STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235205	A. Building B. Wing	11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Corewell Health Reed City Hosp Rehab & Nsg Ctr	300 North Patterson Rd Reed City, MI 49677

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30120 Based on observation, interview, and record review, the facility failed to accurately document medication administration times for 1 of 4 residents (R2) observed during the medication administration observation. Findings include: A review of R2's Face Sheet, dated 11/20/24, revealed R2 was a [AGE] year-old resident admitted to the facility on [DATE]. In addition, R2's Face Sheet revealed they had multiple diagnoses that included osteoarthritis, neuropathic (nerve) pain of both feet, closed lumbar spine closed fractures with delayed healing, chronic pain syndrome, pneumonia, closed fracture of the humerus (bone in the upper arm), and right hand pain. During the medication administration observation on 11/19/24 from 6:45 AM to 7:30 AM, the surveyor observed Registered Nurse (RN) A administer Tylenol, docusate sodium (a stool softener), Vitamin B Complex, metoprolol (a blood pressure medication), Eliquis (a blood thinner), Lasix (a water pill), pantoprazole (a medication for gastric reflux- heartburn), gabapentin (a pain medication), and Oxycontin (a pain medication) to R2. RN A stated R2 also had a potassium packet (powered potassium) ordered. However, RN A did not have the packet because it looks like it's a new order, so pharmacy did not send it. She stated she will have to wait until pharmacy makes their next delivery of medications, which will probably be tomorrow. In addition, RN A stated R2 had an order change where she was only receiving 25 milligrams (mg) of metoprolol. She had 50 mg ordered before. But the doctor changed her pain medication, so she has not required that high of a dose. RN A verbally verified R2's medications and doses as she prepared them. The surveyor observed these medications being administered to R2. In addition, the surveyor heard RN A tell R2 that she was only receiving 25 mg of metoprolol because the physician changed her pain medications and the new pain medications had been helped to lower her blood pressure by reducing her pain. A review of R2's Medication Administration Record (MAR), dated 11/19/24 from 7:01 AM to 9:53 PM, revealed the following: - Voltaren (diclofenac sodium) gel (a medication for osteoarthritis) was documented as given at 7:16 AM (not observed by the surveyor during the medication administration observation) (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235205	A. Building B. Wing	11/20/2024

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Flonase (fluticasone) nasal spray was documented as given at 7:01 AM (not observed by the surveyor during the medication administration observation) - Metoprolol succinate (Toprol-XL- a medication for high blood pressure) 50 mg was documented as given at 7:01 AM (the surveyor only observed RN A administer a 25 mg dose to R2 during the medication administration observation) - Potassium chloride 20 mEq (millequivalents) packet (a medication for low potassium levels) was documented as given at 7:01 AM (not observed by the surveyor during the medication administration observation) A review of R2's physician orders revealed the physician discontinued R2's metoprolol 25 mg dose on 11/18/24 at 10:54 AM and started R2 on metoprolol 50 mg beginning with her daily morning dose on 11/19/24. During an interview on 11/20/24 at 10:26 AM, RN A stated stated she administered R2 her potassium packet later (she did not specify the time) after she received it from the pharmacy. She also stated she administered the Voltaren and Flonase after the nursing assistant had settled R2 in her chair with her blankets (the nursing assistant had toileted and dressed R2 immediately prior to the medication administration observation and had finished up getting her settled in her chair after RN A had administered the medications that the surveyor observed). RN A stated she did not remember the exact dose of metoprolol that she had administered to R2, but was sure that she had verified the dose with R2's MAR and the surveyor when she prepared it. However, the surveyor's procedure (which was adhered to) was to only check the medications when they are prepared with the packages that they come in, to have the nurse verbalize the medications and their doses, and to not view the MAR during the medication administration observation in case the physician's order does not match the MAR (this would be discovered when the medications are reconciled with the physician's orders after the observation was completed). During an interview on 11/20/24 at 11:32 AM, the Director of Nursing (DON) was notified that the surveyor had a concern with the administration times that were documented for R2's potassium chloride packet, Voltaren gel, and Flonase. The surveyor shared with the DON that these medications were administered after the medication administration observation was completed (after 7:30 AM) and RN A had verified this during their interview with the surveyor an hour before. The DON stated RN A should have documented the actual times that these medications were given and should not have documented that they were given at 7:01 AM or 7:16 AM if those were not the times they were given. A review of the facility's Medication Management policy, dated 4/21/23, revealed, All medications will be prepared and administered for one resident at a time following the rights of medication administration . right dose . right time, and right documentation .