STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235157	A. Building B. Wing	07/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sanilac Medical Care Facility	137 N Elk St Sandusky, MI 48471

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37771 This Citation Pertains to Intake MI00142721 Based on observation, interview and record review, the facility failed to administer a nebulizer treatment according to professional standards for Resident #35, administer medications as prescribed by the physician for Resident #224 and Resident #322, and ensure standards of practice for appropriate diagnosis and use of multiple psychotropic and antipsychotic medications for Resident #377, of seven residents reviewed for medication administration and five residents reviewed for medication regimen review, resulting in Resident #35 not assessed prior to administration or monitored during the duration of a nebulizer treatment with the potential for complications to go unnoticed, untreated or not receive the prescribed amount of medication used to treat lung disease, the potential for exacerbation of medical conditions for Resident #35, Resident #224 and Resident #322, and inappropriate diagnosis and treatment for Resident #377. Findings include: Resident #35: On 6/27/24 at 8:40 AM, an observation was conducted during the medication administration task of the survey of Nurse L preparing to give Resident #35 an Albuterol 2.5mg (milligrams)/3 ml (milliliters) breathing treatment. Resident #35 was sitting up in their wheelchair. The Nurse put the medication into the medication chamber of the nebulizer that was attached to a mask. The Nurse put the mask on the Resident, turned on the nebulizer at 8:45 AM and left the room. The Nurse was not insight of Resident #35. Nurse L continued with her medication pass. On 6/27/24 at 8:50 AM, an observation was made of CNA B entering Resident #35's room. The CNA left the room and had shut the door. The Resident was not insight of Nurse L who had administered the nebulizer treatment nor did Nurse L monitor the inhalation therapy. On 6/27/24 at 8:55 AM, CNA B entered the Resident #35's room with another surveyor and closed the door. Surveyor observation of CNA and Resident #35 (continued on next page)

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

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/27/24 at 8:55 AM, an observation was made of Resident #35 sitting in their wheelchair and had a nebulizer mask on receiving a nebulizer treatment. The Nurse was not in the room. The CNA was observed to remove the nebulizer mask from the Resident, shut the nebulizer machine off and laid the mask on the bedside table. The CNA performed morning care for the Resident. At 9:18 AM, on the completion of AM care, CNA B was queried regarding the nebulizer treatment. The CNA stated, I have to have the nurse do it. On 6/27/24 at 9:18 AM, CNA B and the surveyor were observed to leave Resident #35's room. Nurse L was not informed of the discontinuation of the nebulizer treatment. The Nurse did not check on the Resident after the AM care was given. On 6/27/24 at 10:15 AM, an interview was conducted with Assistant Director of Nursing, Education Nurse C regarding the administration of nebulizer treatments and facility policy. The Education Nurse was asked about standards of practice of assessment of lungs and vital signs. The Education Nurse indicated that the lung sounds should be assessed and vital signs taken prior to receiving the nebulizer treatment and the Nurse should monitor the Resident while the breathing treatment was given. A review of the facility policy that the Education Nurse indicated they followed revealed the following with a title Performance Checklist Skill 21.8 Using Small-volume Nebulizers, Assessment: .5. Assessed pulse, respirations, breath sounds, pulse oximetry, and peak flow measurements if ordered . 12. Had patient take a deep breath; encouraged brief, end-inspiratory pause; had patient exhale passively: .b. Reminded patient to repeat breathing pattern until drug was completely nebulized . Evaluation: 1. Assessed patient's respirations, breath sounds, cough effort, sputum production, pulse oximetry . On 6/27/24 at 10:56 AM, an interview was conducted with Nurse L regarding Resident #35's nebulizer treatment and facility policy. When asked about assessment of lung sounds, pulse, respirations and O2 saturation, the Nurse stated, I didn't know we had to do that. The Nurse was asked about not staying with the Resident during the treatment and if the Resident had received the full treatment. The Nurse stated, Yes, I should be sure he gets it all. An observation was made with Nurse L of Resident #35's room. The Resident was not in the room at that time. The nebulizer mask was assembled and laying on its side on the bedside table. An observation was made of the medication chamber with a small amount of liquid in the chamber. The Nurse stated, I can see some of the liquid still in there. The Nurse was asked about storage of the nebulizer and the Nurse reported they store them inside a bag. When asked if they rinsed and dried the nebulizer equipment prior to storage, the Nurse stated, No not usually, we just put it in the bag. A review of the facility policy titled, Nebulizer Equipment, dated 10/27/21, revealed, Policy: Nebulizer equipment will be properly cleaned and stored to prevent contamination and the potential for spread of infection. Procedure: Equipment for the treatment of respiratory conditions will be disassembled, cleaned, and stored in the Resident's room after every use . e. Wash, in Resident bathroom, using warm water and using a wash basin/barrier. d. Rinse thoroughly, pat excess water with paper towels. e. Allow to air dry on a barrier with second barrier covering the equipment. f. May store in respiratory bag once completely dry . Resident #224: (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/27/24 at 9:11 AM, during observation of medication administration task, Nurse L was observed to prepare medication for Resident #224. The Nurse prepared the Residents medication and put them in a cup. The Protonix 40mg delayed release was not available. When asked why the medication was not available, Nurse L indicated that it had to be ordered and they did not have it available in the facility. The Nurse retrieved the Resident's inhaler from the box with the Residents name on the inhaler and box. The Nurse had to retrieve medication from the medication storage room refrigerator. Prior to retrieving the refrigerated medication, the Nurse wrote the Resident's name on the cup of medications and placed the cup and the inhaler in a top drawer of the medication cart. The Nurse retrieved the medication from the med room refrigerator and took out the cup of medications from the top drawer and administered the medications to the Resident who was at the medication cart waiting for their medication. The Nurse did not retrieve the inhaler from the top drawer or administer the inhaler to the Resident. At 9:12 AM, the Resident was waiting at the medication cart and an observation was made of Nurse L administering the oral medication to Resident #224. The Resident was waiting for the medication and had Therapy staff that was taking him to therapy. The medication received included: Augmentin ES-600 5 ml (milliliters). Calcium Carbonate chewable 500 mg (milligram) tablet. Prednisone 10 mg tablet. Fenasteride 5 mg tablet. Flomax 0.4 mg capsule. Psyllium Husk powder, 6 gm (grams) mixed in water. A review of Resident #224's medication orders and scheduled administration times revealed the following: -An order for Augmentin ES-600 oral suspension, give 5 ml (milliliters) by mouth every 12 hours for post-surgery for 7 days and was scheduled to be given at 7:00 AM. The medication was given late. -An order for Protonix tablet delayed release 40 mg, give 1 tablet by mouth two times a day for GI (gastrointestinal) upset and scheduled at 7:30 AM. The medication was not given due to not being ordered or available in the facility. -An order for Calcium Carbonate tablet chewable 500 mg, give 1 tablet by mouth before meals for GI upset and scheduled at 7:30 AM. The medication was given late and the Resident was heading to therapy. -An order for Symbicort inhalation aerosol, 2 puff inhale orally two times a day for SOB (shortness of breath), COPD (chronic obstructive pulmonary disease). The medication was not given during the observation of medication administration. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #322: On 6/27/24 at 9:26 AM, an observation was made of Nurse L setting up medication and administering medication to Resident #332. The medication included: Aspirin EC (enteric coated) 81 mg. Acetaminophen 325 mg, two tablets. Omeprazole DR (delayed release) 20 mg. Prednisone 10 mg, two tablets. Folic Acid 1 mg tablet. Lexapro 10 mg tablet. Lispro insulin 16 Units SQ (subcutaneous). A review of Resident #322's medication orders and scheduled administration times revealed the following: - Aspirin EC tablet, Delayed Release 81mg, give 1 tablet by mouth one time a day for supplement, scheduled at 8:00 AM. The medication was given late. -Acetaminophen 325 mg, give two tablets by mouth three times a day for pain, scheduled at 8:00 AM. The medication was given late. -Omeprazole DR (delayed release) 20 mg capsule, give 1 tablet by mouth one time a day for GI upset, scheduled at 8:00 AM. The medication was given late. -Prednisone 10 mg, give two tablets by mouth one time a day related to bullous pemphigoid for 14 days scheduled at 8:00 AM. The medication was given late. -Folic Acid 1 mg tablet, give 1 tablet by mouth one time a day for supplement, scheduled at 8:00 AM. The medication was given late. -Lexapro oral tablet 10 mg, give 1 tablet by mouth one time a day related to depression, scheduled at 8:00 am. -Insulin Lispro 100 units/ml, inject 16 Units subcutaneously three times a day related to Type 1 diabetes mellitus with hyperglycemia. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/27/24 at 9:35 AM, at the conclusion of the observation of medication administration task with Nurse L, the Nurse was asked about the medication left in the top drawer of the medication cart. The Nurse had opened the drawer where she had placed the medication. Resident #224's inhaler was in the drawer with another resident's medication that was placed in a cup. The Nurse was asked about the inhaler for Resident #224 and indicated she had not given it and reported she would give it to the Resident when he came back from therapy. The electronic medical record (EMR) showed the medication on the computer with a red background for Resident #322 that indicated they had not been given timely. When asked about the red background on the EMR for Resident #322 and for Resident #224, Nurse L indicated they were given late and stated, I started late and didn't get to them. On 6/27/24 at 11:07 AM, an interview was conducted with the Clinical Supervisor (CS) E regarding late medications. The late medications during medication administration observation were reviewed with the CS. The CS indicated that many of the medications would be late due to Residents not wanting to wake up early or leave of absence. The CS indicated that the medication was to be given within two hours of when it was scheduled, one hour before scheduled and one hour after scheduled. The CS indicated that the 400 hall was a heavy floor, can't get it done in two hours, and that some of the early meds that need to be taken early, try to get to them first thing but that does not always happen. When asked about the facility policy for the administration of nebulizer treatments, the CS reported that the Nurse was to assess lungs sounds, check SPO2, before and after administration of the nebulizer treatment. 37668 Resident #377: Review of Intake documentation dated as received 2/12/24 revealed allegations that Resident #377 was over sedated. The intake specified, (Resident #377's) health has declined drastically in two weeks. (Resident #377) can no longer walk or talk. The intake detailed the facility is giving (Resident #377) Risperdal (antipsychotic medication commonly used to treat schizophrenia and bipolar disorder) which causes them to be hunched over, and a sleeping medication. Information within the intake revealed the complainant believed the facility was keeping (Resident #377) drugged up so they won't have to deal with them. The intake revealed the Resident was 57-years old male with and they did not believe the facility was used to taking care of a younger man with dementia. Record review revealed Resident #377 was originally admitted to the facility on [DATE] with diagnoses which included early onset Alzheimer's disease, Pick's disease (also called frontotemporal dementia (FTD)- rare neurodegenerative disease that is similar to Alzheimer's disease but effects specific areas of the brain and is the most common type of dementia in individuals younger than 60), generalized anxiety, and dementia. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the Resident was severely cognitively impaired, ambulated independently without an assistive device, and required supervision and/or set up assistance with toileting/personal hygiene activities. The MDS further revealed the Resident displayed no hallucinations and/or delusions but did display wandering, physical and verbal symptoms directed towards others as well as other behavioral symptoms not directed toward others one to three days during the seven-day look back period which did not have a negative impact on the Resident or others. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #377's Face sheet revealed the diagnoses, Psychotic Disorder with Delusions due to Known Physiological Condition and Anxiety Disorder were added to the Resident's medical record while at the facility on 1/17/24. Review of Resident #377's Electronic Medical Record (EMR) revealed an Attending Physician's Admission and Annual assessment dated [DATE] which detailed, Diagnosis: Pick's Disease - front temporal lobe dementia with behavioral disturbance, generalized anxiety . Pleasant [AGE] year-old . male . has been living at home until now. (Spouse) is still working and is finding it difficult to take care of him at home . (Resident #377) is currently on no medications . quite agitated and behavioral when family was trying to leave him (at facility) . was very upset . lashing out at staff and facility. 1 mg (milligram) Ativan (anti-anxiety medication) IM (intramuscular injection) was given and did calm down . Assessment/Plan . Very behavioral and argumentative and swearing and lashing out at family and staff . did give Ativan . still very alert and active. Going to start Lexapro (antidepressant) 10 mg daily as well as Ativan 0.5 mg every 8 hours as needed . does appear to look as a regular visitor . will be seeing (Mental Health Provider) as well . Review of Resident #377's Electronic Medical Record (EMR) revealed the following Admission Documentation: - 11/30/23 12:50 PM: Nurses Note Narrative . Resident arrived to facility @ 12:30pm via private vehicle. Resident and family were escorted to 700 hall and sat in TV room to wait for Admission's Coordinator. Resident was calm until family went to leave. Resident became verbally combative with family and staff. Pushing on doors, yelling, unable to redirect resident. Resident became physically aggressive with family. Notified (Physician Assistant [PA]). Obtained order for 1 mg (milligram) Ativan (controlled medication used to treat anxiety and agitation) to be given IM (intramuscular injection) STAT . - 12/6/23 at 10:20 AM: Social Service Assessment . 1. Psychosocial: (Resident #377) came to the facility from home . was previously living with (Family Member G) but (Family Member G) is unable to care for him due to his Alzheimer's Disease. (The Resident) is a poor historian and is unable to give information . is known in the community as having worked at (Car Dealership) in the collision department for many years. He enjoys sports, hunting, and fishing . 2. Behavior . has had difficulty adjusting to being placed at the facility for long term care . behaviors are dementia related . (Mental Health Provider) and PCP (Primary Care Provider) are monitoring . Mood . scored 0/27 on PHQ-9 assessment indicating . no depressive symptoms . The following care plans pertaining to psychoactive medications were present in Resident #377's EMR: - The resident uses psychotropic medications Risperdal (antipsychotic medication indicated for the treatment of schizophrenia and bipolar disorder) and Haldol (antipsychotic medication indicated for the treatment of schizophrenia) r/t Alzheimer's disease with psychotic disturbance (Initiated: 12/7/23; Revised: 1/17/24). Haldol was added to the care plan as the revision on 1/17/24. Note: Both Risperdal and Haldol have black box warnings from the Food and Drug Administration (FDA) detailing the medications are not approved for the treatment of patients with dementia-related psychosis and may increase risk of death. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- The resident uses anti-anxiety medications Ativan (controlled benzodiazepine class medicine used to treat anxiety) r/t Anxiety Disorder (Initiated and Revised: 12/7/23) - The resident uses antidepressant medication Lexapro (medication used to treat depression and anxiety) r/t Poor adjustment to admission to the facility. Resident also has a DX (diagnosis of Alzheimer's Disease with Psychotic Disturbance (Initiated and Revised: 12/7/23) Note: The diagnosis Alzheimer's Disease with Psychotic Disturbance was not included on Resident #377's face sheet/diagnosis list. An interview was completed with Social Services Director H on 6/26/24 at 2:27 PM. When queried if they recalled Resident #377, Director H verbalized they did and stated they were admitted directly from home to the facility because, Their (spouse) couldn't handle them at home. When asked about their stay at the facility, Director H replied, (Resident #377) could be aggressive with other residents and staff. When asked what happened to the Resident, Director H replied, Went out to the hospital, was put on Hospice and never came back. When queried if Resident #377 was receiving psychotropic medications, Director H confirmed they were. With further inquiry, Director H disclosed Resident #377 was not taking any psychotropic medications upon admission and all psychoactive medications were initiated at the facility. Resident #377's psychoactive medication consents and related documentation were requested from Director H at this time. At 2:54 PM on 6/26/24, Social Services Director H provided a paper consent form for Resident #377 titled, Informed Consent Psychotropic Medications. The form was signed by Resident #377's Representative Family Member Witness G and Social [NAME] Director H on 2/8/24. The Health Care Provider signed the consent form on 2/26/24. The consent included five medication names with no doses and/or administration routes. When asked if all the medications listed were started on 2/8/24, Director H replied, No. Director H was asked why the consent was dated 2/8/24 if the medications were not started then and stated, We get rid of old consents and only keep the new ones. When asked why, Director H replied, I don't know, just what we do. Review of the provided Informed Consent Psychotropic Medications form dated 2/8/24 for Resident #377 detailed, The resident's physician has ordered, or is considering ordering the following psychotropic medication (s) . Olanzapine (brand name - Zyprexa-antipsychotic medicine for treatment of schizophrenia and bipolar disorder), Ativan, Lurasidone (brand name- Latuda- antipsychotic medication indicated for the treatment of schizophrenia and bipolar disorder), Lexapro, Trazodone (indicated to treat major depressive disorder). Related Diagnosis: Psychotic Disorder with Delusions, Anxiety, Major Depressive Disorder . Therapeutic Classification: Antianxiety . Antidepressant . Antipsychotic . Note: Both Olanzapine (Zyprexa) and Lurasidone (Latuda) have black box warnings from the FDA specifying the drugs are not approved for the treatment of patients with dementia-related psychosis and may increase risk of death. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	When queried if all the psychoactive medications which had been prescribed and/or administered to Resident #377 were listed on the consent form, Director H did not reply. When asked why Haldol and Risperdal were listed on the Resident's care plan but included on the provided consent, Director H repeated prior statement that the facility only maintains the most recent psychotropic medication consent. Director H was then asked how they were able to show that informed consent was obtained prior to initiation of all medications and revealed they were not. When queried why multiple antipsychotic medications were initiated, Director H revealed the medications were started due to Resident #377's behavior. With further inquiry, Director H revealed Resident #377 was very confused, wanted to leave the facility, and would become very agitated and aggressive with others. When queried what non-pharmacologic interventions were attempted prior to medication initiation, Director H indicated staff attempted to redirect the Resident. When asked about revision and implementation of personalized interventions, Director H restated staff would attempt to redirect the Resident but did not provide specific interventions. Director H then stated the Resident had been sent to the hospital ER more than once due to their behaviors. Director H was asked how many times Resident #377 was sent to the ER related to behaviors and indicated it was more than once but were unsure without reviewing the EMR. When asked what happened when the Resident was sent to the ER related to behaviors, Director H relayed the ER would simply send the Resident back to the facility. A timeline of all Resident #377's non-pharmacological and pharmacological interventions were requested as well as the facility policies/procedures related to Dementia/Alzheimer's care and Psychoactive Medications at this time. Review of Resident #377's Order Summary documentation in the EMR revealed the Resident was started on Ativan, Haldol, Klonopin, Lexapro, Lurasidone, Olanzapine (Zyprexa), Risperdal, and Trazadone at the facility. A detailed review revealed the following psychoactive medication orders: - Ativan Injection Solution 2 mg (milligram)/mL (milliliter) .Inject 1 mg intramuscularly one time only for anxiety/aggressive behavior . Completed . (Ordered: 11/30/23; Discontinued: 11/30/23) - Ativan Solution 2 mg/mL . Inject 1 mg intramuscularly one time only for Anxiety/Aggression for 1 day (Ordered: 11/30/23; Discontinued: 12/1/23) - Ativan Oral Tablet 0.5 mg . Give 1 tablet by mouth every 8 hours as needed for anxiety . for 14 Days (Ordered: 11/30/23; Discontinued: 12/5/23) - Ativan Oral Tablet 0.5 mg . Give 1 tablet by mouth every 6 hours as needed for anxiety . for 14 Days (Ordered: 12/5/23; Discontinued: 12/19/23) - Ativan Oral Tablet 0.5 mg . Give 1 tablet by mouth every 6 hours as needed for anxiety . for 14 Days (Ordered: 12/19/23; Discontinued: 1/2/24) - Ativan Oral Tablet 0.5 mg . Give 0.5 mg by mouth one time only . Completed . (Ordered: 12/25/23; Discontinued: 12/26/23) - Ativan Oral Tablet 0.5 mg . Give 1 tablet by mouth every 6 hours as needed for anxiety . for 14 Days (Ordered: 1/2/24; Discontinued: 1/15/24) -Ativan Oral Tablet 0.5 mg . Give 1 tablet by mouth two times a day for Anxiety/agitation (Ordered: 1/4/24; Discontinued: 1/22/24) (continued on next page)

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Sanilac Medical Care Facility	137 N Elk St Sandusky, MI 48471

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Risperdal . 2 mg . Give 1 tablet by mouth two times a day related to dementia . (Ordered: 12/5/23; Start Date: 12/9/23; Discontinued: 2/2/24). The discontinuation reason listed was, reduced per POA (Power of Attorney) request. - Risperdal . 2 mg . Give 0.5 tablet by mouth two times a day related to dementia . (Ordered: 2/2/24; Discontinued: 2/7/24) - Trazadone . 100 mg . 1 tablet by mouth at bedtime for insomnia (Ordered: 1/11/24) - Trazadone . 50 mg . 1 tablet by mouth at bedtime for insomnia (Ordered: 1/8/24; Discontinued: 1/11/24) Review of Resident #377's EMR revealed Family Member Witness G was Resident #377's elected and activated Durable Power of Attorney (DPOA). Review of documentation in Resident #377's EMR demonstrated behaviors were not documented daily in progress notes. Additionally, the Behavioral Monitoring and Interventions report from 1/1/24 to 6/2/24 revealed no documentation of any behaviors and/or interventions and no behavior monitoring documentation was present in the scanned section of the EMR. Review of Mental Health Provider documentation in Resident #377's EMR revealed the following: -- 12/21/23: Social Worker Note: Complaint: Picks disease . Disposition: (Resident #377) is trying to engage self- level of frustration gets high and that is when his anger and agitation increases Has a hard time with word finding and engaging in conversations. This has been a process up until he could no longer manager at home . outbursts seem to be a build of thoughts in his mind that he is not able to express. Encourage activity level . - 1/15/24 PA Note: Complaint: agitation pacing, aggressive, poor concentration . spoke with staff . has not improved . according to nursing staff, has declined. The holidays were overwhelming for him . attention is poor . does not retain information. Redirection is hit and miss . Demeanor: Impulsive . Judgement: Impaired . Insight: Impaired . Impulse Control: Impaired . Speech: Word finding . cannot express anger or frustration . Thought Process: Disorganized . Flight of Ideas: It is difficult to determine what he is thinking . Memory . Severe Impairment . Mood: Distressed, aggressive, angry, combative, aggressive, sad, irritable . Trouble staying asleep . Assessment and Plan: Major depression disorder, single episode . Plan: 1:1 supportive care . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235157	A. Building B. Wing	07/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sanilac Medical Care Facility	137 N Elk St Sandusky, MI 48471

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- 1/17/24: PA Note: Complaint: aggressive behavior, choking staff member . Current Medications: Trazadone . 100 mg (at bedtime), Lexapro . 20 mg, Risperdal . 2 mg (two times per day), Ativan 0.5 . (Two tablets . every six hours PRN .) Changes in psychiatric and/or other relevant medications include the following: Started on Lexapro (start date: 11/30/23). Ativan PRN ordered by PCP (Primary Care Provider) . (Resident #377) has since started being physically aggressive, grabbing CNA by the throat against the wall. Redirection and Ativan use not effective. Was sent to ER . came back with no new orders recommending . start Haldol 1 mg TID (three times a day) .met with resident in person today . Demeanor: Impulsive, Resistant, Oppositional . Judgement: Impaired . Insight: Impaired . Impulse Control: Impaired . Speech: Disorganized . Thought Process: Disorganized . Thought Content: Delusional Material Not Expressed . Memory . Severe Impairment . Mood: anxious, angry, irritable . Delirium: + Present (Believes he is able to go home, does not know he has severe dementia. Does know know his own reality [sic]) . Assessment and Plan: Major depression disorder, single episode . Plan: 1:1 supportive care . Anxiety disorder . Plan: Lexapro; Ativan PRN 14 days . Dementia . Picks Disease . Plan: Supportive Care . Psychotic disorder with delusions due to known physiological condition (new). Plan: Haldol . Recommending . non-pharmacologic interventions such as: creating a calm environment and removing stressors when possible . implementing soothing rituals. Limit caffeine use. Avoiding environmental triggers noise, glare, and background distraction can act a triggers . Check for pain, hunger, thirst, full bladder, fatigue, infections . Making sure the room is at a comfortable temperature. Being sensitive to fears, misperceived threats and frustration with expression what is wanted. Simplifying tasks and routines, Providing an opportunity for exercise. Document any symptoms of aggression . - 1/29/24: PA Note: Complaint: agitation . seen my request of staff and PCP for immediate action . patient continues to have psychosis, delusions with agitation, hitting, refusing care, throwing items, resisting care/medications, striking staff member . Picks disease dementia. Last visit Haldol was increased . seen wandering in memory care unit, staff continues to provide one on one care, they state he continues with stated agitation, Ativan PRN very little help . Demeanor: Impulsive, Resistant, Oppositional . Judgement: Impaired . Insight: Impaired . Impulse Control: Impaired . Speech: Disorganized . Thought Process: Disorganized . Thought Content: Delusional Material Not Expressed . Memory/Immediate: Severe Impairment . Memory/Recent: Moderate Impairment .Mood: anxious, angry, irritable . Delirium: + Present (Believes he is able to go home, does not know he has severe dementia. Does know know his own reality [sic]) . Assessment and Plan: Major depression disorder, single episode . Plan: 1:1 supportive care . Anxiety disorder . Plan: Lexapro; Ativan PRN 14 days . Dementia . Picks Disease . Plan: Supportive Care . Psychotic disorder with delusions due to known physiological condition . Plan: Haldol . Will increase Haldol to 10 mg BID (two times a day). Continue supportive care . Review of Resident #377's Medication Administration Record (MAR) and Treatment Administration Record (TAR) for January 2024 revealed the Resident refused two medications during the month, once on 1/7/24 and one on 1/30/24. An interview was completed with Family Member Witness G on 6/27/24 at 7:24 AM. When queried regarding Resident #377, Witness G stated,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235157	A. Building B. Wing	07/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sanilac Medical Care Facility	137 N Elk St Sandusky, MI 48471

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37666 This Citation pertains to Intake Number MI00140471. Based on observation, interview and record review the facility failed to ensure nail care was routinely provided for one resident (Resident #68) of 4 residents reviewed for Activities of Daily Living (ADL), resulting in Resident #68 having long, soiled, fingernails and long, cracked toenails. Findings Include, Resident #68 Activities of Daily Living On 6/25/24 at 12:51 PM, during a tour of the facility, Resident #68 was observed to have her left foot with long, cracked toenails. Her fingernails were extremely long and soiled. The resident said she couldn't trim them herself, but her granddaughter helped trim a couple of her toenails, although she couldn't trim 2 of them because the toenails were too long and difficult to cut. When asked if the staff assisted her, she said they had not trimmed them in a while. A review of the Face sheet and Minimum Data Set (MDS) assessment for Resident #68, indicated the resident was admitted to the facility on [DATE] with diagnoses: kidney failure, right above the knee amputation, Stage 4 sacral pressure ulcer, weakness, depression, intestinal fistula, colostomy, Pulmonary hypertension, and atrial fibrillation. A review of the MDS assessment dated [DATE] revealed the resident had full cognitive abilities with a Brief Interview for Mental Status (BIMS) score of 15/15 and she needed substantial/maximal assistance with hygiene care. A review of the Care Plan for Resident #68 revealed the following: The resident has an ADL self-care performance deficit related to pain, date initiated and revised 5/15/2024, with Interventions: Bathing/showering: Avoid scrubbing and pat dry sensitive skin, date initiated 5/17/2024. There was no mention of nail care. The resident has actual impairment to skin integrity of the Sacrum . Resident is at moderate risk for impairment in skin integrity related to age, skin fragility and thinness, decreased mobility, dry skin, . date initiated 5/15/2024 and revised 5/16/2024 with Interventions: . keep fingernails trimmed, clean and filed . dated initiated 5/16/2024. On 7/01/24 at 11:19 AM, the Director of Nursing was interviewed about Resident #68's lack of nail care. She said nail care was supposed to be provided with the resident's shower. She said if the resident was diabetic only nurses could cut them, and if they couldn't then podiatry could help with the toenails. The Director of Nursing said she would provide staff education on nail care. A review of the facility policy titled, A.M. (morning) and H.S. (night time) Care, dated November 4, 2021 provided the following, Personal care will be provided in a consistent manner to all residents daily . There was no mention of nail care.

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	235157	A. Building B. Wing	07/01/2024

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Sanilac Medical Care Facility	137 N Elk St Sandusky, MI 48471

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39059 This Citation pertains to Intake Numbers MI00142202 and MI00144560. Based on interview and record review, the facility failed to assess and monitor hydration status timely and notify family for one resident (Resident #376) of one resident assessed for Intravenous (IV) fluids, resulting in an undocumented amount of IV fluids administered, no family notification and ultimately hospitalization . Findings include: Resident #376: On 6/26/24, at 10:15 AM a review of Resident #376's electronic medical record revealed an admission on 11/16/2021 with diagnoses that included Diabetes Type 2, Dysphagia and Chronic Kidney Disease. A review of a laboratory result verified on 1/10/2024 . Sodium Lvl (level) Value 158 (H) .Ref. Range/Units 135 - 145 . A review of the Medication Administration Record 1/1/2024 - 1/31/2024 revealed no entry for the 1 liter or normal saline intravenous documented. A review of the IV Assessment Effective Date: 01/11/2024 16:48 . Location of IV Right Forearm . Type of IV Solution 0.9 % sodium Chloride . Bolus . there was no documentation noted as to how much the resident received and or how fast the IV solution was to be infused. A review of the progress notes revealed . 1/9/2024 12:46 . Per (Physician assistant) CBC, BMP, TSH to be collected r/t significant weight loss within a month. 1/11/2024 08:18 . Resident labs resulted. Valued indicate dehydration. (Physician Assistant) called and voicemail left . 1/11/2024 11:47 . Clinical addressed lab results. Per (Physician Assistant), we will give 1L(liter) bolus to resident . 1/11/2024 16:47 . PIV insertion completed. Resident tolerated well. Assist of one needed. 22 g placed without difficulty. Patent and infusing without difficulty . 1/11/2024 20:38 . IV NS infusing as ordered. IV site clear . 1/12/2024 06:333 . resident removed i.v. at 0130, no bleeding noted, site cleansed and covered with band aid . 1/13/2024 15:20 . 700 hall cart nurse . asked this writer to assess resident. Resident is noted to have a fever at this time. Resident is resting in bed comfortable. (Physician Assistant) and at this time we will continue to monitor patient. BP 110/62 p 56 r 18 temp 99.8. [NAME] sounds clear active bowel sounds noted. Educated floor staff to push fluids. Resident was tested for Covid and is negative at this time . 1/13/2024 19:11 . Resident was admitted to (local hospital) this evening. Per Clinical Nurse Family was in visiting and did request resident be admitted to the hospital. This Nurse did call hospital and give them report. Clinical Nurse sent paper work and resident was taken over to the hospital. (continued on next page)

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	235157	A. Building B. Wing	07/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sanilac Medical Care Facility	137 N Elk St Sandusky, MI 48471

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/26/24, at 4:06 PM, the Director of Nursing (DON) was interviewed regarding Resident #376's condition prior to their discharge to the hospital. The DON was asked how much of the 1 liter of NS did the resident receive and the DON offered that the facility generally does an IV sheet. A review of Resident #376's electronic medical record along with the DON revealed no IV sheet and no other documentation as to how much of the IV fluids Resident #376 received prior to pulling it out. The DON was asked if they were aware the resident pulled out their IV and the DON offered, yes and that they don't think the resident got the whole amount. The DON planned to look for an IV sheet that may have not been scanned to the electronic medical record. On 6/26/24, at 4:30 PM, the DON offered that they didn't find any documentation as to how much IV fluid Resident #376 received prior to pulling out the IV. On 6/27/24, at 1:30 PM, a record review of Resident #376's hospital documents revealed a diagnosis of Hypernatremia (high blood sodium) with a level of 161 . Physical Exam: . Not responding . Dry mucus membranes . Date of Service 1/13/2024 Time: 1802 . 1853 lab called with critical sodium level of 161 . On 6/27/24, at 3:43 PM, the DON was asked if Resident #376's family was made aware of the IV; the need for it and that the resident pulled it out, and the DON stated, no.

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	235157	A. Building B. Wing	07/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sanilac Medical Care Facility	137 N Elk St Sandusky, MI 48471

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38471 This Citation pertains to Intake Numbers MI00140471 and MI00142854. Based on observation, interview, and record review the facility failed to ensure comprehensive documentation and evaluation to prevent the development of an unstageable facility-acquired pressure ulcer for one resident (Resident #63) of seven residents reviewed for alterations in skin integrity, resulting in Resident #63 acquiring and developing an unstageable pressure ulcer. Findings include: Resident #63: During initial tour on 6/25/2024, Resident #63 was observed sitting in bed visiting with his wife. He stated his goal was to return home but know he has some work to do before that can occur. On 6/25/2024 at approximately 1:30 PM, a review was completed of Resident#63's medical records and it revealed he initially admitted to the facility on [DATE] with multiple readmissions with diagnoses that included, Chronic Osteomyelitis, Diabetes, Acute Kidney Failure, Metabolic Acidosis, Monoplegia, Pressure Ulcer of Sacral Region, Stage 4, Bipolar disorder, Anxiety and Agoraphobia. Resident #63 is alert and oriented and able to make his needs known. Further review was complete of the records the resident discharged from the facility on 3/14/2024 and readmitted on [DATE]. On 06/27/24 at 09:00 AM, an interview was conducted with Wound Nurse J regarding Resident #63's coccyx/sacrum wound. Nurse J explained he readmitted to the facility on [DATE] and the area was documented at MASD on admission, 3/19/2024 and 4/5/2024. The area was not documented on the initial nursing admission assessment and there was not consistent, ongoing assessment/monitoring of the area. The wound developed as an unstageable coccyx wound that was facility acquired. Further review was conducted of Resident #63's record and yielded the following results: Progress Notes: 4/6/2024 at 12:36: .Noted resident's coccyx excoriated area now open with slough and necrotic tissue covering wound bed . 4/23/2024 at 08:24: .Coccyx Sacrum large necrotic unstageable pressure ulcer, staged at stage 4 per wound clinic however wound base is not visible with wound bed being 100% necrotic grey attached slough and scattered eschar noted, wound edges are irregular and non-rolling, large amount of purulent grey dark bloody drainage noted soaked entire dressing, however no odor noted, with noting BM was also in wound base as wound is very close to anus . 5/7/2024 at 07:32: .Coccyx wound has decreased some still remains unstageable with necrotic grey slough and eschar scattered throughout . Care Plan Revisions: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235157	A. Building B. Wing	07/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0686 Level of Harm - Actual harm Residents Affected - Few	.FA (facility acquired) unstageable to coccyx sacrum . Admission Assessment 3/18/2024: .wound to foot . There was no documentation regarding coccyx/sacrum skin alterations. Skin Observation Assessments: 3/19/2024: .intra-gluteal cleft- masd .MASD skin noted to intra-gluteal clef and peri area. Will continue to monitor and apply barrier cream after toileting . It can be noted after reviewed March 2024 MAR (Medication Administration Record) it showed the order for barrier cream was not ordered until 3/30/2024. 3/25/2024: There were skin concerns documented. 3/29/2024: There were skin concerns documented. 4/5/2024: Sacrum 11 x 3.1 x 0- MASD .Area remains present with MASD. Area appears to be getting smaller .Odor continues, moderate amount of drainage noted. 4/6/2024: Coccyx- pressure- unstageable .Resident noted with open area to sacral/coccyx, area previously presented at irritation from fecal contact; resident has been sitting in recliner without relief of pressure. Wound care initiated and message to wound nurse for assessment . 4/12/2024: .Sacrum presents with both beefy red, necrotic, and slough . There were no measurements listed. 4/20/2024: Coccyx- Pressure . There were no measurements listed. 4/23/2024: .Coccyx/sacrum- Pressure- 8.2 cm x 7.5 cm UTD (unable to determine) - Unstageable .Coccyx Sacrum large necrotic unstageable pressure ulcer, staged at stage 4 per wound clinic however would base is not visible with wound bed being 100% necrotic grey attached slough and scattered eschar noted ,wound edges are irregular and non -rolling, large around of purulent grey dark bloody drainage notes soaked entire dressing . 5/2/2024: Coccyx/sacrum- Pressure- 8.2 cm x 7 UTD- Unstageable . Coccyx Sacrum large necrotic unstageable pressure ulcer, staged at stage 4 per wound clinic however would base is not visible with wound bed being 100% necrotic grey attached slough and scattered eschar noted ,wound edges are irregular and non -rolling, mod amount of sero/sang grey tinged bloody drainage noted . 5/7/2024: Coccyx/sacrum- Pressure- 7.5 cm x 6.9 cm x UTD- Unstageable . Coccyx Sacrum large necrotic unstageable pressure ulcer, staged at stage 4 per wound clinic however would base is not visible with wound bed being 100% necrotic grey attached slough and scattered eschar noted, wound edges are irregular and non -rolling, mod amount of sero/sang grey tinged bloody drainage noted . (continued on next page)

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	235157	A. Building B. Wing	07/01/2024

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F 0686 Level of Harm - Actual harm Residents Affected - Few	5/17/2024: Coccyx/sacrum-Pressure-7.5 cm x 6.8 cm x UTD Unstageable . Coccyx Sacrum large necrotic unstageable pressure ulcer, staged at stage 4 per wound clinic however would base is not visible with wound bed being 100% necrotic grey attached slough and scattered eschar noted ,wound edges are irregular and non -rolling, mod amount of sero/sang grey tinged bloody drainage noted . When the wound was acquired there the wound measurements were not consistently documented. Wound Clinic Notes: 3/25/2024: There was no mention of coccyx wounds. 4/15/2024: wound care for L (left) foot and BIL buttocks wounds . Wound #5 status open. Original cause of wound was Pressure Injury. The date acquired was: 3/1/2024. The wound is currently classified as Category/Stage IV wound with etiology of Pressure Ulcer and is located on Right Medial Coccyx. The wound measures 5.2 cm length x 7.3 cm width 3.1 cm depth .There is a medium amount of purulent drainage noted . 4/22/2024: .Wound #5 status open. Original cause of wound was Pressure Injury. The date acquired was: 3/1/2024. The wound is currently classified as Category/Stage IV wound with etiology of Pressure Ulcer and is located on Right Medial Coccyx. The wound measures 6.3 cm length x 5.6 cm width x 3.3 cm depth . 4/29/2024: .Stage 4 coccyx wound which was surgically debrided while inpatient. Patient has a lot of necrotic non viable tissue present to wound bed of coccyx wound. Wound debridement was done today .Wound #5 status open. Original cause of wound was Pressure Injury. The date acquired was: 3/1/2024. The wound has been in treatment 2 weeks. The wound is currently classified as Category/Stage IV wound with etiology of Pressure Ulcer and is located on the Right Medial Coccyx. The wound measures 7.2 cm length x 6.7 cm width x 4 cm depth; 37.888 cm ^2 area and 151.55 cm ^3 volume .foul odor after cleansing was noted .There is a small (1-33%) amount of necrotic tissue within the wound bed including Eschar and Adherent slough . 5/6/2024: .Pressure ulcer of right buttock, stage 4 . 5/13/2024: .Pressure ulcer of right buttock, stage 4 . On 6/27/2024 at 11:00 AM Resident #63's wound was observed in the presence of Wound Nurse J. Resident observed lying in bed on back, air mattress on bed, resident turned to left side, he said he can't turn to the right side because he does not have a grab bar on that side and can't turn himself over that way. He has a small grab bar on the upper left side of his bed. Resident with dressing dated 6/26/2024- dressing with copious amount brown drainage and a very foul smell. The wound nurse was asked about it and she said it was wound drainage and she thought it might be infected. She said the resident was routinely seen by the wound clinic and they did not culture the wound on his last visit. (continued on next page)

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	235157	A. Building B. Wing	07/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sanilac Medical Care Facility	137 N Elk St Sandusky, MI 48471

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F 0686 Level of Harm - Actual harm Residents Affected - Few	The resident was observed to have a large wound between the gluteal folds- the wound nurse said she completed measurements, and they were in the chart Skin Observation dated 6/25/2024. The wound was approximately 4 cm x 2 cm with depth. Very near the resident's anus. The wound was bright red with some yellow and black necrosis. The nurse cleansed the wound with normal saline and applied the dressing: triad paste to outside of wound, calcium alginate silver to wound bed and abd pad over top. The resident was asked if he already had the wound on admission and he stated, No. I got it here. He said he came to the facility for wounds on his feet and then developed the wound on his sacrum. He said he has trouble turning in bed, fell out of bed and then had been sitting for prolonged periods of time in a bedside recliner. He said the wound developed after that. On 07/01/24 at 01:06 PM, an interview was conducted with Nurse Practitioner I regarding Resident #63's coccyx/sacrum wound. Nurse Practitioner I stated the wound began at the facility. Review was completed of the facility policy entitled, A.M and H.S. Care, revised 11/4/21. The policy stated, . Inspect residents' skin for redness and open areas during care. Report any changes in condition to charge nurse . Review was completed of the facility policy entitled, Wound Care, revised 6/24/29. The policy stated, All new wounds noted will be measured by the wound care nurse or designee within one business day .Wound care nurse to document wound progress note with all new admission that skin assessment was reviewed and skin treatments are in place ordered.

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	235157	A. Building B. Wing	07/01/2024

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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** 37666 This Citation pertains to Intake Numbers MI00144103 and MI00144517. Based on observation, interview and record review, the facility failed to ensure appropriate interventions were in place, interventions were followed and supervision was provided to prevent falls with injury for 2 residents (Resident #38, and Resident #44) of 5 residents reviewed for falls, resulting in Resident #38 falling during a transfer, having pain and a decline in transfer status to a Hoyer lift, and Resident #44 sustaining fractures in her right foot during a transfer. Findings Include: Resident #44: Accidents: On 6/25/24 at 10:56 AM, Resident #44 was observed sitting in a wheelchair in her room. She was alert and talkative. She said she broke some of her toes on her right foot during a transfer in the bathroom. She said she was supposed to have 2 people help her with the transfer and only one staff member assisted her; She stated, I have a twist it board to stand on with transfers and my foot wasn't on it quite right. They said I broke my toes. A record review of the Face sheet and Minimum Data Set (MDS) assessment indicated Resident #44 was admitted to the facility on [DATE] and recently readmitted on [DATE] with diagnoses: history of a stroke, right sided weakness, heart disease, diabetes, COPD, peripheral vascular disease, hypothyroidism, bipolar disorder, dementia, neuropathy, history of falls, unsteadiness on feet, displaced fracture of third metatarsal (toe) right foot 4/9/2024, displace fracture of fourth metatarsal (toe) right foot 4/9/2024. The MDS assessment dated [DATE] revealed the resident had full cognitive abilities with a Brief Interview for Mental Status (BIMS) score of 15/15 and the resident was dependent with transfers. A record review of an incident investigation for Resident #44 revealed the following: Resident #44 complained of pain in right foot on 4/7/2024. An x-ray was ordered 4/8/2024 that identified a fracture of distal fourth metatarsal (toe) and a fracture of the third metatarsal right foot. Initially the resident said she did not know how it happened. The resident continued to experience pain and Norco (pain medication) was ordered every 6 hours. An ortho consult was ordered and the resident was ordered to transfer via an electronic lift/Hoyer. The facility interviewed all staff assigned to the resident's hall during a 3 day period 4/5/2024-4/7/2024. Nurse E said on 4/7/2024 she was called to the shower room by an aide because Resident #44 was complaining of pain on the top of her right foot and was unable to put weight on the foot and stand up. It took 3 staff to assist her to transfer. At that time the physician was notified and x-rays were ordered. Nurse E said the resident had also complained of pain to her right foot on 4/6/2024 and requested something for pain. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235157	A. Building B. Wing	07/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sanilac Medical Care Facility	137 N Elk St Sandusky, MI 48471

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The facility interviewed Certified Nursing Assistant/CNA R on 4/10/2024, she was assigned to care for Resident #44 on 4/5/2024, she said the resident complained of pain during a toilet transfer on 4/5/2024. She said when the resident sat down on the toilet, she said her right foot twisted. She said it hurt at the time, but didn't complain about it for the rest of the night. CNA R said the resident would voice concerns about her right foot at times, because that was the side she had weakness on. The CNA said the resident did twist her foot at times. On 4/12/2024 CNA S was interviewed and said she was assigned to Resident #44 on 4/6/2024 and 4/7/2024 and said the resident complained of pain and needed 3 staff to assist her with transferring. On 4/12/2024 the resident was seen by the orthopedic surgeon and was ordered a EZ Tracker [NAME] boot to be worn for 6 weeks. A review of the physician orders for Resident #44 identified the following: 3/21/2024: Transfers- . Toilet and Shower chair transfers- assist of two. A review of the Care Plans for Resident #44 provided, The resident has an ADL (activities of daily living) self-care performance deficit related to Hemiplegia and Hemiparesis (weakness) following a CVA (stroke), dementia, with Intervention: Transfers: . 2 assist for toileting using stand and pivot disc. On 6/25/24 at 2:43 PM PM Corporate Compliance Officer B was interviewed related to Resident #44.-She said the resident started complaining of pain in her right foot about 4/5/2024 asking the nurse for Tylenol; after a couple days the pain increased. The resident initially said she had not injured it: no fall and she did not bump it. An x-ray was ordered and identified fractures on the right foot 3rd and 4th toes 4/8/2024. The right foot was re-x-rayed 5/9/24 and identified healing, although not yet healed. She said the facility interviewed staff from several days and shifts and identified Certified nurse aide R on 4/5/2024 as transferring the resident by herself with 1 assist. She said the aide was using a twist transfer board that the resident stood on. The Corporate Compliance Officer B said the aide received a reprimand from the Director of Nursing/DON in writing for transferring the resident in the bathroom by herself with 1-assist when she was supposed to have 2-assist. On 7/1/2024 at 11:30 AM, the DON was interviewed about Resident #44 fracturing two toes on her right foot during a transfer in the bathroom. The DON said CNA R had confirmed she transferred Resident #44 with 1 assist in the bathroom and then the resident complained of pain in her right foot. The DON said the CNA was reprimanded for not following the resident's plan of care, as she needed 2 assist with the toileting transfer. 37771 Resident #38: A review of Resident #38's medical record revealed an admission into the facility on [DATE] with diagnoses that included fracture of right femur, obesity, osteoporosis, unsteadiness on feet, difficulty in walking, and muscle weakness. The Minimum Data Set assessment revealed the Resident had a Brief Interview for Mental Status (BIMS) score of 12/15 that indicated intact cognition. (continued on next page)

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	235157	A. Building B. Wing	07/01/2024

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Further review of Resident #38's medical record of progress note dated 5/2/24, (Physician's Assistant) notified of possible injury from lowering resident to the floor. Order obtained for Right Knee x-ray and Right hip x-ray for post-fall [lowered to floor from standing position] . Progress note dated 5/3/24, Phone call to (hospital). Spoke with (Nurse's name), floor nurse. Verified per (Doctor's name) resident does not have an Acute Femur Fracture . A review of the Facility Reported Incident revealed the following: Alleged Action: On 5/2/2024 resident (name and medical record number (Resident #38)) was being assisted by CNA (certified nursing assistant also CENA), (name of CNA) with transferring from the side of her bed to her wheelchair. As (name of Resident) was being assisted with sitting on the edge of the bed with gait belt being applied and 2 wheeled rolling walker present, resident slipped resulting in the resident being lowered to the floor with the assistance of CNA, (name). (Resident's name) complained of pain in the right knee/leg immediately post incident with resident receiving PRN (as needed) Oxycodone for pain management. An X-ray of the right knee was obtained with results showing Postsurgical change with a spiral lucency of the distal femur suspicious for fracture. At the time the incident had occurred, it was noted that CNA, (name) was not following the residents plan of care as resident required assist of 2 using a 2 wheeled rolling walker for all transfers. The Resident was sent to a second hospital, and it was determined she did not have a fracture though she was admitted with sepsis, urinary tract infection, right lower leg cellulitis and acute diverticulosis. The Resident was readmitted into the facility on [DATE]. A review of the facility incident report revealed date and time 5/2/24 at 10:15 AM. Incident Description Staff called this writer into resident's room, reported resident lowered to floor after attempting to transfer from bed to WC (wheelchair). Resident found sitting at 90-degree angle on floor, leaning against bed, with both legs bent at the knees, to the right. Resident stated CENA was getting her up for therapy, was sitting on the side of the bed and when CENA helped stand her up, she felt her legs give out. CENA and resident's husband assisted lowering her to the floor On 6/26/24 at 1:42 PM, an interview was conducted with Corporate Compliance Staff, regarding the investigation for Resident #38's fall on 5/2/24. The Staff reported the Resident was getting ready to get up for therapy, husband was in room, sitting on edge of the bed, was being assisted into wheelchair by CNA D, Resident had stood up from the bed and stated she was going down, and assisted to the floor by the CNA. When asked what the Resident's transfer status was at that time, the Staff reported the transfer status was two-person assist with rolling walker or Hoyer lift. The Staff was asked if the CNA had followed the plan of care and indicated the CNA had been by themselves and should have had two staff assisting. When asked why he was not following the plan of care the Staff stated, He could not give me a definitive answer. The Staff reported the husband had not had training in transferring the Resident. The Staff reported the Resident had gone for x-rays at the emergency room , findings indicated post-surgical change and suggestive of a fracture and the Resident was transferred to another hospital from order from the surgeon where it was determined there was not a fracture. The Staff reported that the CNA who had not followed the plan of care for Resident #38 had been suspended until further investigation and was given education. (continued on next page)

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	235157	A. Building B. Wing	07/01/2024

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Sanilac Medical Care Facility	137 N Elk St Sandusky, MI 48471

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 6/27/24 at 10:45 AM, an observation was made of Resident #38 in bed with a gown on. The Resident indicated she was to go out again today for a bone density test. The Resident answered questions and engaged in conversation. The Resident was asked about the fall when the Resident had been lowered to the floor. The Resident explained the CNA was helping her into the wheelchair from the bed, had a gait belt on, felt like she was slipping when going to the wheelchair and stated, I ended up on the floor. When asked if one CNA was helping her, the Resident indicated one CNA and stated, They were supposed to have two, and explained that she had been a Hoyer lift and therapy had worked with her on transferring with the walker and they said that was ok, to transfer with the two-person assist. The Resident stated, Now since the accident, they have me getting up with the Hoyer lift now. On 6/27/24 at 1:00 PM, an interview was conducted with Assistant Director of Nursing, Education Nurse C regarding education of staff post Resident #38's fall on 4/2/24. The Education Nurse indicated that a message was sent to all Nursing Staff CNA/RN/LPN: There is new education in Relias CNA Closet Guideline and Transfer Education. Please complete this ASAP. Thank you, dated 5/6/2024. A review of the list of staff that completed the training from the facility document titled, Learner Status, revealed, the course assigned to 107, course completed on time 43, Course completed late 29 and course not complete overdue 35, with a total completion of 67.29% and total compliance % of 40.19%. When asked when the educations due was, the Education Nurse the due date was for 2 weeks and that some staff had not completed the education and stated, it is way past the due date. On 6/27/24 at 2:15 PM, an interview was conducted with the Director of Nursing (DON) regarding Resident #38 being lowered to the floor by the CNA on 4/2/24. A review of the CNA not following the plan of care for two-person assist was reviewed. The education provided to staff was reviewed with the DON that not all education was completed by the staff assigned. The DON reported that the Restorative Nurse started doing spot checks for transfers and staff were following transfer status.

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	235157	A. Building B. Wing	07/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37668 This Citation pertains to Intake Number MI00142721. Based on interview and record review, the facility failed to operationalize policies and procedures to mitigate potential adverse consequences of psychotropic medications for one resident (Resident #377) of two residents reviewed for behaviors, resulting in a lack of baseline laboratory testing prior to the initiation of multiple psychotropic medications, ongoing in facility monitoring, and identification of potential adverse consequences in a timely manner with Resident #377 suffering decreased liver and kidney function, and a decline in overall health. Findings include: Resident #377: Review of Intake documentation dated as received 2/12/24 revealed Resident #377 was 57-years old male with dementia and including the allegations that Resident #377 was over sedated, and their health had rapidly and drastically declined including no longer being able to walk and talk. The intake detailed the facility is giving (Resident #377) Risperdal (antipsychotic medication commonly used to treat schizophrenia and bipolar disorder) which causes them to be hunched over, and a sleeping medication. Information within the intake revealed the complainant believed the facility was keeping (Resident #377) drugged up so they won't have to deal with them. The intake revealed they did not believe the facility was used to taking care of a younger man with dementia. Record review revealed Resident #377 was originally admitted to the facility on [DATE] with diagnoses which included early onset Alzheimer's disease, Pick's disease (also called frontotemporal dementia (FTD)- rare neurodegenerative disease that is similar to Alzheimer's disease but effects specific areas of the brain and is the most common type of dementia in individuals younger than 60), and dementia. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the Resident was severely cognitively impaired, ambulated independently without an assistive device, and required supervision and/or set up assistance with toileting/personal hygiene activities. The MDS further revealed the Resident displayed no hallucinations and/or delusions but did display wandering, physical and verbal symptoms directed towards others as well as other behavioral symptoms not directed toward others one to three days during the seven-day look back period which did not have a negative impact on the Resident or others. Further record review revealed Resident #377 was transferred to the local hospital on 2/12/24 due to behaviors and a change in medical condition. Resident #377 was transferred from the local hospital emergency room to a tertiary hospital where they passed away on 2/15/24. Review of Resident #377's Face sheet revealed the following diagnoses were added to the Resident's medical record while at the facility: - Psychotic Disorder with Delusions due to Known Physiological Condition on 1/17/24 (continued on next page)

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	235157	A. Building B. Wing	07/01/2024

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Major Depressive Disorder, Single Episode, Moderate on 1/15/24 - Anxiety Disorder on 1/17/24 - Wandering in Diseases Classified Elsewhere on 1/10/24 Review of Admission documentation in Resident #377's Electronic Medical Record (EMR) dated 11/30/23 revealed the Resident was admitted to the facility directly from home. Resident #377 was not taking any psychotropic medications when they were admitted to the facility. Review of Resident #377's Order Summary documentation in the EMR revealed the Resident was started on Ativan, Haldol, Klonopin, Lexapro, Lurasidone, Olanzapine (Zyprexa), Risperdal, and Trazadone at the facility. A detailed review revealed the following psychoactive medication orders: - Ativan Injection Solution 2 mg (milligram)/mL (milliliter) .Inject 1 mg intramuscularly one time only for anxiety/aggressive behavior . Completed . (Ordered: 11/30/23; Discontinued: 11/30/23). Note: Liver and kidney function should be monitored during prolonged therapy. - Ativan Solution 2 mg/mL . Inject 1 mg intramuscularly one time only for Anxiety/Aggression for 1 day (Ordered: 11/30/23; Discontinued: 12/1/23) - Ativan Oral Tablet 0.5 mg . Give 1 tablet by mouth every 8 hours as needed for anxiety . for 14 Days (Ordered: 11/30/23; Discontinued: 12/5/23) - Ativan Oral Tablet 0.5 mg . Give 1 tablet by mouth every 6 hours as needed for anxiety . for 14 Days (Ordered: 12/5/23; Discontinued: 12/19/23) - Ativan Oral Tablet 0.5 mg . Give 1 tablet by mouth every 6 hours as needed for anxiety . for 14 Days (Ordered: 12/19/23; Discontinued: 1/2/24) - Ativan Oral Tablet 0.5 mg . Give 0.5 mg by mouth one time only . Completed . (Ordered: 12/25/23; Discontinued: 12/26/23) - Ativan Oral Tablet 0.5 mg . Give 1 tablet by mouth every 6 hours as needed for anxiety . for 14 Days (Ordered: 1/2/24; Discontinued: 1/15/24) -Ativan Oral Tablet 0.5 mg . Give 1 tablet by mouth two times a day for Anxiety/agitation (Ordered: 1/4/24; Discontinued: 1/22/24) - Ativan Oral Tablet 0.5 mg . Give 1 tablet by mouth every 6 hours as needed for anxiety . for 14 Days (Ordered: 1/15/24; Discontinued: 1/22/24) - Ativan Oral Tablet 1 mg . Give 1 tablet by mouth every 4 hours as needed for anxiety/agitation related to Dementia . for 14 Days (Ordered: 1/22/24; Discontinued: 1/31/24) (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sanilac Medical Care Facility	137 N Elk St Sandusky, MI 48471

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Ativan Oral Tablet 1 mg . Give 1 tablet by mouth two times a day related to dementia . (Ordered: 1/22/24) - Ativan Oral Tablet 1 mg . Give 1 tablet by mouth every 4 hours as needed for anxiety/agitation related to Dementia . for 14 Days (Ordered: 1/31/24) - Ativan Injection Solution 2 mg (milligram)/mL (milliliter) .Inject 1 mg intramuscularly Inject 1 mg intramuscularly every 8 hours as needed for Anxiety-severe agitation for 14 days . (Ordered: 1/31/24) - Ativan Solution 2 mg/mL . Inject 1 mg intramuscularly every 8 hours as needed for anxiety/agitation for 7 Days (Ordered: 12/1/23; Discontinued: 1/8/24) - Haloperidol (Haldol) Tablet 1 mg . Give 1 tablet by mouth three times a day related to Dementia . (Ordered: 1/17/24; Discontinued: 1/22/24). Note: Electrocardiogram (EKG - recording of electrical signals of the heart) should be monitored as medication may interfere with the electrical signals in the heart and prolong the QT interval. May also increase liver enzymes. - Haloperidol Tablet 5 mg . Give 1 tablet by mouth three times a day related to Dementia . (Ordered: 1/22/24; Discontinued: 1/29/24) - Haloperidol Tablet 10 mg . Give 1 tablet by mouth two times a day for anxiety (Ordered and Discontinued: 2/7/24) - Haloperidol Tablet 10 mg . Give 1 tablet by mouth two times a day for Anxiety and severe agitation (Ordered: 1/29/24; Discontinued: 2/7/24) - Klonopin Oral Tablet 0.5 mg . Give 2 tablet by mouth one time only for anxiety for 1 Day (Ordered: 1/12/24; Completed: 1/13/24). Note: Medication is known to increase liver function test values and decrease [NAME] Blood Cell (WBC- cells which fight infection) count. - Klonopin Oral Tablet 1 mg . Give 1 tablet by mouth at bedtime for anxiety/agitation (Ordered: 1/11/24; Discontinued: 1/17/24) - Lexapro Oral Tablet 10 mg . 1 tablet by mouth one time a day for anxiety (Ordered 11/30/23; Discontinued: 1/4/24). Note: Medication may increase liver enzymes. - Lexapro Oral Tablet 20 mg . 1 tablet by mouth one time a day for anxiety (Ordered: 1/4/24) - Lurasidone . 20 mg . 1 tablet by mouth one time a day for agitation (Ordered: 1/31/24). Note: Medication may cause cardiac arrhythmias and decreased renal function. - Olanzapine . 5mg . 1 tablet by mouth one time a day for anxiety (Ordered: 2/7/24). Note: Medication may affect liver function and testing results. - Risperdal . 2 mg . Give 1 tablet by mouth one time a day related to dementia .for 3 Days (Ordered: 12/5/23; Discontinued: 12/9/23). Note: Medication may affect liver function and testing results and should be used cautiously in individuals with prolonged QT intervals on EKG. (continued on next page)

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	235157	A. Building B. Wing	07/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sanilac Medical Care Facility	137 N Elk St Sandusky, MI 48471

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Risperdal . 2 mg . Give 1 tablet by mouth two times a day related to dementia . (Ordered: 12/5/23; Start Date: 12/9/23; Discontinued: 2/2/24). The discontinuation reason listed was, reduced per POA (Power of Attorney) request. - Risperdal . 2 mg . Give 0.5 tablet by mouth two times a day related to dementia . (Ordered: 2/2/24; Discontinued: 2/7/24) - Trazadone . 100 mg . 1 tablet by mouth at bedtime for insomnia (Ordered: 1/11/24). Medication may affect liver function and testing results. - Trazadone . 50 mg . 1 tablet by mouth at bedtime for insomnia (Ordered: 1/8/24; Discontinued: 1/11/24) The following laboratory testing results were present in Resident #377's EMR: Review of laboratory testing results in Resident #377's EMR revealed no diagnostic laboratory testing and/or EKG at the time of admission to the facility. Review of laboratory testing in the EMR revealed the following: Collection Date: 2/4/24; Reported Date: 2/6/24: Complete Blood Count (CBC) and Complete Metabolic Panel (CMP) blood tests. -The CBC showed a slightly elevated [NAME] Blood Count (WBC- indicative of infection) at 10.86 (normal is 4.00 to 10.50), elevated neutrophils (type of WBC which elevate during infection, inflammation, and stress) at 82.9 (normal 42.2- 75.2), decreased lymphocyte (type of WBC which protect body from infection) at 8.9 (normal 20.5 to 51.1) and slightly decreased Red Blood Count (RBC - cells which transport oxygen) of 4.36 (normal 4.70 to 6.00). -The CMP revealed Resident #377's Blood Urea Nitrogen (BUN- amount of nitrogen in blood, high levels can indicate kidney damage) was 30 (normal 9-20), Aspartate Aminotransferase (enzyme released into blood when liver is damaged) was 232 (normal is 17-59), and Alanine Aminotransferase (ALT- elevated levels indicate liver damage) was 97 (normal is 0 to 50). Collection Date: 2/8/24; Reported Date: 2/9/24: Hepatic Function Panel was completed. The results showed and elevated AST level of 63. Review of hospital documentation for Resident #377 revealed the facility sent the Resident to hospital emergency room (ER) three times on 1/16/24, 1/26/24, and 2/12/24. Review of laboratory testing completed in the ER revealed the following: - 1/16/24: CBC was completed and showed RBC level of 4.26, decreased lymphocyte level of 16.2, and elevated neutrophil level of 6.67. CMP completed which showed and elevated BUN - 23.3 and elevated serum creatinine (test used to assess kidney function) - 1.40 (normal is 0.66 to 1.25). - 1/26/24: CBC completed which showed decreased RBC level of 4.53, decreased lymphocyte level of 15.6, and elevated monocyte (type of WBC which fight infection) of 11. (continued on next page)

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	235157	A. Building B. Wing	07/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 2/12/24 at 7:55 AM: CBC showed elevated WBC of 16.38, elevated neutrophils, decreased lymphocytes, and elevated monocytes. The CMP showed elevated sodium level (may be caused by dehydration and some medications), elevated BUN at 47.2, elevated serum creatinine at 2.56, elevated AST level of 270, elevated ALT level of 110, and elevated total bilirubin (can be caused by medications, liver or gallbladder dysfunction) of 1.4 (normal is 0.2 to 1.3). A review of documentation in the EMR revealed no documentation related to baseline and/or initial monitoring prior to initiation of psychotropic medications. An interview was completed with Family Member Witness G on 6/27/24 at 7:24 AM. When queried regarding Resident #377, Witness G stated, (Resident #377) passed away. When queried regarding the Resident's care at the facility, Witness G stated, There honestly needs to be more attention to early onset Alzheimer's. When asked what they meant, Witness G replied, They (staff) need more training related to early onset Alzheimer's disease and stated, I think (Resident #377) was a little bit to much for the facility. When queried regarding behavior interventions in the facility, Witness G stated, Started antipsychotic pills. With further inquiry regarding psychoactive medications, Witness G verbalized the Resident was not taking anything when they were admitted to the facility. Witness G stated, The drugs (psychotropic medications) were a little stupid. Witness G was asked what they meant and revealed the facility just kept adding medications. With further inquiry, Witness G revealed the Resident was walking when they entered the facility and was only in a wheelchair when they were sent to the hospital and ultimately passed away from infection and pneumonia. Witness G stated, The drugs (psychotropic) medications) caused (Resident #377's) back to hunch, but I think in all that they missed the pneumonia. Witness G was asked to clarify what they were saying regarding the Resident's back hunching and revealed the Resident would not stand up straight. Witness G then stated, We knew something was wrong, but we didn't know what. When queried if the facility obtained their consent prior to starting psychotropic medications, Witness G stated, Told me something but did not explain the side effects. When queried who told them that a hunched back was a side effect of the psychotropic medications, Witness G revealed a nurse at the facility but were unable to recall their name. When queried if facility staff discussed ongoing monitoring of the medications, such as blood tests, Witness G revealed they were not aware of potential effects of the psychotropic medications which would necessitate blood tests. (continued on next page)

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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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with the Assistant Director of Nursing (ADON) on 6/27/24 at 4:34 PM. When queried regarding Resident #377's behaviors, the ADON verbalized the Resident was very young, strong, and active in comparison to the typical Alzheimer's/dementia residents in the facility. When asked if Resident #377 was admitted to the facility on any psychotropic medications, the ADON confirmed they were not. Resident #377's psychotropic medications, including the dosages and dates of initiation were reviewed with the ADON at this time. When queried regarding the volume and dosages of the psychotropic medications initiated, the ADON confirmed Resident #377 was placed on multiple psychotropic medications. The ADON was asked if the medications ordered/administered at the facility have potential affects on liver and kidney function and confirmed they do. Resident #377's laboratory testing results were reviewed with the ADON at this time. The ADON confirmed the abnormal results including abnormal liver and kidney function. When queried if baseline laboratory tests were completed prior to initiation of psychotropic medications, the ADON revealed the EMR, and verbalized baseline testing was not completed. When asked if an EKG had been completed, due to the potential for QT prolongation, the ADON revealed it was not and stated the facility does not typically complete baseline EKG's. With further inquiry, the ADON revealed baseline labs for Resident #377 should have been completed but may have been missed because the Resident was admitted from home rather than coming from a hospital setting. When queried regarding facility policy/procedure related to consent for psychotropic medications and if the potential side effects should be reviewed with the resident/resident representative, the ADON confirmed they should be. When queried regarding Witness G saying they were not really made aware of the side effects of the medications, Witness G verbalized education should be provided for each medication. Review of facility policy/procedure entitled, Use of Psychotropic Medications (Dated: 11/1/21) revealed, Residents are not given psychotropic drugs unless the medication is necessary to treat a specific condition, as diagnosed and documented in the clinical record . 3. Residents and/or representative shall be educated on the risks and benefits of psychotropic drug use and the appropriate party to sign the consent .