STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235295	A. Building B. Wing	05/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakeview Extended Care and Rehabilitation	210 South First Street Harbor Beach, MI 48441

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to Intake Number 3008221.Based on observation, interview and record review, the facility failed to ensure the accurate dispensing of medication, as ordered, for one resident (Resident #1) of three residents reviewed for medication administration.Findings include: Resident #1 (R1):On 5/11/26 at 6:25 PM, an interview was conducted with Confidential Person (CP) B regarding allegation details of Resident 1 (R1) receiving extra amount of metoprolol succinate capsules. The CP reported the Resident was ordered to receive the metoprolol (Kapspargo) sprinkles 100 mg (milligrams) one capsule but was administered 4 capsules (four 100mg capsules equals 400mg). The Resident had to be transferred to the emergency room, given charcoal, stay overnight in the hospital for observation and had loose bowel movements as a reaction to the charcoal causing exhaustion for the Resident.The CP reported that the medication was labelled as 25mg in the packaging from the facility pharmacy. The order was for 100mg, to take one capsule. The packaging had read to take one capsule but was labeled as 25mg. The nurse had questioned the discrepancy with a pharmacist and was told to give 4 capsules. The nurse had given the 4 capsules, meanwhile the Pharmacist looked into the discrepancy and realized they were 100 mg capsules that were in the packaging, called the facility and the resident was taken to the emergency room since the 4 capsules had been administered. The CP reported that Poison Control had been contacted, the Resident had to drink charcoal and stayed for observation. The CP was concerned about how the error occurred and if it could happen again. A review of Resident 1's medical record revealed an admission into the facility on 2/12/25 with diagnoses that included Parkinson's Disease, and hypertensive heart disease. A review of the Minimum Data Set assessment revealed the Resident had severely impaired cognition and needed substantial/maximal assistance or was dependent on a helper with activities of daily living. A review of R1's medication orders revealed an order for Metoprolol Succinate Oral Capsule ER (extended release) 24 hour sprinkle 100mg, give 1 capsule by mouth one time a day for Hypertension with a start date on 5/1/26 to be administer at 8:00 AM. Prior to that the Resident had been on Metoprolol Succinate ER tablet extended Release 24 hour 50mg, give 1 tablet by mouth one time a day. Kapspargo Sprinkle-metoprolol succinate used for the treatment of high blood pressure, angina pectoris (chest pain) and heart failure. Common side effects include tiredness, dizziness, shortness of breath, [NAME] cardia (low heart rate), hypotension (low blood pressure) and diarrhea. On 5/12/26 at 9:55 AM, an interview was conducted with the Director of Nursing (DON) regarding medication errors. The DON reported one recent medication error involving Resident 1 receiving Metoprolol Succinate Capsules with the Resident receiving a total of 400mg when the order was for 100mg. The DON reported the label had said 25 mg, but what was in the packaging was 100mg capsules. The DON reported that the Resident had been increased to 100mg tablets but since that medication could not be crushed and the resident had issues with swallowing larger medication, it was changed to the sprinkles. The new medication had come in on Thursday afternoon to start on Friday morning. The Nurse had questioned the discrepancy with the Pharmacist on the unit and was told to give four of the capsules. The Pharmacist had checked with the retail store and discovered the medication packaging (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was labeled wrong, had immediately called the Nurse but the medication had been given. The Resident was immediately taken to the emergency room that was connected to the facility and treated with charcoal and Poison Control was notified. The DON reported that Poison Control had released her at 4:30 PM but the Resident stayed for continued monitoring overnight. The DON reported no critical drop in blood pressure or heart rate that needed to be treated. The Resident returned to the facility in the morning and had not had any adverse cardiac effects. The DON reported having meetings with the Pharmacists and the family. They reviewed their processes and with the pharmacy had changed the labels with bigger printing of descriptions of the medication and they started scanning the medication which puts another check into the system. Education was provided to the Nurses and Pharmacists were working diligently on identifying problems and corrective actions. The DON reported the Resident did not present with any low heart rate, blood pressure, or arrythmia concerns that had to be treated. The Resident was on IV (intravenous) fluids while in the ER. On 5/12/26 at 10:21 AM, an interview was conducted with Pharmacist C who reported she had looked at the card of medication that had capsules, the order was for 100mg but the sticker on the med card had Kapspargo 25mg and had directed the nurse to give the four capsules. The Pharmacist reported the label had said to give one capsule and that was what the Nurse had questioned. The Pharmacist reported she had left the unit and had called the technician and found out we only had the 100mg Kapspargo Sprinkle and stated, I called the nurse, but they had already given it to her. The Pharmacist reported the breakdown was the label. When the label was made, the wrong strength of 25mg was selected and stated, If I would have looked at the imprint, I would have seen the capsule did not match the description. The Pharmacist reported that the Pharmacist does a second check before it goes to the facility, but it had not been caught with that check and the card with the medication was delivered to the facility. The Pharmacist reported they had changed the labeling. On 5/12/26 at 11:00 AM, the DON reported the timeline as the medication given at 7:43 AM, Pharmacist C had called the Nurse approximately 8:05 AM, the Resident was transferred to ER. She was notified at 8:18 AM and the Resident was already in ER. The processes put in place were reviewed and when asked if they were in sustained compliance, the DON stated, No not yet, we are still working on the processes to ensure this does not happen again. The (name of computer program used) is new and we are still working to make sure everything is as accurate as possible, and expressed they will be following this in QA (quality assurance program). On 5/12/26 at 12:15 PM, an observation was made of Nurse A passing medication and reviewing the checks she does prior to giving medication. The Nurse explained that the label on the med card had said 25mg and on the computer it had 25mg also, but it had said give one capsule, she had questioned the Pharmacist C who was on the unit at the time and reported the Pharmacist had said to give the four capsules. An observation was made of a photo of the med card had one capsule crossed off and handwritten 4 that was signed by the Pharmacist C. The Nurse reported that the imprint description had been made bigger and she checks the description of the medication to make sure it is accurate. An observation was made of the Nurse passing medication to R1 at 12:46 PM, without any concerns with medication administration. The scanning process was new to the facility, and the card was scanned. The nurse verified the correct medication on the computer. On 5/12/26 at 1:41 PM, an interview was conducted with Pharmacist D who explained that they got the order in for the Kapspargo Sprinkle 100 mg, but the tech put it in as 25mg but was dispensed with the 100 mg. The Pharmacist reported that he did not catch the mistake when checking the medication and it was sent to the facility. The Pharmacist indicated that most of the time the medication was prepopulated, if not we have to put it in manually and the tech inadvertently put it in for the 25mg.