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	11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Canal View - Houghton County	1100 Quincy St 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 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** 49735 Based on interview and record review, the facility failed to ensure that appropriate interventions were in place to prevent a burn for one Resident #70 (R70) of ten residents reviewed for burns resulting in the potential for further burns, pain and disfigurement. Findings include: Resident #70 (R70) Review of R70's Minimum Data Set (MDS) assessment dated [DATE], revealed admission to the facility on [DATE], with active diagnoses that included: coronary artery disease, hypertension, heart failure, diabetes mellitus, and anxiety disorder. R70 scored a 7 of 15 on the Brief Interview for Mental Status (BIMS) assessment reflective of severe cognitive impairment. Review of facility incident notes, read in part . per video review of the day 10/25/24 .R70 was seating in the dining tower for supper. R70 was observed picking up a bowl from the table and holding it over her chest while spooning something into her mouth. R70 puts the spoon and bowl back on the table and began to fan the clothing protector that was on [R70's] chest .A copy of the supper meal ticket that day was reviewed, and tomato soup was on the menu .Certified Nurses Aide (CNA) .recalls serving soup to [R70]. Review of facility document titled Hot Food Temperature Log dated 10/2024, read in part . (10/25/24) food item tomato soup .temp 188 degrees Fahrenheit. Review of R70's Incident report dated 10/25/24 revealed [R70] was unable to rate pain, but does state there is some there . Other info .Hot beverage -spillage. Review of R70's Hot liquid assessment dated [DATE], read in part . There exists a high probability to cause the resident to spill a liquid every time a resident handles a hot liquid, the resident is deemed at high risk with hot liquids .Resident is at high risk for liquid spills due to .muscle weakness . [Resident} is not safe to have hot liquids without a lid Review of R70's care plan did not reveal any intervention to prevent further burns from hot soup. (continued on next page)

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/19/24 at 10:04 a.m., R70 touched her chest and stated that is where my burn was . During an interview on 11/20/24 at 1:38 p.m., the Nursing Home Administrator (NHA) acknowledged that R70 received a burn from hot soup. During an interview on 12/20/24 at approximately 3:15 p.m., the Director of Nursing (DON) stated, I have not considered safety related to hot soup as the hot liquid assessment was only for drinks. Review of facility policy titled Hot Liquids Policy last revised 5/2024, read in part . Residents will be assessed for management of hot liquids to determine risk for hot liquid spills .the facility's hot liquid assessment addresses lid use on hot liquids .lids should be placed on hot liquids .

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. 45123 Based on observation, interview, and record review, the facility failed to provide adequate pain management for one Resident (#30) of two residents reviewed for pain management resulting in R30 experiencing uncontrolled pain during a routine dressing change. Findings include: Resident 30 (R30) Review of R30's face sheet revealed the following diagnosis: low back pain. Review of R30's Minimum Data Set (MDS) assessment, dated 9/4/24, revealed a Brief Interview for Mental Status (BIMS) assessment of 9 (0-15) indicating moderately impaired cognition. R30 had no rejections of care, was dependent on staff for all cares except substantial/maximal assistance for upper body dressing, and had an unhealed pressure ulcer, not present on admission. Review of R30's Electronic Medication Administration Record (EMAR), revealed the following, Morphine Sulfate (concentrate) Oral Solution 20 MG/ML (milligrams per milliliters) Give 0.25 ml by mouth every 2 hours as needed for pain . (5 mg) . Review of R30's Treatment Administration Record (TAR), revealed the following, Pressure injuries to coccyx: Cleanse ., pat dry, apply (brand name dressing) to wound bed after moistening with NS (normal saline), then apply 4 x 4 (brand name) dressing. Check daily on every shift and change if there is ANY exudate shadow. Change on shower day, also, (Tuesday am) . R30 was receiving daily dressing changes. On 11/19/24 at 11:07 AM, an observation was made of R30 receiving a dressing change. R30 was observed to be crying out, Ow, Ow, Ow, (repeatedly) .I can't do it .I want my son . Review of R30's MAR, dated 9/26/24 through 11/18/24, revealed no documentation of medication being provided prior to receiving dressing changes on the following dates: a.) September 28th and 29th, b.) October 1st, 2nd, 3rd, 4th, 9th, 11th, 12th, 13th, 14th, 15th, 16th, 17th, 18th, 20th, 23rd, 25th, 26th, 27th, and 28th, c.) November 3rd, 6th, 8th, 9th, 11th, 15th, 17th, and 18th. Review of R30's care plan, dated 9/10/24, read in part, .I have pain related to my osteoarthritis, coccyx wound .I will not have an interruption in normal activities due to pain through the review date .Evaluate the effectiveness of pain interventions Review for compliance, alleviating of symptoms, dosing schedules and my satisfaction with results, impact on functional ability and impact on cognition .Monitor/record/report to Nurse my complaints of pain or requests for pain treatment .Notify physician if interventions are unsuccessful or if current complaint is a significant change from my past experience of pain. Observe and report changes in usual routine, sleep pattens, decrease in functional abilities . (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/19/24 at 11:10 AM, an interview was conducted with Certified Nursing Assistant (CNA) D and was asked about R30's discomfort during the dressing change observation and replied, It is hard for them to roll on their right side., which was the side CNA D had to R30 roll on. During the dressing change R30 also stated, It hurts so bad while cleaning the wound. I can tell when it hurts. R30 also refused their shower on 11/19/24. On 11/19/24 at 3:10 PM, an interview was conducted with R30 in their room regarding their pain during the dressing change that morning and how they were feeling now and replied, Pain is ok right now. This morning it was worse during the dressing change and hurt bad during that time. On 11/19/24 at 3:27 PM, an interview was conducted with CNA D who was asked about R30 and her pain during dressing changes. CNA D agreed R30 had increased pain with dressing changes, with rolling on their side and with changing their incontinence brief. CNA D was asked if they have ever let nursing know about R30's pain issues observed while providing cares for R30 and replied, No, I don't think so. On 11/20/24 at 9:05 AM, an interview was conducted with Registered Nurse (RN) E who was asked about R30's pain with dressing changes. RN E replied, I'm not sure why they haven't had an increase in pain medication or why it is not scheduled prior to their dressing changes as that is when they need it most. I did pre-medicate them. When they are resting, they are not in any pain. Just pain with movement and the dressing changes. On 11/20/24 at 12:20 PM, an interview was conducted with the Assistant Director of Nursing (ADON) A who was asked about R30 and the observation of R30 crying out during the dressing change. The ADON A replied, If they were having that much pain during dressing change after being pre-medicated then that was not enough medication. On 11/20/24 at 1:49 PM, an interview was conducted with the Director of Nursing (DON) who was asked about pain management and re-assessment after implementation of medication when pressure ulcer and dressing changes started for R30 and replied, Normally discuss with quarterly reviews. The DON reviewed the progress notes for R30 and confirmed a lack of any discussion or follow up in care conference or reviews regarding R30's pain management. The DON stated, It should be scheduled prior to each dressing change if they are in that much pain. The DON was going to address R30's pain with the physician. Review of policy titled, Pain Assessment and Management, dated 11/2024, read in part, The facility will keep its residents as pain free as possible so they can achieve their highest level of function and quality of life. Pain relief measures will be implemented to comply with professional standards of practice, focusing on comprehensive person centered care planning to include the resident's goals and preferences . D. When assisting residents with ADL's (Activities of Daily Living), direct care staff should observe for pain by assessing for signs and symptoms of pain and or verbally inquiring about a resident's pain, such as: intensity, duration, frequency, location, onset, pattern etc. Documentation and follow-up should occur as needed . F. A plan for pain and symptom management will be developed based upon the assessment data . G. Nursing should evaluate pain status, interventions and effectiveness of pain interventions and document in the nursing notes and the EMAR as applicable. Update the Physician as needed .

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 41978 Based on observation, interview and record review, the facility failed to ensure expiration dates were present on multi-dose medications and biologicals and failed to remove expired medications from the active supply in one medication cart of four medication carts reviewed, resulting in the potential for administration of expired medications and biologicals and the potential to have a reduced medication effect. Findings include: A review of the 200 Hall medication cart with Licensed Practical Nurse (LPN) C on 11/19/2024 at 1:54 p.m. revealed the following: A multi-dose Trelegy Ellipta (inhaled medication used to treat asthma and chronic obstructive pulmonary disease) 200-62.5-25 MCG (microgram) inhaler with 22 doses out of 30 doses remaining. Further review of the inhaler and the box housing the inhaler revealed no date indicating when the medication was first opened or when the medication would expire. An open insulin aspart (rapid-acting insulin) FlexPen with 75 units out of 100 units remaining. The insulin pen and the clear plastic bag housing the pen contained no legible date indicating when the medication was first opened or when the medication would expire. An open container of latanoprost (medication used to treat glaucoma) eye drops with a written expiration date of 11/16/2024, indicating the medication expired three days prior to the observation. During an interview at the time of the observation, LPN C reported there were no open dates written on the multi-dose Trelegy Ellipta inhaler or the insulin aspart FlexPen, so she was unable to determine if or when the medications expired. LPN C confirmed the open container of latanoprost eye drops were expired and should have been removed from the medication cart and a new container ordered from the pharmacy. Review of the facility policy titled, Medication Storage, Labeling, Dating, Expirations, Destructions, and Returns, last revised 12/2023, revealed the following: Once a medication or biological package is opened . Record the date opened on the primary medication container (vial, bottle, inhaler) and storage packaging if, once opened, the item has a different expiration date than the manufacturer expiration date . Apply an expiration label (i.e. neon orange or yellow) when the medication has a shortened expiration date once opened (i.e. less than 30 days) . Facility should destroy or return all discontinued, outdated/expired or deteriorated medications or biologicals .