STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235074	A. Building B. Wing	08/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marlette Community Hospital Ltcu	2770 Main Street Marlette, MI 48453

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview and record review, the facility failed to ensure food was properly labeled, dated and stored to maintain best practices resulting in the potential to spread food borne illness to all residents that consume food from the kitchen.Findings include:On 8/5/25 at 9:00 AM, observations and interview during Initial kitchen include: On the prep table there was a large plastic container with an open blue bag in it, the container had no label, no open or expiration date on it. During interview with dietary supervisor “C”, when asked what the product was, Dietary Supervisor C stated it was rice, and acknowledged there is no dates or label present, but reports “there should be”. Walk in freezer with (2) Large plastic baggies of pepperonis that have been opened and have no open/expiration dating on them and sitting on shelf near a box of sealed pepperonis. On another shelf there is an open bag of frozen sugar snap peas no open date, closed with a rubber band. In the dry storage line in the kitchen, there is a box of cream of wheat and pancake mix both open in plastic bags, no open / expiration dates. The flip top cooler that holds the individual cartons of milk is at 45 degrees, asked dietary supervisor “C” about what temp it should be, “well under 40”. Overheard her asking kitchen staff member “E” about it, kitchen staff member “E” said that “the cooler latches on the inside, (shows dietary supervisor “C”) and if it gets loose and doesn't close tight so if people are not paying attention and that could be the issue”. In the short cooler a crossed from the flip top milk cooler there is ~8 individual cottage cheese served out into cups, 3 sandwiches wrapped on plates, all covered with clear wrap but no labels, date made or expiration on them (nor on the tray). Kitchen staff “J” member comes over and says, “I just made those up, they are for resident's trays if they want extra or something different, so I don't label them since I am going to use them”. In the stand-up cooler there is ~2 dozen individual Jello and yogurt served out into cups, individually covered with plastic but prepare/expiration dates on them (nor on the tray). When shown, dietary supervisor verbally acknowledges there is no dating. On the dry cookie sheet tray storage rack there are 2 pans with cooked bacon (that were cooled as there was firm film of grease on tray) that was also located on the same rack as the clean cookie sheet trays. When shown, dietary supervisor “C” responds, “I do not know why those are there they definitely should not be here with the clean trays”. (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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	In stand-up freezer for café' there is an open bag of unidentifiable frozen item, asked CDM “B” what is this? She says, “its chicken strips” pulled it out the bag of what appeared to be freezer burned crumbs and says, “oh no I think its onion rings”, proceeded to throw them in trash. Record review of the facility's policy on labeling -Dietary, according to procedure step(s) Step 1 All foods prepared in operations must be covered and dated appropriately prior to storage in refrigerators, following all food storage and temperature guidelines. All open food containers are labeled to indicate the expiration date. All perishable open/prepared foods will be evaluated, used or discarded within the timeframe associated with the 2013 food code. All foods items requiring time/temperature control will be dated to expire 3-7 days from date being prepared or open.” Step 2 “All open food must be dated; When dating dairy products, like milk or cottage cheese, the manufacture date applies. If the printed date is before the used date, go by the printed date. If the use by date is before the printed date once the product is opened, go by the use by date. Milk must be dated once opened by location.” Step 3 “Purchased, ready to use foods removed from the original containers must be handled and dated as above. A label stating the common name of the product must be used if the product is not readily recognizable. Step4 “for quality and safety purposes of cut fruit, vegetables, and prepared sandwiches are dated three days with the date of reparation counted as day one.” Step 5 “foods maintained in dry storage must be labeled and dated with the date the original carton was opened.” On 08/06/2025 at 8:13 - 9:00 AM During the kitchen tour with the Dietary Supervisor C, expired roast beef was observed with a use by date of 8/2/25 in the walk-in cooler. The dietary supervisor proceeded to throw out the roast beef. Record review of the facility's policy on labeling, The food service storage area are inspected before the kitchen/cafe opens, and all items that have reached the expiration date are disposed of. According to the 2022 Food Code, 3-501.18 Ready-to-Eat, Time/Temperature Control for Safety Food, Disposition, .Time/temperature control for safety refrigerated foods must be consumed, sold or discarded by the expiration date.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on interview and record review the facility failed to maintain a comprehensive infection control program, resulting in the facility not mapping infections or completing audits and the potential for infection clusters to go unnoticed. Findings include: DPS 2 Based on interview and record review, the facility failed to have an active plan for reducing the risk of legionella and other opportunistic pathogens of premise plumbing (OPPP). This deficient practice has the increased potential to result in water borne pathogens to exist and spread in the facility's plumbing system and an increased risk of respiratory infection among any or all of the residents in the facility. Findings include:On 08/07/2025 at 1:13PM, an interview was conducted with the Director of Nursing (DON). The DON acts in the role of the infection preventionist. During record review of the monthly infection control reports, it was noted that there was no mapping of infections being completed by the facility and minimal audits being completed for infection control. The DON was asked if the facility is mapping infections that occur on the halls? The DON stated that no, they were not mapping infections. When the DON asked why not, the DON replied, it was an oversight, I really don't know. The DON stated that another nurse will be assisting with infection control moving forward. The DON was asked what other audits are performed monthly to identify areas for improvement for infection control? The DON stated, we don't necessarily do audits monthly, we use to do hand washing, but staff had been good about that, so we stopped doing it. I audit all call in slips for staff to see if there are any trends to pay attention to. PPE audits have been done in the past, but the last one was completed in February 2025. No evidence of audits being completed for the laundry area and the kitchen were observed since the last survey. Review of the policy titled, Infection Prevention and Control (IPC) Program & Plan, revealed, Statement of Purpose: To provide an effective infection prevention plan to minimize risk of infection for healthcare personnel,patients, residents, and visitors. Through continuous monitoring as well as focused improvements tothe plan, our goal is to achieve optimal outcomes in a cost-effective manner and to use all availableresources in the formulation and execution of the plan. Procedure: 3.Prevention, monitoring, and control of the transmission of HAI and infectious/communicable diseases, including but not limited to:a. Surgical prophylaxis provided as appropriateb. Aseptic techniques employed as appropriate (e.g., invasive bedside procedures such as catheter insertion or central line insertion)c. Proper hand hygiene promoted and monitoredd. Encourage prompt removal of invasive devices (e.g., foley catheters, central lines) if no longer needed 8. Maintenance of a sanitary environment for personal, patients, visitors, contractedpersonnel, volunteers and students:a. Infection Control Surveillance rounding to be completed in each clinical area quarterly and each non-clinical area at least annually. Any rounding fall outs will be reviewed by the Infection Prevention Committee during quarterly meetings with corrective actions being implemented as needed. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	DPS 2 On 08/06/2025 at 1:00 PM, an environmental tour with the Facilities Supervisor K and Director of Maintenance L was conducted. On 08/06/2025 at 1:00 PM, observed the water softener drain line sitting directly inside drain instead of having an air gap of at least one inch. On 08/06/2025 at approximately 1:00 PM, when asked about whether the chlorine residual is tested on site, Director of Maintenance L stated that the chlorine residual isn't tested on site. On 08/06/2025 at approximately 1:00 PM. when questioned about the chlorine levels in the drinking water at the facility, Facilities Supervisor K stated that the city doesn't use chlorine in the water. Record review of the Water Quality Report from the city listed guidelines for the maximum contaminant disinfectant level but did not list the chlorine residual results. Record review of the Water Management Plan for chlorine levels, Chlorine will be used as a disinfectant in the water lines. As such, water samples will be collected by maintenance staff from areas considered to be of high risk and will be monitored for any dramatic drops in the chlorine levels once per quarter. The results from these tests will be recorded on a log sheet and submitted to the Infection Prevention/Control Committee for review. According to the Centers for Disease Control and Prevention, Controlling Legionella in Potable Water Systems dated January 3rd, 2025, the guidance for control measures states, Ensure disinfectant residual is detectable throughout the potable water system.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on interview and record review, the facility failed to evaluate and document the clinical rationale for the continuation of a PRN (as needed) anti-anxiety medication beyond 14 days and failed to identify a stop date of the medication for one resident (R6) of five residents reviewed for unnecessary psychotropic medication use, resulting in potential for overuse of the medication.Facts and Findings include: Record review of R6 quarterly minimum data Set (MDS) revealed Brief Interview of Mental Status (BIMS) of 2, defined as cognitively severely impaired never/rarely made decisions. Medical diagnosis included: Alzheimer's, COPD, Anxiety, Residual Schizophrenia, ASHD, Colon cancerRecord review of R6 physician order from 04/09/2025 for Ativan 0.5 mg tablet by mouth daily PRN (as needed for) anxiety, may give 1/2 hour prior to showers. Signed by NP F. There is no stop date / review date for this order.Record review of drugs.com internet search for Ativan (lorazepam) drug class: benzodiazepine anticonvulsant is used for anxiety disorders and insomnia.Record review of the latest Psychiatry note dated 6/25/25, according to the note the order for Ativan remains unchanged, it has no end date or next review noted. The medications heading of this note reads the active order as Ativan 5mg, take 1 tab, status unchanged. reconciled by NP G. The assessment and plan state continue Ativan 0.5 mg, note signed by NP G.On 8/6/25 at ~3:00pm Interview with DON, requested Psychotropic medication policy to egress. Asked what the policy on duration for PRN Psychotropic medications is, she states that medication needs to be reviewed every 14 days if it is to continue. When asked specifically about R6 PRN Ativan order from 4/09/25 with the last review date of 6/25/25, she states well he really gets the PRN mostly on shower days, he gets really upset on those days and I try to review the psychiatry notes and recommendations when we get them, you can see I put that addendum in the chart for this psychiatry note because the note said Ativan 5 mg in one spot and continue with Ativan 0.5mg in another, the original order was for Ativan 0.5 mg. She says, it was just a typo error, and no dose change was made, DON acknowledged that there is still no end or review date to this Ativan order/continued order. Inquired if a PRN Psychotropic med should have an end date, then, she replied well for antipsychotics yes, but Ativan isn't an antipsychotic it is for anxiety, so it does not need a 14-day review or end date. According to a record review of the facilities policy on Psychotropics medications:A Psychotropic drug is one that affects brain activities associated with mental processes and behavior. Psychotropic drugs include but are not limited to the following categories: antipsychotics, antidepressants, anti-anxiety, and hypnotics. PRN orders for psychotropic medications, excluding antipsychotic medications, shall be limited to no more than 14 days, unless the attending physician or prescribing practitioner believes it is appropriate to extend the order beyond the 14 days. The medical record should include documentation from the physician or prescriber for the rationale for the extended time period and indicate a specific duration.The attending physician will assume leadership in medication management by developing, monitoring, and modifying the medication regimen in collaboration with resident, their families or representatives, other professionals, and the interdisciplinary team.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to develop a baseline care plan for one resident (R25) of two reviewed, resulting in the lack of a baseline care plan for oxygen administration. Findings include: R25 is [AGE] years old and admitted to the facility on [DATE] with diagnoses that include chronic respiratory failure with hypoxia, hypertensive heart disease with heart failure, congestive heart failure and pulmonary fibrosis.On 08/06/2025 at 8:56AM, R25 was observed sitting in bed receiving oxygen via nasal cannula. R25 stated that she usually receives 7 liters per minute (LPM) of oxygen, but due to having different tubing she is now having to receive 8LPM and her oxygen saturation isn't nearly as high as it usually is. On 08/06/2025 at 2:33PM, record review revealed a physician's order for administration of oxygen at 7LPM, dated 7/24/25. Record review revealed there is a care plan is in place for oxygen use, it is dated 8/6/25. On 08/06/2025 at 2:46PM, record review of care plans revealed that a care plan wasn't developed for oxygen use until 8/6/25, the resident admitted to the facility on [DATE]. No baseline care plan was present for oxygen. On 08/06/2025 at 2:56PM, the minimum data set (MDS) assessment dated [DATE] indicated the resident was receiving oxygen therapy on admission. On 08/07/2025 at 2:35PM, an interview was conducted with the Director of Nursing (DON). The DON was asked if there should've been a baseline care plan in place for oxygen administration? The DON replied, Yes, I honestly believe there should have been a baseline care plan in the electronic charting. I did notify the staff on the floor that she was on 7LPM, and it varied from 7-10LPM in the hospital. But there was no baseline care plan in the electronic charting. Review of the policy titled, MRH Baseline Care Plan, revealed:Policy:A baseline care plan will be established and implemented for each resident within 48 hours of admission. The plan will include instructions needed to provide effective and person-centered care of the resident and meet professional standards of care. Procedures:B. The baseline care plan will at a minimum include: initial goals, provider orders, dietary orders, therapy services, social services and PASARR recommendations if applicable.C. The baseline care plan will be updated with any significant changes by the nurse supervisor and/or MDS coordinator and will be utilized until the interdisciplinary team completes a comprehensive assessment and develops a comprehensive care plan in accordance with state and federal guidelines.

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to provide routine dental services for one resident (R15) of one reviewed for dental services. Findings include: R15 is [AGE] years old and admitted to the facility on [DATE] with diagnoses that include malignant neoplasm of the pancreas, neuropathy, type 2 diabetes and hypertension. On 08/05/2025 at 12:01PM, R15 was observed in her room sitting on the edge of her bed. R15 was observed to not have any upper teeth, lower teeth were visible. R15 was asked about not having upper teeth in. R15 stated that she left her upper dentures at home and that they don't fit. R15 was asked if she had been seen by the dentist since being in the facility. R15 stated she was not sure if she sees the dentist here or not, but that she would like to. R15 stated that she would like to eat more salads but cannot eat them due to not having upper dentures. On 08/06/2025 at 12:38PM, an interview was conducted with Social Worker (SW) A. SW A was asked if they are the staff member that gets consents for 360care (this is the provider of dental, vision and podiatry). SW A replied, yes. SW A was asked if the residents get information about 360 care on admission? Typically, yes they get information on admission. SW A was asked if R15 consented to be seen by the dental providers. SW A produced a document that revealed R15 had orders for dental services to be received, it was dated 11/19/2024. In addition, R15 has orders to be seen by podiatry, vision and ear cleaning. SW A was asked when was the last time R15 was seen by dental in the facility? SW A stated that R15 admitted on [DATE] and that R15 has not seen the dentist since admission. SW A was asked when the dentist was last in the facility. SW A replied that the dentist was in the facility in December of 2024 and July 30th, 2025. SW A stated that R15 has not been put on the list to be seen by the dentist. SW A was asked why R15 hasn't been put on the list since admission. SW A replied they didn't know, and it was an oversight. On 08/06/2025 at 1:05PM, record review of the minimum data set (MDS) assessment dated [DATE], indicates that the resident is edentulous (without natural teeth). On 08/07/2025 at 2:33PM, an interview was conducted with the Director of Nursing (DON). The DON was asked if R15 should have been seen by the dentist since she has been in the facility. The DON replied, yes, R15 should've been seen by now. R15 is on the list for next time. Record review of the policy titled, MRH Dental Services, revealed, Policy:Routine and emergency dental services are available to meet the resident's oral health needs in accordance with resident's assessment and plan of care. Procedure:C. [NAME] Regional Hospital Skilled Nursing Facility is contracted with 360 care to provide dental services at the facility.F. The nurse supervisor or designee is responsible to notify social worker or designee of a resident's need for dental services.