STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235257	A. Building B. Wing	04/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Iron CO Medical Care Facility	1523 U S Highway 2 Crystal Falls, MI 49920

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41978 This citation pertains to intakes MI00140019 and MI00140881. Based on interview and record review, the facility failed to prevent misappropriation of narcotic medication for one Resident (R266) of two residents reviewed for misappropriation. Findings include: All time recorded in Eastern Daylight Time (EDT) unless otherwise noted. R266 was admitted to the facility on [DATE] with diagnoses including unspecified fracture of T7-T8 vertebra (spinal fracture) and ankylosing spondylitis of the thoracic region (inflammatory arthritis affecting the spine). Review of R266's Minimum Data Set (MDS) assessment, dated 10/2/2023, revealed R266 was cognitively intact. Review of R266's Controlled Substance Proof of Use Record, revealed the following: Hydrocodone-Acet [acetaminophen] 5MG [milligram] - 325MG give 1 Tablet By Mouth Every 4-6 Hours As Needed. Amount Received: 30. Date Received: 9/26/23. Further review of the Record revealed the following doses of the medication were signed out by Registered Nurse (RN) H as administered to R266: 9/28/2023 at 2130 (9:30 p.m.), one tablet. Review of R266's September 2023 Medication Administration Record (MAR) revealed the hydrocodone-acetaminophen 5mg-325mg was not signed as administered to R266 by RN H on 9/28/2023 at 9:30 p.m. Review of the [RN H] Drug Diversion Investigation, signed by the Director of Nursing (DON), Assistant Director of Nursing (ADON) and the Nursing Home Administrator (NHA), dated 10/6/2023, revealed the following, in part: (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
	235257	A. Building B. Wing	04/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Iron CO Medical Care Facility	1523 U S Highway 2 Crystal Falls, MI 49920

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/28/2023: At 2130 [9:30 p.m.], [RN H] Trillium Neighborhood nurse, signed out a PRN [as needed] Norco [hydrocodone-acetaminophen] 5/325 tablet for [R266] in the narcotic sign out log. At 2347 [11:47 p.m.] DON received a phone call from [Licensed Practical Nurse (LPN) J] stating that [R266] was requesting a PRN Norco for his back pain at 2230 [10:30 p.m.] and when the neighborhood nurse [LPN I] went to sign it out it was noted that [RN H] had signed one out at 2130 [9:30 p.m.] in the narcotic sign out log but not in the EMAR . [R266] was adamant that he had not received a PRN Norco at 2130 . [R266] was able to tell [LPN J] the time he received his Norco's for that day, and this was noted to be accurate within 10 minutes per the EMAR. [R266] stated that something was wrong, and he was upset about this . Further review of [RN H] Drug Diversion Investigation, revealed the following, in part: On 9/29/2023: At 0830 [8:30 a.m.] the personnel record for [RN H] was reviewed . She was given a discipline on 2/10/2023 for careless documentation. This was in relation to administering a controlled substance to a resident and signing it out in the EMAR [electronic Medication Administration Record] but not on the narcotic sign out log . At 0900 [9:00 a.m.] [RN H] was called . notified she needed to come to the facility for interview . [RN H] was asked about the discrepancy . she stated she did give it to him sometime after 9pm [sic] . she stated he was asleep and she had to wake him up . [RN 'H] was told going out to her vehicle during her shift without permission as well as her history of increased PRN administration versus other nurses is suspicious behavior. It was interated [sic] to her that the issue of her increased PRN administration has been discussed with her in the past as well . [RN H] was told she would need to drug test . When asked by [ADON] if she has ingested anything that could come up on this drug test that we need to know about before . [RN H] stated, I am not going to get drug tested . I am not going to do it. [NHA] informed [RN H] that this would then be immediate termination. She stated understanding . During an interview on 4/24/2024 at 3:15 p.m., the DON reported RN H was terminated due to refusal to submit to drug testing and refusal to submit to testing was treated as a positive test result per facility policy. The DON confirmed RN H, prior to the current incident involving R266, was written up for inconsistent documentation due to signing out narcotic medications on the proof of use log but not documenting the administration of the medication in the MAR. The DON reported this as the previous incident involving RN H referred to in the [RN H] Drug Diversion Investigation, document. The DON stated RN H was re-educated after the first incident, but no change in policy occurred as a result of the incident at that time. During an interview on 4/24/2024 at 3:30 p.m., the NHA confirmed RN H was terminated due to failure to submit to drug testing after the discrepancy in R266's record was identified. The NHA stated refusing the drug test was considered a positive test result according to facility policy. An attempt to reach RN H by telephone was conducted on 2/24/2024 at 3:34 p.m., no connection could be made. A review of the facility policy titled Medication Administration, effective 10/7/2021, revealed the following, in part: Sign MAR after administered . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235257	A. Building B. Wing	04/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Iron CO Medical Care Facility	1523 U S Highway 2 Crystal Falls, MI 49920

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility policy titled Drug and Alcohol Abuse Policy, last revised 10/16/2021, revealed the following, in part: Refusal to submit (to an alcohol or drugs/controlled substance test) means that an employee: 1. Fails to provide adequate sample without a valid medical explanation after he or she has received notice of the requirement for the urine, breathe or blood sample. 2. Engages in conduct that clearly obstructs the testing process . An employees' refusal to submit to a required alcohol or drugs/controlled substances test will be treated as a positive test . During the onsite survey, past noncompliance (PNC) was cited after the facility implemented actions to correct the noncompliance which included:1. Immediate termination of RN H from employment and notification of the appropriate licensing board and law enforcement; 2. Immediate audit of all Controlled Substance Proof of Use Log(s), in reconciliation with resident MARs for residents residing in the Trillium Neighborhood; 3. Psychosocial and pain assessments for all Trillium residents prescribed control substance medications, including R266; 4. Revision to the Medication Administration policy to include the requirement of verification by two licensed nurses for the administration of as needed controlled substance medications; 5. Licensed clinical staff education on the Code of Conduct, Drug and Alcohol Abuse Policy, and the updated Medication Administration policy, completed on 10/11/2024; 6. Formation of the Drug Diversion Committee, charged with auditing procedural compliance with audits showing compliance as of 4/16/2024. The facility was able to demonstrate monitoring of the corrective action and maintained compliance.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235257	A. Building B. Wing	04/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Iron CO Medical Care Facility	1523 U S Highway 2 Crystal Falls, MI 49920

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49310 Based on interview and record review, the facility failed to report injuries of unknown source to the state agency for two Residents (R87 and R34) of two residents reviewed for abuse. Findings include: All times are recorded in Eastern Daylight Time unless otherwise noted. Resident #87 (R87) was admitted to the facility with a primary diagnosis of Alzheimer's Disease. A Minimum Data Set (MDS) assessment dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of two of fifteen, indicating R87 was severely cognitively impaired. The MDS documented R87 as having impaired range-of-motion in both upper extremities and both lower extremities. The MDS assessed R87 as being dependent on staff for all Activities of Daily Living (ADL) including mobility and transfers. The MDS indicated R87 was unable to stand or walk. R87 required a mechanical lift to transfer with the assistance of 2 staff. R87's care plan documented the use of a specialized wheelchair for mobility. The care plan indicated R87 was dependent on staff to propel the wheelchair. On 3/3/24 at approximately 4:55 p.m., staff found R87 lying on the floor in the sitting area at the end of the 700-unit. R87 was lying in the corner of the room with facial injury and bleeding. R87 was sent to the hospital emergency department where a CT scan was obtained and revealed facial fractures. The CT read in part: . Acute minimally displaced/depressed fracture of the anterior wall of the left maxillary sinus (cheek area) with a small amount of hemorrhage layering within the sinus, and an acute nondisplaced orbital floor fracture on the left involving the infraorbital canal (eye socket). The Director of Nursing (DON) was interviewed on 4/23/24 at 3:43 p.m. The DON provided a written investigation dated 3/5/24. The written investigation consisted of interviews with staff assigned to the 700-unit on 3/3/24. The DON admitted the new cameras were not yet installed on 3/3/24 so she could not validate the employees' statements. The DON produced a form 'In-depth Case Review For: Resident Falls as an incident report. The form documented in part: doesn't know what happened. Unable to tell what happened. walked into living room saw her on the floor on her left side went to check her blood on floor& her eye [sic]. The DON said the event was not reported to the state agency. Registered Nurse (RN) C was interviewed on 4/23/24 at 3:15 p.m. RN C confirmed she was the staff member who found R87 on the floor in the sitting room on 3/3/24. RN C said she entered the sitting room just prior to dinner and observed R87 lying on the floor repeatedly saying, Help me, help me. RN C stated R87's wheelchair was toward the center of the room and the resident was in the corner of the room approximately 10-12 feet from the wheelchair. RN C said R87 could not explain how the injury was sustained due to confusion and dementia. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235257	A. Building B. Wing	04/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Iron CO Medical Care Facility	1523 U S Highway 2 Crystal Falls, MI 49920

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Certified Nursing Assistant (CNA) F was interviewed on 4/23/24 at 3:29 p.m. CNA F said he saw R87 approximately 20 minutes before the resident was found on the floor. CNA F said on 3/3/24 he saw R87 in her wheelchair in the sitting room at the end of the 700-unit hall pushing on the exit door. CNA F said he moved R87's wheelchair away from the exit door to the middle of the sitting room. CNA F said R87 asked for water, and he left the sitting room to obtain water for R87. CNA F said he got busy passing another resident's meal tray before he could deliver water to R87. CNA F said he heard RN C calling out R87 was on the floor before he could obtain the water and return to R87. The Nursing Home Administrator (NHA) was interviewed on 4/24/24 at 8:22 a.m. The NHA was asked if R87's event on 3/3/24 was reported to the state agency. The NHA confirmed it was not reported because the investigation results ruled out abuse. (*Note: Facility was not able to immediately rule out abuse) 49735 Resident #34 (R34) Review of R34's Minimum Data Set (MDS) comprehensive assessment, dated 7/17/23, revealed admission to the facility on [DATE] with a primary diagnosis of Alzheimer's Disease. R34 scored 3 of 15 on the Brief Interview for Mental Status (BIMS) indicating severe cognitive impairment. The MDS revealed R34 required substantial to maximum assistance with transferring from the bed to a chair. R34's care plan documented, I have short term memory impairment and confusion . According to a Facility incident report, staff found R34 on the floor of her room on 11/29/24 at 1:30 a.m. R34 was sent to the hospital for x-rays and a CT scan and returned to the facility. R34 continued to experience pain and was sent back to the hospital on 12/1/24. Additional testing revealed a left inferior pelvic fracture, an anterior pelvic fracture, and a patella (kneecap) fracture. During an interview on 4/24/24 at 3:22p.m., the Director of Nursing (DON) did not explain the reason a report was not made to the state agency regarding a resident with severe cognitive impairment who sustained multiple fractures and had been hospitalized . The source of the injury was unwitnessed and R34 could not explain how the injury was sustained due to severe cognitive impairment, short term memory loss, and confusion. Review of facility policy Incident Reporting Procedure 2.d. Major/Adverse Event with an effective date of January 25, 2021, read in part: Major/Adverse event: an incident that reached the resident and caused significant or permanent harm. These incidents are to be reported to the Administrator, and to the State Health Department. i. Any incident requiring hospitalization .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235257	A. Building B. Wing	04/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Iron CO Medical Care Facility	1523 U S Highway 2 Crystal Falls, MI 49920

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49735 Based on Interview and record review the facility failed to conduct a thorough and complete investigation for an incident for one Resident (#34) of four residents reviewed for incidents. This deficient practice could result in adverse outcomes and unmet care needs. Findings include: (All times are recorded in Eastern Daylight Time unless otherwise noted.) Resident #34 (R34) Review of R34's Minimum Data Set (MDS) comprehensive assessment, dated 7/17/23, revealed admission to the facility on [DATE], with active diagnoses that included: Alzheimer's disease, anxiety disorder, major depressive disorder, type 2 diabetes, chronic pain, congestive heart failure, and primary hypertension. R34 scored 3 of 15 on the Brief Interview for Mental Status (BIMS) reflective of severe cognitive impairment. The MDS reveals that R34 requires substantial to maximum assistance to transfer. Review of facility incident report titled In-depth Case Review dated 1/29/23 revealed R34 had a incident on 11/29/23 at 1:30. R34 was found on the floor next to her wheelchair complaining of left pelvic pain. Incident report revealed CNA was doing rounds and heard R34 moaning on the floor next to the wheelchair. R34 was sent to the hospital for xrays and a CT scan. Results from the hospital revealed a left inferior pelvic fracture, an anterior pelvic fracture, and a patella (kneecap) fracture. During an interview on 4/24/24 at 3:22p.m., the Director of Nursing (DON) acknowledged R34 had an incident and the investigation into the incident was not completed. Review of facility Incident Report Procedure: Incident Investigation 10.b, read in part investigations should be started within 2 working days . investigations and actions should be completed by fourteen days for all incidents.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235257	A. Building B. Wing	04/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Iron CO Medical Care Facility	1523 U S Highway 2 Crystal Falls, MI 49920

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 0686 Level of Harm - Minimal harm or potential for 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** 49310 Based on observation, interview, and record review, the facility failed to assess and monitor pressure injuries to promote the healing of a facility-acquired pressure injury for One Resident (R109) of six residents reviewed for pressure injuries. Findings include: All times are recorded in Eastern Daylight Time unless otherwise noted. Resident #109 (R109) was admitted to the facility on [DATE]. A Minimum Data Set (MDS) Assessment completed on 12/20/24 documented R109 had no pressure injuries at the time of the assessment. During an interview on 4/23/24 at 9:23 a.m., R109 stated, They told me I have a sore on my bottom from laying on my back. R109 said he did not know how long the wound had been there. When asked if nurses had been assessing and treating the area, R109 said the nurses did not look at it, but instructed him to refrain from lying on his back. A form 'Acute & Chronic Wound Assessment V2' was reviewed. The form documented R109 had a facility-acquired left gluteal pressure injury identified on 3/7/24. The form included wound measurements but did not include the stage of the pressure injury. There were no additional 'Acute & Chronic Wound Assessment V2' forms in the medical record. There were no further assessments or documentation regarding the pressure injury on R109's gluteal area. A form 'Skin & Wound Evaluation V7.0' dated 3/18/24 assessed a facility-acquired pressure injury staged as Deep Tissue Injury (DTI: persistent non-blanchable deep red, maroon, purple discoloration due to damage of underlying soft tissue) to R109's left heel. In the area labeled exact date of identification, the date 3/12/24 was entered, six days prior to the assessment being completed on 3/18/24. No additional assessments or documentation of the pressure injury to the left heel were in R109's record. A nurse's progress note dated 4/3/24 at 3:46 p.m. read in part: . had a stage 1 (pressure injury) on his coccyx which has healed and a DTI (Deep Tissue Injury) on left heel which as of this note [sic] has healed . There were no assessments of a coccygeal pressure injury in R109's medical record. Registered Nurse (RN) C was interviewed on 4/23/24 at 9:27 a.m. RN C was asked if R109 had pressure injuries. RN C replied R109 had pressure injury to his sacral area. On 4/24/24 at 8:06 a.m., The Director of Nursing (DON) was asked if R109 had pressure injuries. The DON said she did not know and accessed R109's electronic medical record. She announced R109 had an assessment completed on 3/18/24 for a pressure injury on R109's left heel. When asked if the pressure injury was still present, the DON said she did not know. The DON reviewed R109's medical record and said she could not locate additional information in the health record regarding the pressure injury on R109's left heel. The DON said there were no additional areas of skin impairment documented. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235257	A. Building B. Wing	04/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Iron CO Medical Care Facility	1523 U S Highway 2 Crystal Falls, MI 49920

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	When the DON was asked the status of the pressure injury to the left gluteal area identified on 3/7/24, the DON said she would have to get an updated log of pressure injuries. The DON reviewed R109's medical record and said there was no additional documentation of a wound on R109's left gluteus, and there were no measurements or assessments documented regarding the presence of a gluteal wound. When asked regarding assessment and monitoring of the pressure injury on R109's coccyx, the DON said she was not aware R109 ever had a wound on his coccyx. The DON was asked if R109's physician was aware of R109's pressure injuries and if the physician had assessed and documented on the pressure injuries. The DON reviewed R109's medical record and said there was no physician documentation on the pressure injuries. Skin assessment documentation for the previous two months and documentation of weekly assessments for pressure injuries were requested but not provided by the end of the survey. The DON was asked regarding assessment, monitoring, documentation, and dates of resolution for R109's wounds on the left heel, coccyx, left buttock, and sacrum. The DON confirmed most of the requested information was not in R109's medical record and provided a form '(name of facility) - Pressure Injury Tracking Form' and said it was the updated pressure injury log. R109 was not listed on the log. On 4/24/24 at 9:45 a.m., a skin assessment for R109 was observed being completed by Licensed Practical Nurse (LPN) D with the assistance of Certified Nursing Assistant (CNA) E. The skin assessment revealed a stage II pressure injury (Partial-thickness loss of skin with exposed dermis, presenting as a shallow open ulcer) on R109's sacrum measuring 0.5 cm x 0.25 cm x 0.1 cm. LPN D was asked when the pressure injury on R109's sacrum was identified. LPN D stated, I don't know for sure, but he's had it a while. CNA E was asked when R109 developed the pressure injury on the sacrum. CNA E said the wound was identified more than a week prior to 4/24/24 but she could not specifically recall the date it was first observed. When asked if the Treatment/Wound nurse or DON were aware of the pressure injury, CNA E said she was pretty sure the Wound Nurse was aware, and added, She hasn't seen it yet, but I'll ask her to take a look at it today. CNA documentation for R109 from 3/27/24 through 4/24/24 was reviewed and revealed no documentation of open areas or areas of skin impairment. Nurses' progress note documentation did not reveal assessments, monitoring, or treatment to R109's sacral wound. R109's physician orders were reviewed. There were no orders for treatment or activated standing orders for treatment to R109's sacrum. The policy 'Standing orders for Pressure Injuries' dated 4/25/22 read in part: .a. If an area of redness or open areas is [sic] identified, measures [sic] the wound, and complete the appropriate charting. The policy 'Pressure Injury Risk Assessment and Risk Reduction' dated 2/24/22 read in part: . Residents determined to be at an increased risk for pressure injuries will have weekly skin assessments completed by Licensed Nursing Staff and documented in electronic medical record [sic]. These residents will also have skin audits completed by Nursing Assistants with baths/showers and daily cares. Interventions will be implemented in accordance with MD orders.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235257	A. Building B. Wing	04/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Iron CO Medical Care Facility	1523 U S Highway 2 Crystal Falls, MI 49920

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 0851 Level of Harm - Potential for minimal harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. 49735 Based on interview and record review the facility failed to report Payroll Based Journal (PBJ) information to CMS (Centers for Medicare and Medicaid). This deficient practice resulted in inaccurate reporting of staffing levels with the potential to affect all 115 residents. Findings include: (All times are recorded in Eastern Daylight Time unless otherwise noted.) Review of the CMS PBJ Staffing Data Report FY (fiscal year) Quarter 1 2024 (October 1- December 31) revealed the metric No RN hours and Failed to have Licensed Nursing Coverage 24 hours/day Triggered with Infraction dates being: No RN hours on- 10/8, 10/14, 10/15, 10/21, 10/22, 10/28, 10/29, 11/4, 11/5, 11/11, 11/12, 11/18, 11/19, 11/25, 11/26, 12/2, 12/3, 12/9, 12/10, 12/16, 12/17, 12/23, 12/24, 12/30, and 12/31. Failed to have licensed nursing coverage 24 hours/day-10/14, 10/15, 10/21, 10/22, 10/28, 10/29, 11/4, 11/5, 11/11, 11/12, 11/18, 11/19, 11/25, 11/26, 12/2, 12/3, 12/9, 12/10, 12/16, 12/17, 12/23, 12/24, 12/30, and 12/31. An interview was conducted on 4/24/24 at approximately 11:55a.m., with Registered Nurse (RN) C. When ask if RN C was responsible for PBJ data submission, RN C acknowledged she was responsible and indicated the facility missed the deadline for submitting the PBJ information to CMS.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235257	A. Building B. Wing	04/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Iron CO Medical Care Facility	1523 U S Highway 2 Crystal Falls, MI 49920

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 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly 40383 . Based on interview and record review, the facility failed to ensure that the Quality Assurance and Performance Improvement (QAPI) committee met at least quarterly with the required committee members. This deficient practice placed all 115 residents in the facility at risk for quality care concerns. Findings include: (All times are recorded in Eastern Daylight Time unless otherwise noted.) During an interview on 4/24/24 at 1:34 PM, the Risk Manager, Registered Nurse (RN) G reviewed the QAPI policy, the attendance documentation for the QAPI meetings and identified the people and positions who were in attendance. The QAPI meeting sign in sheets revealed: 6/28/23: The Director of Nursing (DON), Nursing Home Administrator (NHA), Medical Director, Infection Preventionist (IP), and more than two others were present. 9/27/23: The DON, NHA, IP and more than two others were present. The Medical Director or designee was not present. 11/29/23: The DON, IP and more than two others were present. The Medical Director and NHA were not present. 1/16/24: The DON, NHA, IP and more than two others were present. The Medical Director was not present. 2/28/24: The NHA and more than two others were present. The Medical Director, DON, and IP were not present. 4/12/24: The NHA, Medical Director, IP and more than two others were present. The DON was not present. The facility 2024 Quality Assurance & Performance Improvement (QAPI) PLAN dated as Updated on 4/19/24 read in part: The QAPI Committee provides the backbone for QAPI. The core members are the Medical Director or his/her designee, the DON, the Infection Preventionist, the Administrator, owner, or board member and department leaders .