STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235094	A. Building B. Wing	08/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wexford Senior Care Center	460 Pearl Street Cadillac, MI 49601

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. (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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview and record review, the facility failed to honor the advanced directive for code status for one Resident (#71) of one resident reviewed for advanced directives (a legal document that allows a person to identify decisions about end-of-life care ahead of time). This deficient practice resulted in the potential for decisions regarding end-of-life care to not be honored by the facility. Findings include:Resident #71 (R71)The Electronic Medical Record (EMR) of R71 included an active physician's order dated 7/18/25 that read DNR [do not resuscitate].A Power of Attorney (POA) document in the EMR was signed by R71 on 1/5/24. The document indicated R71 designated her daughter to make health care decisions if R71 became incapable of making independent healthcare decisions.The POA document read, in part: 4. Specific instructions for life-support treatment. 'Life-support treatment' includes, for example, a breathing machine, getting food or water through tubes, and CPR. The document directed R71 to select and initial a Choice for end-of-life care. R71 initialed Choice 3, which read I always want life-support treatment to the greatest extent possible consistent with sound medical practice - regardless of my condition, my chance for recovery, or the cost. Under the portion of the document to indicate specific instructions to the agent (person designated at POA), a hand-written entry made by R71 read as follows: Regarding #4. Specific instructions for life-support treatment: I always want life-support treatment to the greatest extent possible for at least 30 days. After this 30 day period my choice on #4 changes from Choice 3 [I always want life support treatment to the greatest extent possible .] to Choice 1 [I do not want life-support treatment if any of these conditions exist .] I understand that changing my choice after 30 days of life support could lead to my death. The hand-written entry was signed by R71 and expressly conveyed the designated POA(s) were to follow these specific instructions regardless of R71's competence to make medical decisions.A code status form dated 3/26/24 was in the EMR of R71. The code status form read In the event of Cardiopulmonary Arrest, I wish to be given CPR. The form was signed by R71 and dated 3/26/24.On 9/25/24, two physicians signed documents stating R71 was now unable to make healthcare decisions. As a result, the POA was activated. On 7/18/25, the daughter and POA for R71 signed a DNR code status for R71 that read, in part: .I authorize that in the event the declarants/ward's heart and breathing should stop, no person shall attempt to resuscitate the declarant. An advanced directive care plan dated 7/18/25 was in the EMR of R71. The first goal documented on the care plan read: I want to be active in my advance care planning decisions/or honor my decisions.The Director of Nursing (DON) was interviewed on 8/6/25 at 3:27 PM. The DON agreed residents have the right to determine their own code status and make decisions regarding end-of-life care. The conflicting information pertaining to R71's advanced directive/POA designation versus the code status of DNR was shared with the DON. The DON reviewed the documents and said she would follow up with the daughter/POA of R71. On 8/6/25 at 4:40 PM. The DON said the daughter/POA of R71 was currently out of the country, but she spoke with R71's grandson. The DON said the grandson indicated R71 had changed her advanced directive and would provide the document. On 8/7/25 at 9:46 AM, the DON said she spoke with the POA of R71 and R71 did not revise or amend the advanced directive dated 1/5/24. The DON said she spoke with R7 about code status directives. The DON said R71 was confused but said, CPR can keep you alive. The DON stated they did not recall any conversation with the POA about R71's express wishes regarding code status and stated there was no documentation of any discussion with the POA prior to the code status change which expressly went against R71's wishes expressed while they were still of sound mind. The DON acknowledged the facility should have advocated for the express wishes of R71.R71 was interviewed on 8/7/25 at 10:00 AM. R71 appeared confused when queried regarding end-of-life care decisions, but when asked if she wanted CPR if her heart stopped beating, R71 responded, Yes.The policy Advance Directives [sic] dated as revised 3/25/15 read, in part: .We are obligated to follow the resident's wishes as expressed in valid Advance Directives.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, interview, and record review, the facility failed to monitor and assess nutritional interventions and modify or implement revised interventions for one resident (#6) of two residents reviewed for nutrition with significant weight loss. Findings include:Resident #6 (R6)R6 was admitted to the facility 2/21/24 with primary diagnoses of psychotic disturbance, mood disturbance, and anxiety. On 8/6/25 at 1:08 PM, R6 was observed at a table in the dining room during the lunch meal. R6 had a plate of Salisbury steak, mashed potatoes, and peas in front of her. R6 was not eating and did not appear interested in the meal. R6 was not encouraged to eat or assisted by staff. Licensed Practical Nurse (LPN) J offered R6 an alternate meal but R6 declined. LPN J provided R6 a MightyShakes(R) (a liquid nutritional supplement) but R6 refused to drink any of the supplement. LPN J said, Sometimes [R6] doesn't drink her shake.A Minimum Data Set (MDS) assessment for R6 dated 7/1/25 documented a weight loss of 5% or more in the past month or loss of 10% or more in the past six months without being on a physician-prescribed weight loss regimen. The MDS did not code swallowing disorders or issues with dentition. The MDS indicated a Brief Interview for Mental Status (BIMS) score of six, reflecting R6 had severe cognitive impairment. Further review of the MDS revealed R6 required supervision or touching assistance for eating.Review of the Electronic Medical Record (EMR) of R6 disclosed a weight of 172 pounds on 2/1/25 and a weight of 150 pounds on 8/1/25, a weight loss of 12.79% in six months. The EMR reflected R6 was weighed monthly with no indication of increased monitoring of weight following a weight loss trend. Physician's orders in the EMR of R6 included an order dated 12/2/24 for a regular diet with MightyShakes(R) TID (three times daily) with meals. There were no other physician orders pertaining to dietary or nutritional interventions. R6's Medication Administration Record (MAR), Treatment Administration Record (TAR) and Task documentation in the EMR were reviewed but there was no documentation of the amount of MightyShakes(R) consumed by R6 nor was there documentation of the frequency R6 was offered MightyShakes(R).The nutritional care plan for R6 included an intervention dated 12/8/24 that read offer hs (hour of sleep - bedtime) snacks. The MightyShakes(R) were not documented as an intervention on the care plan.Task documentation in the EMR did not contain the option for Certified Nursing Aides (CNA) to document the offering or acceptance of any snacks to R6 at bedtime as directed in the care plan. Review of the EMR did not disclose documentation of hs snacks being offered to R6 or if R6 consumed hs snacks as directed in the care plan intervention.An assessment by the Registered Dietician (RD) in the EMR dated 4/1/25 and documented on a form Dietary Profile read, in part: . She receives a Healthshake [sic] @ [at] dinner. Sig. [significant] weight loss x 90 [days] and 180 days; stable x 30 d [days].CP reviewed and updated. Recommend weekly weights x 4 [weeks] due to weight loss. No nutritional interventions or amendments to dietary interventions were noted in the Dietary Profile despite R6 being identified with significant weight loss over the previous 90 days and 180 days, and no new interventions were reflected in the nutritional care plan.There were no subsequent Dietary Profiles in the EMR by the RD until 7/8/25. The Dietary Profile of 7/8/25 noted R6 had a stable weight for 30 days but continued with significant weight loss for 180 days related to increased meal refusals.The RD was interviewed on 8/6/25 at 2:04 PM. The RD was asked what interventions were attempted aside from MightyShakes(R) to address R6's weight loss. The RD initially answered that Med Pass(R) 2.0 (a high calorie and protein drink designed for people at high risk for malnutrition) was initiated but refused by R6. The EMR was reviewed by the RD who then said Med Pass(R) 2.0 was not ordered or implemented for R6. The RD said, Oatmeal was added and as far as I know she's eating it. When asked the root cause of the weight loss, The RD said it was meal refusals. The RD admitted R6 had continued to lose weight and required reassessment. When asked where MightyShakes(R) consumption was documented, the RD said it is included in the meal percentage intake. When asked where hs snacks were documented, the RD responded hs snacks were provided by nursing and documented on the MAR. The RD was asked the standard process when a resident was identified with weight loss greater than 10% in six months. The RD said interventions would be revised and reviewed, the family and physician would be notified, and the resident would be placed on weekly weights.The Director of Nursing (DON) was interviewed on 8/6/25 at 3:22 PM. The DON said she was aware of the concern with the weight loss, and said R6 would be re-evaluated by the RD for appropriate interventions and recommendations, evaluated by the physician, placed on weekly weights and meal observations, and referred to Occupational Therapy. The DON was asked where nutritional supplements and hs snacks were documented. The DON confirmed the