STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235031	A. Building B. Wing	09/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Canal View - Houghton County	1100 Quincy Street Hancock, MI 49930

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This deficiency pertains to Intake 2574829.Based on observation, interview and record review the facility failed to provide comfort care based on the individual's personalized care plans, for one Resident (R1) of one resident reviewed for quality of care. This deficient practice resulted in unaddressed anxiety and fear related to shortness of breath during the dying process. Findings include: Review of R1's Minimum Data Set (MDS) assessment, dated [DATE], revealed R1 was re-admitted to the facility on [DATE] with active diagnoses that included the following, in part: cancer, septicemia, anxiety disorder, chronic obstructive pulmonary disease (COPD), respiratory failure, parainfluenza virus pneumonia and pulmonary embolism. R1 Scored 14 of 15 on the Brief Interview for Mental Status (BIMS) reflective of intact cognition. The Resident (R1) was placed on Hospice on [DATE] and remained as her own responsible party for medical decisions until [DATE], the day of the Resident's death. An abbreviated survey was conducted on [DATE] in response to a complaint, which included the following information, in part: . Resident (R1) was on Hospice due to COPD and emphysema . On [DATE] at approximately 8:30 p.m., the resident was struggling to breathe and begging for help . The resident was in a complete panic because she couldn't breathe . Complainant states the resident died in agony and fear at (approximately) 9:30 p.m. and staff didn't give her anything to ease her pain or help her breathe .Review of R1's Physician Order Summary revealed the following medication orders, in part:1. Ipratropium-Albuterol Inhalation Solution 2.5 - 0.5 MG/3ML (Ipratropium-Albuterol) 1 vial inhale orally every 4 hours for SOB (shortness of breath). This order was addressed by R1's attending physician on [DATE] in response to a written request from Hospice Registered Nurse (RN) K. Attending Physician/Medical Director T ordered this medication to be retained as an active prescription for R1's shortness of breath.2. Morphine Sulfate (Concentrate) Oral Solution 20 MG/ML (Morphine Sulfate) Give 0.75 ml by mouth every 2 hours as needed for comfort.3. Morphine Sulfate (Concentrate) Oral Solution 20 MG/ML (Morphine Sulfate) Give 0.75 ml by mouth every 4 hours for Comfort.4. Lorazepam Oral Tablet 0.5 MG (Lorazepam) Give 2 tablets by mouth every 4 hours as needed for anxiety give 0.5mg - 1mg every 4 hours PRN. Review of R1's Progress Notes documented the following, in part: [DATE] 6:27 (a.m.): Resident resting in bed with eyes closed at this time. Arouses to name and will answer questions appropriately. [DATE] 8:13 (a.m.): . Resident presents s/s (signs and symptoms) of pain, morphine gave as PRN order (every 2 hours) . [DATE] 12:05 (p.m.) Order was received via telephone from hospice nurse (Hospice RN K), conveying the physician's (Physician S's) directive to discontinue the following medications and interventions: .DuoNeb [an inhalation solution containing a combination of two bronchodilators, albuterol and ipratropium, that is used to treat bronchospasm in people with chronic obstructive pulmonary disease (COPD)] . [DATE] 12:10 (p.m.), Communication Method: Phone .Order Summary: Ipratropium-Albuterol Inhalation Solution 2.5 - 0.5 MG/3ML (Ipratropium-Albuterol, 1 vial inhale orally every 4 hours for SOB, DISCONTINUE: [DATE] 12:10 (p.m.), Discontinue Date/Reason: MD (Physician) order per hospice nurse [RN K]. [DATE] 12:19 (p.m.): Morphine Sulfate (Concentrate) Oral Solution 20 MG/ML. Give 0.75 ml by mouth every 2 hours as needed for comfort. PRN Administration was: Effective. Follow-up Pain Scale was: 1. [DATE] 13:13 (1:13 p.m.): Morphine Sulfate (Concentrate) Oral Solution 20 MG/ML. Give 0.75 ml by mouth every 4 hours for Comfort. No documentation of Follow-up effectiveness. 7/18.25 19:33 (7:33 p.m.): Lorazepam Oral Tablet 0.5 MG. Give 2 tablet(s) by mouth every 4 hours as needed for anxiety give 0.5 mg - 1 mg every 4 hours PRN . Resident (R1) very anxious. No follow-up documentation of effectiveness. Medication administered by Licensed Practical Nurse (LPN) E. [DATE] 19:36 (7:36 p.m.): Morphine Sulfate (Concentrate) Oral Solution 20 MG/ML. Give 0.75 ml by mouth every 2 hours as needed for comfort. Resident (R1) asked for pain medication. No follow-up documentation of effectiveness. Medication administered by LPN E. [DATE] 20:35 (8:35 p.m.): Lorazepam Oral Tablet 0.5 MG. Give 2 tablets by mouth every 4 hours as needed for anxiety give 0.5 mg - 1 mg every 4 hours PRN. PRN Administration was Effective. Medication documented as given to R1 by LPN E. [DATE] 20:57 (8:57 p.m.): Morphine Sulfate (Concentrate) Oral Solution 20 MG/ML. Give 0.75 ml by mouth every 2 hours as needed for comfort. PRN Administration was Effective. Follow-up Pain Scale was: 2. Documented as given to R1 by LPN E. [DATE] 21:45 (9:45 p.m.): Called to res. (resident R1's) room to confirm res. Death. Observed absent respirations and absent apical pulse for 1-2 minutes. Comfort offered to family who were still present in res. Room . Funeral home updated per phone per family request . Signed by Registered Nurse (RN) N. Review of R1's Controlled Substance Proof-of-Use Record for the Lorazepam 0.5 tablets

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure adequate toileting assistance to prevent a fall, for one Resident (R2) of three residents reviewed for falls. This deficient practice resulted in a fall with major injury, including fractured facial bones and subdural hematoma. Findings include: This deficiency pertains to Intake 2625013,Review of R2's Electronic Medical Record, revealed R2 was admitted to the facility on [DATE], with diagnoses that included the following, in part: Alzheimer's disease with late onset, dementia with agitation, dementia with anxiety, reduced mobility, need for assistance with personal care, stiffness of right hip, stiffness of left hip, and stiffness of right knee. R2 score 0/15 on the Brief Interview for Mental Status (BIMS) performed in August of 2025, reflective of severe cognitive impairment.Review of the Incident Report dated 9/14/25 at 1545 (3:45 p.m.), revealed the following: .Incident Description: . CNA (Certified Nurse Aide) called this nurse into common bathroom stating resident fell on floor. Upon entering the bathroom resident (R2) was observed lying face down on bathroom floor bleeding from the head. Resident assessed with assistance of CNA for bleeding and pressure applied to laceration on right side of head. Attempted to get blood pressure twice but unable to related to positioning and resident crying out. Charge nurse informed of situation and took control of notifying EMS (Emergency Medical Services) and family . Immediate Action Taken: Pressure applied to laceration and transferred to ER (emergency room) via EMS . 9/17/25 Notes: .The resident was assisted to the toilet in the shower bathroom by [CNA's J and I] with an EZ Stand. While standing, [Resident R2] was unable to wait and soiled his clothing. [R1] was then seated on the toilet. CNA I exited the room, and CNA J continued assisting the resident by changing his soiled clothing. A towel was placed on the floor to prevent slipping. While removing clothing from the resident's legs he leaned to the right, lost balance, and fell. R1 sustained lateral and floor (sic) right orbital wall fractures, right zygomatic arch fracture (a break in the bone that forms the lower part of the cheekbone and extends to the temple), right maxillary sinus wall fracture, and a subdural hematoma. Root cause: Care plan was not followed. Resident is care planned to have two caregivers present for the entire toileting process . Intervention: CNA was re-educated on the importance of adhering to the resident's care plan. The care plan was updated to specify use of commode with two-person assist for the full toileting duration and contact guard assist during clothing changes. Therapy will evaluate residents. Review of R2's Care Plans revealed the following, in part: DO NOT leave me unattended as I have fallen in the past. Two people must remain with for the entire toileting duration. Date Initiated: 08/17/2023 . Revision on 05/16/2025.Review of the facilities' Investigation Summary revealed the following interventions to prevent recurrence and ensure residents' safety, in part: .Staff members will remain with the residents throughout the entire toileting process. During clothing changes, staff will remain contact guard assist to ensure stability and prevent loss of balance. A commode with armrests will be used to provide additional support and stability during toileting. Random audits will be conducted daily for 2 weeks, 3x's week for 1 week, 2x week for 1 week and 1x a week for 1 week for a duration of 5 weeks to ensure adherence to the updated protocol and care plan requirements .