STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235076	A. Building B. Wing	05/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Newaygo CO Medical Care Facili	4465 W 48th St Fremont, MI 49412

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** 37573 Based on observation, interview and record review, the facility failed to follow policy and procedures, monitor and assist 1 (Resident #18) of 4 residents reviewed for accidents and hazards, related to toileting, and implement meaningful care plan interventions that are re-evaluated for the effectiveness. Findings include: Resident #18 (R18) Review of a Face Sheet revealed R18 admitted [DATE] with pertinent diagnoses of Alzheimer's disease, dementia, muscle weakness and reduced mobility. Review of the Minimum Data Set (MDS) dated [DATE] revealed R18 was severely cognitively impaired and required partial/moderate assistance with toilet transfers and needed substantial/maximal assistance with walking 10 feet. During an observation on 5/6/24 at 11:40 AM, R18 was observed in his bathroom sitting in his manual wheelchair and transferring himself to the toilet with the room door and the bathroom door open with no privacy barrier. When R18 finished toileting, he stood up at the sink and brushed his teeth, then sat back down in the wheelchair and self-propelled further into his room. During an observation on 5/6/24 at 2:10 PM, R18 was in his room and self-propelled to the bathroom in his wheelchair and transferred himself to the toilet. When he finished toileting, he stood up at the sink to wash his hands and sat back down in the wheelchair. During an observation on 5/7/24 at 1:00 PM, R18 was in his room and self-propelled himself to the end of the bed that was against the wall near the window. R18 stood up and walked over to the window to close it and then walked back to his wheelchair. He was visiting with his wife and when asked if he remembered this surveyor from the day before, he said no. (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and an interview on 5/8/24 at 9:00 AM, R18 was sitting reclined in his recliner with the padded call light that was observed hanging on the wall out of reach from the resident. The second call light was observed wrapped around the enabler bar (a bar attached to the bed that a resident uses to assist in turning in bed) on his bed across the room. R18 did not remember this surveyor from the day before and said he does not remember things. When asked, he did not know where his call light was or how to ask for help if needed. R18 reported when he must use the bathroom, he just goes by himself. There was a sign in his room on the wall to remind him to use the call light. In an interview on 5/8/24 at 10:44 AM, the Assistant Director of Nursing (ADON) B reported the care plan is in the residents' rooms inside the closet doors for the staff to reference when caring for the residents. She did not know the current ambulatory status for R18 and reported she would have to reference the care plan to know how the resident would transfer and other care needs. At 1:26 PM, the ADON B reported there was not a system to evaluate interventions put in place after a resident has a fall to see if they were effective. Review of the following incident reports for R18 revealed: -1/25/24 at 7:20 PM- Resident had called out for help while attempting to self-transfer in the bathroom from the toilet to his wheelchair and was lowered to the floor. He was alert to self only. The care plan was revised to reflect a touch pad call light and a therapy request for commode over the toilet. No documentation when the resident was last toileted or offered toileting. -1/27/24 at 7:40 AM, Resident had an witnessed fall when he was found on the floor in his room facing the bathroom and incontinent of urine. New intervention was to encourage toileting (check/change) every two hours. No post fall neuro-checks (neurological checks) done. No documentation when the resident was last toileted or offered toileting. -1/27/24 at 2:50 PM, Resident had an unwitnessed fall near his bathroom and was incontinent of bowel and bladder. His bathroom call light had been activated by the housekeeper. He was oriented to self only and was ambulating with a walker. New intervention was to not leave unattended to finish my business. I forget to wait for you after I call you for assistance back to my previous activities. -2/12/24 at 10:40 PM, Resident had and unwitnessed fall near the bathroom and found on the floor with the wheelchair brakes unlocked and was incontinent. He was oriented to self only. Interventions included anti-rollback device was added and reminders given to use the call light and wait for staff assistance. The last care provided was at 10:10 PM for medication pass. -2/19/24 at 9:35 AM- Resident had an unwitnessed fall in the bathroom and the restroom call light was on. New intervention was to refer to optometry for possible depth perception difficulties for corrective lenses and signs with reminders to pull call light/call string and wait for assistance in bathroom and near bed [related to] short term memory impairment. He was last toileted approximately 7:30 -7:45 AM before breakfast. -3/20/24 at 8:00 AM- Resident had an unwitnessed fall near his bathroom when he stated he was trying to toilet himself. He was oriented to self only. The bathroom was dark and an intervention for a night light in the bathroom was implemented. No documentation when the resident was last toileted or offered toileting. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a I am a high risk for falls [related to] confusion, deconditioning, gait/balance problems, impulsiveness, muscle weakness, urinary incontinence care plan last revised 1/27/24 revealed interventions that included: -High fall risk, initiated 1/24/24. -Alternate call light pendant-I may forget to use my call light. Please anticipate my needs. Initiated 1/24/24. -Anti-roll backs to wheelchair. Initiated 2/13/24. -Anticipate and meet the elder's needs. Initiated 1/24/24. -Encourage toileting (check/change) every two hours and as needed. Initiated 1/27/24. -Ensure that I am wearing appropriate footwear grip socks/nonskid shoes when ambulating or propelling wheelchair. Initiated 1/24/24. -Follow facility fall protocol. Initiated 1/24/24. -I require a safe environment with a room free from clutter, adequate lighting, call light within reach and personal items within reach. Initiated 1/24/24. -Night light in bathroom. Initiated 3/20/24. -Offer toileting prior to bed for the night. Initiated 2/13/24. -Once assisted into the restroom, please do not leave me unattended as I forget to wait for assistance. Initiated 1/27/24. -Refer to optometry for possible depth perception difficulties and/or need for corrective lenses. Initiated 2/19/24. -Signs with reminders to pull call light/call string and wait for assistance in bathroom and near bed [related to] short term memory impairment. Initiated 2/21/24. -Touch pad call light. Initiated 1/25/24. Review of the Activities of Daily Living (ADL) Care Plan for R18 revealed: -ORAL CARE ROUTINE [morning, after meals, night]: I have my own teeth. Supervision/touching assist with cuing to brush teeth, rinse mouth with wash. Initiated 1/24/24. -TOILET USE- The resident requires part/mod (partial/moderate) assist with toileting hygiene and transfer. Please encourage me to toilet approx. every 2-4 [hours]. I will attempt to self-transfer to toilet. Initiated 1/24/24. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-TRANSFER: The resident requires sub/max (substantial/maximum) assist for transfer from bed to chair. Initiated 1/24/24. -Encourage the resident to use bell to call for assistance. Initiated 1/24/24. Review of a policy titled Fall Prevention Program last revised 2/5/24 revealed: Each resident will be assessed for fall risk and will receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls . -5. Low/Moderate Risk Protocols: .iii. Call light and frequently used items are within reach. Iv. Adequate lighting. b. Implement routine rounding schedule. -6. High Risk Protocols: a. The resident will be placed on the facilities Fall Prevention Program . b. Implement Interventions from Low/Moderate Risk Protocols. c. Provide additional interventions as directed by the resident's assessment, including but not limited to . ii. Increased frequency of rounds vii. Scheduled ambulation or toileting assistance. Review of a Nursing-Post Fall Evaluation policy last revised 3/9/21 revealed To provide for ongoing evaluations of causative factors or potential factors that may lead to our elders falling or having a significant injury related to a fall. Should a fall occur witnessed or unwitnessed the following will occur: Post Fall Review: Root cause analysis of all falls will be completed by the interdisciplinary team to determine the cause of the fall and interventions will be put in place that addresses the root cause of the fall. Interventions will be re-evaluated to determine effectiveness, at regular intervals (post fall, readmission, significant change, and quarterly with MDS). Review of a Plan of Care Progress Note dated 1/26/24 for R18 revealed: Resident has impaired balance, weakness presence, cognition fluctuations, impaired processing time, and is impulsive. Goals are or resident to be independent with cuing for all ADLS for him to return home. However, therapy unsure if resident will be able to meet current goals. Discussed fall history. Wife stated it is hard to judge how many times he has fallen as sometimes it was daily and sometimes we would go a period of time with no falls. Falls were associated with resident ambulating and R leg would freeze, then he would continue to attempt to ambulate, legs would give out. Also attributed to resident having cognition fluctuations and being impulsive. Forgetting to use walker as well. Review of a IDT (Interdisciplinary Team) Intervention Review progress note dated 1/30/24 for R18 revealed: IDT met to discuss resident's progress with therapy. Physically able to independently dress self, toilet, ambulate. However, impulsive and cognition fluctuates. CGA to min assist for transfers. Processing delayed and needs cuing for standing. Sequencing issues present. Lack of carryover. Cont to work on balance, strengthening, fall risk reduction, how to get up from falls. (sic) Review of a Health Status Progress Note dated 2/4/24 for R18 revealed: Unable to maintain sitting position while sitting on bed. Assist x 1 for transfer from bed to w/c. Requires staff assist for propel w/c. Transfers self randomly and unable to maintain balance and falls. Review of an IDT Intervention Review Progress Note for R18 dated 2/13/24 revealed: IDT met to discuss resident's progress with therapy. Currently at highest potential for skilled therapy. Will be transitioning to restorative program for strengthening and reciprocal training. High fall risk. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a Health Status Progress Note for R18 dated 2/19/24 revealed: Elder frequently noted self-transferring without seeking staff assistance while utilizing assistive devices. Receptive to staff assistance. Elder is unreceptive to education. However, due to his dementia his retention is limited. Staff continues education reinforcement prior to ending all interactions, if appropriate. Review of an IDT Intervention Review Progress Note for R18 dated 2/20/24 revealed: IDT met to discuss resident's skilled therapy ending. Wife had concerns about resident receiving services as he just had falls. Has met goals with therapy and will be transitioned to restorative therapy program. Wife informed of therapy program plan, verbalized understanding with [NAME] specialist.

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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. 30120 Based on observation, interview, and record review, the facility failed to ensure that an insulin pen was labeled with the resident's name for 1 of 2 medication carts inspected (C Wing Medication Cart), resulting in the potential for residents to receive insulin from another resident's insulin pen and the potential for the spread of disease. Findings include: During an inspection of the C Wing Medication Cart with Licensed Practical Nurse (LPN) F on 05/06/24 at 5:40 PM, a previously used Humalog insulin pen without a resident's name on it was observed in an unlabeled slotted compartment in the top drawer of the medication cart with other insulin pens. The other insulin pens in the unlabeled slotted compartment were labeled with R6's name on them. LPN F stated insulin pens should be labeled with the resident's name and the date it was first used and date it is supposed to be discarded. She stated she keeps the insulin pens together in a slotted compartment in the top drawer for each individual resident. LPN F stated that was how she knew that the Humalog pen belonged to R6 and not another resident, even though it did not have R6's name on it. She stated otherwise she would not know whose insulin pen it was. LPN F further stated there was another resident that had a Humalog pen in the C Wing Medication Cart along with R6 and if R6's Humalog pen was not in the slotted compartment with his other insulin pens she would not know for sure if it was his pen or the other resident's. During an interview on 05/07/24 at 7:45 AM, Registered Nurse (RN) G stated if she found a previously used insulin pen without a resident's name on it, she would get another one from the medication refrigerator if she did not know who the pen belonged to. RN G was asked if the insulin pen was not labeled with a resident's name, how would she know whose it was? RN G just stared at the surveyor and could not provide an answer to the question. RN G also stated that she had not ever come across an insulin pen without a resident's name on it because it always comes with a label [on it] from the pharmacy with a resident's name on it. During an interview on 5/07/24 at 8:15 AM, LPN H stated insulin pens come from the pharmacy with a label on them that contains the resident's name. She stated the only time an insulin pen would not have a label with the resident's name on it would be if the insulin pen was pulled from the medication back-up box. LPN H stated if she pulls an insulin pen from the medication back-up box, then she would label the pen with the resident's name and the date it was opened and/or the discard date. LPN H stated if she finds an insulin pen without a label or a resident's name on it, then she would throw it away because she would not know who the pen belonged to. LPN H further stated she would not want to take a chance that she would give a resident another resident's insulin. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's Labeling of Medications and Biologicals policy, dated 12/1/23, revealed, All medications and biologicals used in the facility will be labeled in accordance with current state and federal regulations to facilitate consideration of precautions and safe administration of medications . 4. Labels for individual drug containers must include: a. The resident's name . 9. Labels for medications designated for multiple administrations (such as inhalers, eye drops), the label will identify the specific resident for whom it was prescribed .