications, R1 commenced vomiting. The telehealth provider was contacted again, and orders were received to transfer R1 to the hospital ED. RN J said that on 1/13/25 or 1/14/25 the Director of Nursing (DON) asked about the situation and events with R1 on 1/11/25. RN J said the DON directed her to enter documentation about the event in R1's EMR. RN J acknowledged not documenting the situation on 1/11/25 with R1 until 1/16/25, five days after the events that lead to R1 being transferred and admitted to the hospital. RN J said there was no provision or offer of teaching or training in response to the event with R1 on 1/11/25. RN J was asked if training or competency evaluations on changing a feeding tube or inserting a urinary catheter in lieu of a gastrostomy tube had ever been conducted. RN J responded, No - we don't really have training, just online videos we watch unless there's something out of the ordinary like wound vacs. RN J acknowledged never receiving training or competency evaluations for changing a gastrostomy tube or inserting a urinary catheter as a feeding tube. The education and training records and the competency evaluations for RN J were reviewed on 2/26/25 and revealed no education or competencies for changing a gastrostomy tube or inserting a catheter to be used as a gastrostomy tube. Licensed Practical Nurse (LPN) K was interviewed on 2/27/25 at 8:15 AM. LPN K indicated they had [AGE] years of employment at the facility. LPN K said R1 had been in the facility since the 1990's and had used a catheter as a feeding tube for many years. LPN K said nurses had been changing R1's catheter for years. LPN K said another floor nurse showed LPN K how to change the catheter but confirmed never receiving training, or competency checks for inserting the catheter as a feeding tube. LPN K said R1 had a history of pulling the catheter causing it to become dislodged. LPN K stated a securement device had never been used to stabilize the catheter to keep R1 from causing the tube to become dislodged. LPN K said the facility did not have securement devices. LPN K said R1 had a MIC-KEY tube now and if the MIC-KEY comes out they will need to send R1 to the hospital because the nurses cannot change MIC-KEY tubes in the facility. Unit Manager/RN L was interviewed on 2/27/25 at 8:21 AM. RN L said the facility completed competency evaluations on nurses but the competencies did not include changing of gastrostomy tubes or inserting a catheter as a feeding tube. RN L denied receiving training or competency evaluations on changing of gastrostomy tubes or inserting a catheter as a feeding tube. RN L said securement devices were not used in the facility with G-tubes or with catheters used as feeding tubes. When asked about changing a MIC-KEY tube, RN L said, We don't change MIC-KEY tubes - that's done in the hospital. The education and training records and the competency evaluations for LPN K and RN L were reviewed on 2/27/25 and revealed no education or competencies for changing a feeding tube or inserting a catheter to be used as a gastrostomy tube. (continued on next page)

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F 0693 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Director of Nursing (DON) was interviewed on 2/27/25 at 11:42 AM. The DON said she was notified by a hospitalist about the catheter being identified in R1's esophagus with the balloon inflated. The DON said she reviewed the facility policies and determined the policy was followed because tube placement was verified according to the documentation. When asked to which documentation she was referring, the DON replied the nurse signed out verification of tube placement on the TAR (Treatment Administration Record). The DON said an investigation was not completed but acknowledged speaking to RN J after being called by a hospitalist the day R1 returned to the facility (on 1/13/25). The DON acknowledged instructing RN J to enter the documentation into R1's EMR. When asked if she had any concerns with the catheter found lodged in R1's esophagus with a 30 ml balloon inflated and subsequent blood-tinged emesis and hypoxia, the DON responded, I think the tube got in his esophagus when he aspirated. The DON confirmed R1 had not been assessed by a gastroenterologist to determine if a urinary catheter in lieu of a feeding tube was beneficial to R1. The DON confirmed R1's physician had no recent documentation for the reason a urinary catheter was used as a gastrostomy tube. The DON said if the physician had documented the risk versus benefit of using a urinary catheter in place of a gastrostomy tube it was years ago. No physician documentation was provided by the end of survey. When asked if any training or competency evaluation had been completed with RN J or the other nurses in the facility, the DON acknowledged no training or competency evaluations had been completed. The DON said nurse competencies should be completed yearly but the competencies did not include changing a feeding tube or inserting a catheter as a feeding tube. When asked why securement devices were not used with feeding tubes, including urinary catheters used as feeding tubes, to help secure the tubes in place and prevent dislodgment or migration of the tubes, the DON replied she did not know why securement devices weren't used. When asked if MIC-KEY tubes were replaced in the facility, the DON replied, We can. We have a policy. The DON did not provide a response when asked if nurses had been trained and competency evaluated on changing MIC-KEY tubes. R1's January 2025 TAR was reviewed and did not reveal documentation by RN J that catheter placement was verified on 1/11/25. The Facility Assessment (FA) dated 1/2025 documented tube feeding as one of the services and cares offered at the facility. The section of the FA for nurse education did not include changing feeding tubes or inserting urinary catheters for use as feeding tubes. R1's physician's orders with start dates after readmission on 1/13/25 were reviewed on 2/27/25. The orders were signed by R1's physician on 1/16/25 at 8:52 AM CT and contained an active order: Change G tube foley catheter 16 Fr with 30 cc balloon **MUST USE LATEX CATHETER** 1 X [time] month 2nd Sat [Saturday]. The physician's orders did not include an order for comfort care. The physician's orders did not include an order for a MIC-KEY tube. (continued on next page)

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F 0693 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R1's care plan provided by the facility contained handwriting at the top of the first page that read; Readmit 1/13/25 reviewed no changes. The care plan did not include the use of the MIC-KEY or interventions to ensure placement of the tube or to direct staff what to do in the event the MIC-KEY was dislodged. A radiology technician from the facility's contracted provider of radiology services was interviewed on 2/28/25 at 9:06 AM. The technician confirmed the company he worked for provided mobile x-ray services for the facility. The technician said their services cover abdominal x-rays for verification of feeding tube placement. The technician said the facility was visited twice monthly or as needed at any time to provide x-ray services when needed and ordered by the physician. The DON was asked on 2/28/25 at 10:31 AM if the Medical Director was aware the nurses in the facility had not been trained and competency-evaluated on changing feeding tubes or the insertion of catheters in lieu of feeding tubes. The DON said the Medical Director was not aware. When asked about the expectations with care plans documenting interventions for the care and maintenance of feeding tubes, the DON said, There should be something in there. According to ASPEN (American Society for Parenteral and Enteral Nutrition) Safe Practices for Enteral Nutrition Therapy, Journal of Parenteral and Enteral Nutrition located at https://aspenjournals.onlinelibrary.[NAME].com/doi/10.1177/0148607116673053 and The National Library of Medicine, Chapter 17, 17.1. Enteral Tube Management found at www.ncbi.nlm.nih.gov/books/NBK593216/ Assessing Tube Placement: .Feedings or medications administered into an incorrectly placed enteral tube result in life-threatening aspiration pneumonia. The placement of an enteral tube is immediately verified after insertion by an X-ray to ensure it has not been inadvertently placed . After X-ray verification, the tube should be marked with adhesive tape and/or a permanent marker to indicate the point on the tube where the feeding tube enters the nares or penetrates the abdominal wall. This number on the tube at the entry point should be documented in the medical record and communicated during handoff reports. At the start of every shift, nurses evaluate if the incremental marking or external tube length has changed. If a change is observed, bedside tests such as visualization or pH testing of tube aspirate can help determine if the tube has become dislocated. If in doubt, a radiograph should be obtained to determine tube location Older methods of checking tube placement included observing aspirated GI contents or the administration of air with a syringe while auscultating (commonly referred to as the whoosh test). However, research has determined these methods are unreliable and should no longer be used to verify placement . The facility policy Tube Feeding dated as effective 3/2024 read, in part: Purpose: To ensure that staff providing care and services to the resident via a feeding tube are aware of, competent in and utilize facility protocols regarding feeding nutrition and care. Feeding tube care and services will be provided in accordance with resident needs and professional standards of practice . Prior to flushing the feeding tube, the administration of medication or providing tube feedings the nurse verifies the proper placement of the feeding tube by . a. Draw up 30 ml of air into a 60 ml syringe . c. Attach the syringe to the tube and inject the 30 ml of air into the feeding tube auscultating for placement . The policy did not include x-ray verification for placement after placing an enteral tube, the marking and documentation of the tube entry point, measuring of tube length, or bedside tests of aspirate if tubes are dislodged. (continued on next page)

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F 0693 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The policy Care of Resident with Gastrostomy Tube dated as effective 3/2024 read, in part: .6. Secure tube with tape to prevent displacement of tube . The Immediate Jeopardy that began on 1/11/25 was removed on 2/28/25 when the facility took the following actions to remove the immediacy: 1. Affected Resident(s) / Other residents at risk: Resident R1 no longer has a foley catheter as a G-tube. The resident returned from the hospital with MIC-KEY low-profile tube in place. On February 27, 2025, the physician clarified that the orders to change the G-tube if plugged or compromised in any way is to be done at the hospital. The nurses are not to change the tube. 2. For current and new residents, On February 27, 2025 all residents receiving tube feeding were assessed for the presence of a G-tube. Only one was identified. [Resident reference redacted] On February 27, 2025 the physician clarified that the orders to change the G-tube if plugged or compromised in any way is to be done at the hospital. The nurses are not to change the tube. On February 28, 2025 the physician ordered Xray verification of the placement of current feeding tube to set a baseline for measuring. The facility's policies Gastric Tube Feeding and Policy and Procedure: Tube Feeding has been amended that the resident will be sent to the ED for replacement and measurements will be done to verify placement prior to medication administration, water flush, or start of formula. Also to notify the physician for any abnormalities including dislodging. The facility policy Insertion on indwelling catheter for gastric feeding has been removed. 3. All nursing staff working day shift have been educated on the policy changes and competency tested for measuring as of February 28, 2025.

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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 0726 Level of Harm - Actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49310 All times are in Eastern Daylight Time (EDT) unless otherwise noted. Based on interview and record review, the facility failed to ensure licensed nurses had the knowledge, competencies, and skill sets to replace the feeding tube of one Resident (#1) of one resident reviewed for nurse training and competency for feeding tube replacement. This deficient practice resulted in R1 being admitted to the ICU when the feeding tube was found to be lodged in R1's esophagus with the balloon inflated. Findings include: Resident #1 (R1) According to the EMR, R1 was transferred to the Emergency Department (ED) on 1/11/25 and was admitted to the ICU with aspiration pneumonia (an infection that occurs after a large amount of food or liquid is breathed into the lungs) after Registered Nurse (RN) J inserted a urinary catheter in his gastrostomy site. A radiology examination in the hospital on 1/12/25 at 12:38 AM CT revealed the balloon portion of the urinary catheter was inflated within R1's esophagus. R1 was placed on comfort measures and returned to the facility on [DATE]. Review of R1's Electronic Medical Record (EMR) revealed admission to the facility on [DATE]. The EMR documented R1 was unable to consume foods or fluids orally and required enteral feeding through a gastrostomy tube (G-tube, a tube placed through the abdominal wall into the stomach for delivery of food, fluid, and medications) for nutrition and hydration. Physician's orders for R1 included an order with a start date of 3/26/23 to change R1's feeding tube monthly using a 16 French urinary catheter (catheter with diameter of 5.3 millimeters). During an interview with Registered Nurse (RN) J on 2/26/25 at 10:14 PM, RN J said there was no teaching or training done in response to the event with R1 on 1/11/25. RN J was asked if training or competency evaluations on changing a feeding tube or inserting a urinary catheter in lieu of a gastrostomy tube had ever been conducted. RN J responded, No - we don't really have training, just online videos we watch unless there's something out of the ordinary like wound vacs. RN J acknowledged never receiving training or competency evaluations for changing a gastrostomy tube or inserting a urinary catheter as a feeding tube. Licensed Practical Nurse (LPN) K was interviewed on 2/27/25 at 8:15 AM. LPN K stated they had been employed at the facility for [AGE] years. LPN K said R1 had been in the facility since the 1990's and had used a catheter as a feeding tube for many years. LPN K said nurses had been changing the catheter for years. LPN K said another floor nurse showed LPN K how to change the catheter but admitted to never received training, or competency checks for inserting the catheter as a feeding tube. (continued on next page)

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F 0726 Level of Harm - Actual harm Residents Affected - Few	Unit Manager/RN L was interviewed on 2/27/25 at 8:21 AM. RN L said the facility completed competency evaluations on nurses, but the competencies did not include changing of gastrostomy tubes or inserting a catheter as a feeding tube. RN L denied receiving training, competency evaluations on changing of gastrostomy tubes, or training on inserting a catheter as a feeding tube. During an interview with LPN M on 2/27/25 at 8:27 AM, LPN M said she watched another floor nurse insert a urinary catheter as a feeding tube, but the nurse no longer worked at the facility. LPN M said no other training was provided but competency was evaluated upon hire over a year ago. The education, training records, and competency evaluations for RN J were reviewed on 2/26/25. The most recent date of hire for RN J was 1/3/24. There were no documented training, education, or competency evaluations for RN J for changing a feeding tube or inserting a catheter to be used as a feeding tube. The most recent competency evaluations for RN J were on 4/20/22 during a previous period of employment with the facility, but the competencies did not include changing a feeding tube or inserting a catheter as a feeding tube. The education, training records, and competency evaluations for LPN K were reviewed on 2/27/25. The date of hire for LPN K was 10/23/00. There were no documented training, education, or competency evaluations for LPN K for changing a feeding tube or inserting a catheter to be used as a feeding tube. The most recent competency evaluations for LPN K were on 4/19/22 but the competencies did not include changing a feeding tube or inserting a catheter as a feeding tube. The education, training records, and competency evaluations for RN L were reviewed on 2/27/25. The date of hire for RN L was 6/10/24. There were no documented training, education, or competency evaluations for RN L for changing a feeding tube or inserting a catheter to be used as a feeding tube. The most recent competency evaluations for RN L were on 5/13/23 but the competencies did not include changing a feeding tube or inserting a catheter as a feeding tube. The education, training records, and competency evaluations for LPN M were reviewed on 2/27/25. The date of hire for LPN M was 12/15/23. There was no documented training or education provided to LPN M for changing a feeding tube or inserting a catheter to be used as a feeding tube. There was no competency evaluations conducted for LPN M. The Director of Nursing (DON) was interviewed on 2/27/25 at 11:42 AM. When asked if any training or competency evaluation had been completed with RN J or the other nurses in the facility, the DON admitted no training or competency evaluations had been completed. The DON said nurse competencies should be completed yearly but the competencies did not include changing a feeding tube or inserting a catheter as a feeding tube. The Facility Assessment (FA) dated 1/2025 documented tube feeding as one of the services and cares offered at the facility. The section of the FA for nurse education did not include changing feeding tubes or inserting urinary catheters for use as feeding tubes.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235026	A. Building B. Wing	03/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gogebic Medical Care Facility	402 North Street Wakefield, MI 49968

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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 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. 49735 All times are Eastern Standard Time (EST) unless otherwise noted. Based on interview and record review, the facility failed to complete a comprehensive facility assessment that included training required to meet the needs of the resident population, resulting in the potential for unidentified resources necessary to provide care and services to all 80 residents. Findings include. Review of the Facility Assessment (FA) last revised 1/2025, did not include training on resident rights, dementia care, behavioral health, ethics, and Quality Assurance Performance Improvement (QAPI). On 3/4/25 at 12:36 p.m., an interview with the Director of Nursing (DON) and Nursing Home Administrator (NHA) revealed competency/training did not include all the specific training required for the resident population within the facility assessment. The DON did not respond and the NHA acknowledged the facility needed to work on the facility assessment to include the required training for staff.

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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 0883 Level of Harm - Actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49310 All times are in Eastern Daylight Time (EDT) unless otherwise noted. Based on interview and record review, the facility failed to offer and provide pneumococcal vaccinations to three Residents (#28, #44 & #1) of five residents reviewed for immunizations. This deficient practice resulted in R28 being hospitalized for pneumonia and subsequently expiring from pneumonia-associated complications. Findings include: Resident #28 (R28) R28 was admitted to the facility [DATE]. An annual Minimum Data Set (MDS) assessment dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 00 indicating R28 had severe cognitive impairment. R28's diagnoses included a primary medical condition of non-traumatic brain dysfunction. There were no pulmonary diagnoses, supplemental oxygen use, nor infections documented in the MDS. Section O documented the pneumococcal vaccination for R28 was up to date. A nurse's progress note in R28's Electronic Medical Record (EMR) dated [DATE] at 7:08 PM CT (Central Time) documented R28 had developed respiratory symptoms over the previous ,d+[DATE] hours. The symptoms included cough, congestion to both lungs, low oxygen saturation, and the need for supplemental oxygen use. R28 was transferred to the hospital Emergency Department (ED) on [DATE] and diagnosed with right upper lobe pneumonia. R28 was admitted to the hospital for treatment of the pneumonia. A hospitalist's discharge summary dated [DATE] documented, in part: . resides at [name of facility redacted] found unresponsive on ,d+[DATE] [2025] by nursing staff. Pt [patient] was hypoxic [low oxygen level] with SpO2 [oxygen saturation] 87% on RA [room air], and she had a temperature of 100.4 [degrees Fahrenheit]. ED findings with fever, altered mental status, and hypoxia. She was found to be dehydrated .CXR [chest x-ray] showed right upper lobe pneumonia . R28 returned to the facility on [DATE] but continued to experience a decline in respiratory status and overall health condition resulting in a significant change MDS assessment being completed on [DATE] for decline in Activities of Daily Living (ADL), use of supplemental oxygen, and weight loss. The significant change MDS documented the primary medical condition as debility, cardio-respiratory condition, with pneumonia and use of supplemental oxygen. A progress note in R28's medical record dated [DATE] at 1:56 PM CT documented the physician did not want to pursue a chest x-ray. The note read, in part: . resident is exhibiting end stage respiratory issues brought on by acute pneumonia . R28 was placed on comfort measures, was started on Morphine and oral medications were discontinued on [DATE]. R28 was documented as deceased on [DATE] at 7:25 PM CT. (continued on next page)

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F 0883 Level of Harm - Actual harm Residents Affected - Few	The Michigan Care Improvement Registry (MCIR - an official state of Michigan Immunization record) for R28 was reviewed on [DATE]. The MCIR documented the following instruction to the provider (facility): Assessment indicates that the vaccinations are overdue and should be administered today if not medically contraindicated. The MCIR listed the PCV20/PCV21 (pneumococcal vaccines) were overdue to be administered as of [DATE]. A pneumococcal vaccination consent form documented as updated on [DATE] was provided by the facility for R28 and was signed by R28's guardian on [DATE]. The consent form only covered consent for the pneumococcal vaccines PPSV23 and PCV13. The PCV20 and PCV21 vaccines were not included on the consent form. The PCV13 vaccine is no longer recommended by the Centers for Disease Control (CDC) for routine use among adults aged 65 and older as of [DATE] (www.cdc.gov/mmwr/volumes/68/wr/mm6846a5.htm). The PCV20 was recommended by the CDC starting [DATE], and would have been the vaccine available for administration when R28 became due for the pneumococcal vaccination on [DATE] (www.cdc.gov/mmwr/volumes/72/wr/mm7239a5.htm). The PCV21 was added as a vaccine option and recommendation by the CDC starting [DATE] (www.cdc.gov/mmwr/volumes/73/wr/mm7336a3.htm?s_cid=mm7336a3_w). There was no documentation found in the EMR or provided by the facility indicating the PCV20 or PCV21 vaccinations were ever offered to R28's guardian. The Infection Preventionist (IP) was interviewed on [DATE] at 3:40 PM. The IP said no additional consent forms for pneumonia vaccination could be found for R28. The IP said she was unable to locate documentation that R28 received the PCV20 or PCV21 vaccination or that R28's guardian was ever offered the PCV20 or PCV21 vaccination. Resident #44 (R44) R44 was admitted to the facility [DATE]. A quarterly MDS dated [DATE] documented R44's pneumococcal vaccinations were up to date. The MCIR was reviewed for R44 which documented R44 was overdue for pneumonia vaccination as of [DATE]. No documentation was found in R44's EMR indicating R44 or his resident representative was provided a consent form offering pneumococcal vaccination. No documentation was found or provided by the facility indicating R44 received the pneumococcal vaccinations as recommended. Resident #1 (R1): R1 was admitted to the facility [DATE]. A quarterly MDS dated [DATE] documented R1's pneumococcal vaccinations were up to date. The MCIR for R1 was reviewed for R1 which documented R1 was overdue for pneumonia vaccination as of [DATE]. No documentation was found in R1's EMR indicating R1 or his resident representative was provided a consent form offering the vaccination. No documentation was found or provided by the facility indicating R1 received the pneumococcal vaccination as recommended. (continued on next page)

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F 0883 Level of Harm - Actual harm Residents Affected - Few	The IP was interviewed on [DATE] at 5:05 PM. The IP confirmed there were no consents for pneumococcal vaccinations for the residents overdue or eligible for the vaccinations, including R44 and R1. The IP validated the consent form utilized by the facility was outdated and contained information for a vaccine that is currently unavailable and not recommended for use in adults. The IP confirmed the form did not include the recommended PCV20 and PCV21 vaccines. The IP confirmed the pneumococcal vaccinations were not administered as recommended, and appropriate consents had not been issued to residents or their representatives. The policy Influenza/Pneumococcal Vaccination Protocol dated as effective ,d+[DATE] read, in part: . All residents residing in the Facility are eligible to receive a pneumococcal vaccination if they meet the CDC recommended criteria . The standard recommended dose will be given after appropriate consent is received .