STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235321	A. Building B. Wing	06/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marquette County Medical Care Facility	200 W Saginaw St Ishpeming, MI 49849

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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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. 45123 Based on observation, interview, and record review, the facility failed to provide activities of daily living (ADL) care in a dignified manner to one Resident (R17) of twenty-five residents reviewed for dignity. Finding include: On 6/3/24 at 3:10 PM, an observation was made of CNA (certified nurse aide) D assisting R17 in his room to his bathroom on the toilet. On 6/3/24 at 3:15 PM an observation was made of R17 in his bathroom with the door open to the bathroom and the room door open. R17 was using the bathroom toilet. R17 was left unattended with both the bathroom door and room door open. On 6/3/24 at 3:17 PM, an observation was made of R57 entering R17's room in her wheelchair. Approximately one minute later CNA G redirected R57 out the room door of R17. On 6/3/24 at 3:20 PM, an interview was conducted with CNA G, and was asked if R17's door should be closed and replied, The other CNA could have, yeah. The other CNA should have closed it part way because R17 is a fall risk and if it was partially closed then she [R57] would not have gone in. On 6/3/24 at 3:25 PM, an interview was conducted with CNA D, and was asked why he left R17 in his bathroom with both the bathroom door and room door open and replied, I had to go get a brief. CNA D was asked why he did not ask for assistance and replied, I don't know. CNA D was asked why he left the door open to R17's bathroom and room entry door and replied, I guess I should have closed it and left it open a little. He is a fall risk. CNA D was asked if R17 had privacy while using the bathroom and replied, No. I should have done that differently. On 6/5/24 at 10:30 AM, an interview was conducted with the Nursing Home Administrator (NHA) and was asked about closing doors to provide privacy when residents were using the bathroom and to prevent wandering residents from entering other resident's rooms and replied, I would expect for bathroom doors to be closed by staff to allow for privacy and wandering residents should not be entering rooms when others are using the bathroom. The CNA should have closed the door and not allowed the wandering resident to enter the room. Wandering residents should be redirected.

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 0684 Level of Harm - 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** 49310 Based on observation, interview, and record review, the facility failed to develop a care plan and offer/recommend diagnostic testing or consultation with a Gastroenterologist or Physician Specialist to determine the source of prolonged nausea and vomiting for one Resident (R16) of one Resident reviewed for change of condition. This deficient practice resulted in R16 sustaining a 27.3% weight loss in 6 months, a decline in activities of daily living (ADL), a significant change of condition, and the development of multiple pressure injuries. Findings include: Resident #16 (R16) R16 was admitted to the facility on [DATE]. A quarterly Minimum Data Set (MDS) Assessment, dated 9/26/23, coded R16 as requiring staff assistance for activities of daily living (ADL), including partial staff assistance with ambulating, toileting, standing, and transfers. The MDS documented a Brief Interview for Mental Status (BIMS) Score of 15, indicating R16 was cognitively intact. The quarterly MDS did not code R16 with weight loss. A Significant Change MDS, dated [DATE], coded R16 as being fully dependent on staff for all ADL except eating. The MDS coded R16 as being dependent on staff for ambulating, toileting, standing, and transfers. The MDS documented a BIMS score of 13, indicated R16 remained cognitively intact. The Significant Change MDS coded R16 with weight loss. On 6/4/24 at 8:27 a.m., R16 was observed lying in bed holding an emesis basin with an untouched plate of breakfast on her bedside table. R16 said she was nauseated and was unable to move because of nausea and vomiting. R16 said she had experienced nausea and vomiting for so long that she lost weight due to inability to eat. A review of the medical record for R16 revealed a weight loss of 69.9 pounds from 12/6/23 until 6/2/24, a 27.3% loss of body weight. The care plan for R16 did not indicate the weight loss as desirable by R16. The nutritional care plan documented R16 was diagnosed with protein calorie malnutrition (a nutritional status in which reduced availability of nutrients leads to changes in body composition and function) starting 3/1/24 due to prolonged low appetite/intakes/weight loss. Progress notes for R16 revealed numerous documentation entries of nausea and vomiting. R16 was documented as experiencing intermittent nausea in August, September, and October 2023. From 11/17/23 through 11/27/23, there were 13 progress note entries detailing R16 experiencing nausea and vomiting with limited ability to eat. The medical record documented a 16.6-pound weight loss from 11/15/23 through 11/30/23, a 9.4% loss of body weight. In December 2023, R16 was transferred and subsequently admitted to the hospital with venous stasis ulcers (wounds that result from blood flow problems in the veins) and cellulitis (a skin infection that can spread rapidly and cause serious complications). R16 returned to the facility from the hospital on 12/24/24. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	There were seven progress notes in January 2024 regarding R16 enduring nausea and vomiting. A progress note by the Registered Dietician (RD) on 1/12/24 described R16's intake as very poor. The note documented R16 was declining most meals and reporting lack of appetite despite the use of an appetite stimulant. The progress note documented, Noted MD is aware of continued poor appetite despite initiation of (a medication used to stimulate appetite) . Nausea and/or vomiting were documented fifteen times for R16 in February 2024, ten times in March 2024, nine times in April 2024, and twenty-eight times in May 2024. A progress note on 5/6/24 documented, in part: .very shaky, increased RR (respiratory rate) and heavy breathing .promethazine given at 10:00 a.m. which provided little to no relief. Stating 'I'm sick of being nauseous, I'm dry heaving, I'm so tired. Why can't I have something else for this nausea?' . Physician visit documentation for September 2023, October 2023, November 2023, December 2023, and January 2024 did not contain documentation of R16 experiencing nausea and vomiting. A physician visit note dated 2/7/24 read, in part: .she has occasional nausea .Reviewing the notes over the last month she has had really a fair amount of GI (gastrointestinal) upset .She is having a lot of nausea, is vomiting, unclear why .The weight loss at this rate is not good and she is getting a lot of (a medication used to treat nausea and vomiting) and having a lot of problems so we will get the labs and then decide . The documentation did not include any discussion with R16 regarding diagnostic testing or consultation with a physician specializing in disorders of the gastrointestinal (GI) system. A physician visit note dated 3/6/24 read, in part: .she has been having ongoing nausea . The documentation did not include a plan to address the nausea by offering to conduct diagnostic testing or referring R16 to a physician specializing in disorders of the GI system. On 4/5/24 the physician documented R16 had an episode of nausea, vomiting and diarrhea but that resolved . The documentation did not include a plan to address the nausea or offering R16 the opportunity for diagnostic testing or referral to a Gastroenterologist. The most recent physician's visit note in R16's record was dated 5/1/24 and read, in part: .reading the notes there is intermittent nausea although it seems, today anyway, being related to being moved in her bed and turned .Will treat her vertigo, which hopefully will help the nausea . The documentation did not document any discussion with R16 regarding consultation with a Gastroenterologist or obtaining diagnostic testing. R16's care plans did not contain a care plan for nausea and vomiting to provide staff with interventions to implement when R16 experienced nausea and vomiting. The medical record did not reveal a discussion with R16 regarding consultation with a specialist to determine and potentially treat the source of the nausea and vomiting, nor was R16 provided with an offer for diagnostic testing to potentially determine the source of the nausea and vomiting. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	The Director of Nursing (DON) and the Registered Nurse (RN) Supervisor L were interviewed on 6/5/24 at 8:05 a.m. The DON confirmed she was aware of R16 experiencing recurrent nausea and vomiting. The DON said R16's physician had ordered antiemetic medications, but admitted she was unaware if diagnostic testing or consultation with a specialist had been discussed with R16. RN L confirmed she was aware of R16 enduring persistent, intermittent nausea and vomiting and weight loss. When asked if consultation options or diagnostic testing was offered to R16, RN L said, I don't know. I'll have to look in the record. R16 was interviewed on 6/5/24 at 8:29 a.m. R16 was lying in bed with an emesis basin next to her. R16 said she was nauseated and said, I've been nauseated for so long. I just wish this was all over. R16 said her physician was in the facility today and had offered to conduct some testing. When asked if she was considering the testing, R16 said, It probably won't do any good because they'd have to move me and that would cause even more nausea. On 6/5/24 at 10:22 a.m., RN M and RN N were observed completing treatments to pressure injuries and moisture-associated skin damage (MASD) on R16's bilateral buttocks. R16 was rolled onto her left side to reveal two Stage 2 pressure injuries (partial-thickness loss of skin with exposed dermis, presenting as a shallow open ulcer) on the right gluteal cleft and one Stage 2 pressure injury on the left gluteal cleft. R16's bilateral buttocks were reddened and inflamed with skin erosion due to MASD. RN L was interviewed on 6/5/24 at 10:46 a.m. When asked if she had the opportunity to review R16's medical record to determine if R16 was offered consultation with a specialist or diagnostic testing to determine the root-cause of the nausea and vomiting, RN L said they had obtained labs and adjusted the medications for R16. RN L said they obtained lab results last week. A progress note of 5/25/24 at 2:06 p.m. was reviewed and read, in part: .Labs recently done WNL (within normal limits). When asked if the labs or medication adjustments had determined the source of the recurrent nausea and vomiting, RN L replied, The doctor is monitoring. RN L said R16's physician had spoken with R16 this morning and the physician said further diagnostic testing was not indicated. RN L said R16 declined any further actions to determine the source of the nausea and vomiting when the offer for diagnostic testing was offered to R16 on 6/5/24. When asked why diagnostic testing was not offered to R16 prior to 6/5/24, RN L said an overall decline had been experienced by R16. RN L said the decline included a change in appetite. She wasn't eating or thriving. When asked if R16 wasn't eating because of nausea and vomiting, RN L said, We were trying to deal with that with medications. When asked if the Medical Director had been made aware of the prolonged amount of time R16 had endured nausea and vomiting of an unknown cause, RN L replied, No, I don't think so. The Registered Dietician (RD) was interviewed on 6/5/24 at 11:08 a.m. The RD confirmed R16 had lost a significant amount of weight due to not eating. The RD said R16 had nausea and vomiting so she would refuse food, or eating would result in R16 vomiting. The RD said the interdisciplinary team had been discussing R16 going on comfort care measures or hospice. The RD said R16 started experiencing significant weight loss from nausea and vomiting in January 2024. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	R16's physician was interviewed on 6/5/24 at 11:22 a.m. The physician was asked what had been done to address R16's prolonged nausea and vomiting. The physician said she had made medication adjustments and said R16 had been on most of the available antiemetic medications. When the physician was asked what was causing the nausea and vomiting, she replied, I'll be honest with you - I don't know. She might have gastroparesis or a tumor or it could be anything. When asked if R16 had been afforded the opportunity for consultation with a Gastroenterologist or other specialist, or if diagnostic testing was offered, the physician said she offered R16 those options today, 6/5/24, and R16 had declined the offer. When asked why R16 was not provided with those options prior to 6/5/24 despite many months of nausea and vomiting with subsequent weight loss and wound development, the physician said, I think I did - I actually know I did - I don't know why I didn't document it. The physician reiterated R16's declination on 6/5/24 of further testing or consultations. The facility policy Significant Change Notification dated 1/4/23 read, in part: .Purpose: To assure that residents and/or their legal representative has the right to make choices about aspects of his/her care that will affect the quality of life of each resident .If the RN Supervisor or Charge Nurse is not satisfied that the physician's response will meet the resident's needs, then he/she may move up the chain of command to: . Medical Director . The DON was interviewed on 6/5/24 at 1:05 p.m. The DON was asked if the Medical Director had been made aware of the concerns with R16 and the prolonged duration of nausea and vomiting without being afforded the opportunity to find out the cause of the nausea and vomiting, the DON replied, No, not to my knowledge.

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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** 34568 Based on observation, interview, and record review, the facility failed to implement and maintain interventions to prevent the development and progression of pressure ulcers (a wound affecting skin, fat, and muscle tissues) for two Residents (#62, #113) of three residents reviewed for pressure injuries. This deficient practice resulted in the development of three stage II pressure ulcers and worsening of pressure ulcers. Findings include: Resident #62 (R62): Review of R62's Electronic Medical Record (EMR) revealed admission to the facility on [DATE] with diagnoses including a collapsed vertebra, muscle weakness, peripheral vascular disease, and diabetes. Review of R62's most recent Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15, indicative of being cognitively intact. Further review of the MDS, section M, revealed R62 did not have pressure ulcers present upon admission. Review of R62's Braden Scale admission assessment (a standardized assessment which calculates risk of pressure injury) on 5/2/24, revealed a score of 13.0, indicating R62 was at risk [for pressure ulcer]. An interview was conducted with R62 on 6/4/24 at 4:30 p.m. R62 stated that he has two pressure ulcers on his buttock that he did not have when he was admitted just over a month ago. R62 expressed frustration that he needs staff assistance to turn and reposition, his wheelchair is uncomfortable, and his feet cannot reach the floor causing pressure on his lower back and buttocks. R62 was currently lying on his back in his bed. On 6/5/24 at 10:40 a.m., R62 was observed sitting in his wheelchair requesting to use the restroom. R62's legs were noted to not be able to touch the ground with his right lower leg rubbing and pushing against the metal of his wheelchair. R62 stated that this causes him immense pain. R62 was transferred to the toilet and an observation of his wheelchair showed that his Roho cushion (device used on wheelchair seats to promote skin integrity) was noted to be deflated. An interview was conducted with Occupational Therapist (OT) S on 6/5/24 at 11:00 a.m., concerning R62's wheelchair. OT S stated that Roho cushions are checked every day but that R62's wheelchair was not the best fit for him. An interview was conducted with Physical Therapist (PT) T on 6/5/24 at 11:05 a.m. PT T stated that R62's wheelchair is lowered as far as it will go, but that his legs will still not touch the ground. PT T stated that R62 did have a smaller wheelchair at the time of admission, but it was too tight and causing pain and discomfort. R62 did have a power wheelchair and was assessed for safety from OT, but since R62 is requiring supplemental oxygen, this power wheelchair is not best suited for him. PT T explained that there are no custom wheelchair companies in the region and that R62 would either need to purchase a wheelchair for himself or that the therapy department could possibly ask the facility to purchase one. PT T observed the Roho cushion and stated that it was not inflated to the correct pressure. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of R62's plan of care revealed the following problem: At risk for skin breakdown R/t (related to): Nicotine dependence, Pacemaker, Type 2 DM (diabetes), Pain, Constipation, Sleep Apnea, Atherosclerotic heart disease, HTN (hypertension) A Fib (Atrial fibrillation), collapsed vertebra of lumbar region. Interventions were listed as: 1. BED: oversized width [NAME] air, keep linen clean, dry, and wrinkle free. Date Initiated: 5/2/24 2.Calmoseptine to scrotum, buttocks (slit), and glutes with cares and episodes of incontinence for protection, [medication name] pump lotion to dry areas w/ (with) cares. Date Initiated: 5/2/24 3.Elevate heels with dermasaver over foam pillow, derma boots to feet when in bed, oversized ROHO to recliner, blue heel protections to be on when in recliner, bedder foot pad to end of bed between mattress and sheet. Date Initiated: 5/2/24 4.Repositioning: Reposition every 2-3 hours when in bed or chair, avoid shearing residents' skin during positioning, transferring, and turning, elevate heels w/ derma over pillow. Date Initiated: 5/2/24 5. Weekly skin assessment to be completed for 4 weeks to observe skin for changes to the skin's integrity. Date Initiated: 5/2/24 Review of R62's Progress Notes revealed the following data: 1. 5/2/24: a) Mid buttock 8.5 cm(centimeter) scar with slight indentation noted. b) Buttock into rectum region: 6.5x3.5 cm blanching redness. 2. 5/6/24: a) No new skin issues or concerns b) Sacral slit area measuring .8 cm with red/blanching area. 3. 5/7/24: a) No new reported skin issues or concerns 4. 5/8/24: a) No new skin issues or concerns 5. 5/9/24: (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	a) Location of Wound - L (left) gluteal cleft. b) Type of Wound - Pressure c) Wound Stage: Stage II d) Wound Measurement - Length 1 cm, Width 1 cm e) Any Changes to Care Plan Interventions? No 6. 5/13/24: a) Location of Wound - L gluteal cleft b) Type of Wound - Pressure c) Wound Stage: Stage II d) Wound Measurement - Length 1.5 cm, Width 0.5 cm e) Any Changes to Care Plan Interventions? No 7. 5/20/24: a) Location of Wound - L gluteal cleft b) Type of Wound - Pressure c) Wound Stage: Stage II d) Wound Measurement - Length 1.1 cm, Width 1 cm e) Any Changes to Care Plan Interventions? No 8. 5/27/24: a) Location of Wound- L gluteal cleft b) Type of Wound - Pressure c) Wound Stage: Stage II d) Wound Measurement - Length 1.1 cm, Width 1 cm and superficial area .9 cm x .6 cm e) Any Changes to Care Plan Interventions? No 9. 5/29/24: (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	a) Location of Wound - Rt (right) gluteal cleft, medial #1 b) Type of Wound - Pressure c) Wound Stage: Stage II d) Wound Measurement - Length 2 cm x 1 cm, Depth .1 cm e) Any Changes to Care Plan Interventions? No 10. 5/29/24: a) Location of Wound - Rt Gluteal Cleft, lateral #1 b) Type of Wound - Pressure c) Wound Stage: Stage II d) Wound Measurement - Length 2 cm, Depth .1 cm, Width 1 cm e) Any Changes to Care Plan Interventions? No 11. 5/29/24: a) Location of Wound - L Gluteal Cleft b) Type of Wound - Pressure c) Wound Stage: Stage II d) Wound Measurement - Length 2 cm, Depth .1 cm, Width 1 cm e) Any Changes to Care Plan Interventions? No 12. 6/3/24: a) Location of Wound - Rt Gluteal Cleft Lateral #1 b) Type of Wound - Pressure c) Wound Stage: Stage II d) Wound Measurement - Length 1 cm, Depth .1 cm, Width .9 cm e) Any Changes to Care Plan Interventions? No 13. 6/3/24 (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	a) Location of Wound - Rt Gluteal Cleft medial #1 b) Type of Wound - Pressure c) Wound Stage: Stage II d) Wound Measurement - Length 1.5 cm, Depth .1 cm, Width 1.2 cm e) Any Changes to Care Plan Interventions? No 45123 On 6/5/24 at 9:30 AM, an observation was made of R62 during wound dressing changes completed by Registered Nurse Q. Wound measurements were as follows: a.) Right buttocks one open area (stage II) measuring 1.0-centimeter (cm) x 1.0 cm with surrounding redness 3.0 cm x 3.0 cm, b.) Left buttocks two open areas (stage II) measuring upper 1.0 cm x 0.5 cm and lower 1.0 cm x 0.4 cm with surrounding redness measuring 7.5 cm x 4.0 cm, c.) Intergluteal cleft from the coccyx to the anus open area (stage II) measuring 3.0 cm x 0.2 cm, d.) Right malleolus (unstageable) with eschar in the center measuring 1.6 cm x 0.6 cm and with surrounding redness measuring 4.9 cm x 4.2, e.) Left heel (deep tissue injury) measuring 2.7 cm x 0.6 cm with mild redness surrounding the area with a scab in the center and light purple in color. On 6/5/24 at 9:45 AM, R62 was asked if any of the wounds hurt or were tender to touch and replied, The one on my right ankle is sore to touch and my butt is really sore. I need to rest now and stabilize. On 6/5/24 at 10:00 AM, an interview was conducted with RN M in charge of wound care and was asked if R62 was admitted to the facility with all of his current open wounds and replied, No. He originally just had the one on his left heel and acquired the others after he was admitted to the facility. 49302 Resident #113 (R113) Review of R113's electronic medical record (EMR) revealed admission to the facility on [DATE] with diagnoses including a left femur fracture, history of transient ischemic attack (a temporary blockage of blood flow to the brain), and encephalopathy (a type of brain injury contributing to an altered mental status). Review of R113's Brief Interview for Mental Status (BIMS) assessment, dated 4/3/24, revealed a score of 3, indicative of severe cognitive impairment. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of Minimum Data Set (MDS) Section M, Skin Conditions, revealed R113 admitted to the facility with 2 stage II (tissue damage that affects the first two layers of skin) pressure ulcers and 1 unstageable deep pressure injury. Review of a Skin Assessment, dated 3/29/24, indicated R113 had two open stage II ulcers on the anterior left leg which measured 1.5 cm (centimeters) x 1.7 cm and 1 cm x 1.2 cm, respectively, and a deep tissue to the left heel measuring 2.6 cm x 3.5 cm. On 6/3/24 at 2:17 PM, an interview was conducted with R113 who was asked about the status of his wounds. R113 stated, It hurts. Review of a Wound Treatment Note dated 5/14/24 read, in part: .Location of Wound: Lt [left] heel . Signs of Symptoms of Infection: Odor, Increased Drainage . Any Change in Wound:? Worsened larger, blister popped, small drainage . .Lt shin with mild odor today, foul smelling . Lt heel-now opened d/t [due to] drainage noted on dressing . Review of a Wound Treatment Note dated 5/24/24 read, in part: .At this time, left shin now Stage 4 [pressure ulcer] down to what is perceived to be exposed tendon, shiny and white . Review of R113's EMR revealed no indication of physician follow-up after identification of R113's worsening wounds as indicated by Wound Treatment Notes on 5/14/24 and 5/24/24. On 6/5/24 at 11:30 AM, an interview was conducted with Wound Care Treatment Coordinator, Registered Nurse (RN) M who verified the worsening of R113's wounds since admission. RN M indicated a foul-smelling odor and/or increased drainage from a wound could be a sign of infection. When asked the reasoning behind the lack of physician follow-up in reference to the worsening of R113's wounds, RN M stated, I asked for an order for a wound care consultation referral from [Physician R] on 5/14/24 but never got a response. I asked again [for a wound care consultation referral] on 5/23/24 with no response . He [Physician R] is notorious for not coming in [to the facility] to sign orders and he doesn't like them faxed . I eventually had my supervisor contact him [Physician R] to forward it [wound care consult referral request] on . Review of email correspondence sent by RN M to Physician R revealed the following: 1. 5/14/24: PLEASE DICTATE ON THE FOLLOWING SKIN ISSUE: .Location of wound: lt heel . Type of Wound: Pressure . Pinpoint area to center of heel DTI [deep tissue injury] opened and drained scant serosanguinous drainage . Would you agree with a Wound Care Consult? 2. 5/23/24: PLEASE DICTATE ON THE FOLLOWING SKIN ISSUE: .Location of wound: left heel . Type of Wound: Pressure . Would you agree with a Wound Care Consult? Review of physician documentation did not address a wound care consult following the email communications from RN M on 5/14/24 and 5/23/24. (continued on next page)

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	235321	A. Building B. Wing	06/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marquette County Medical Care Facility	200 W Saginaw St Ishpeming, MI 49849

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of Nursing Progress Note dated 5/24/28, read: Skin: In to assess resident at this time. D/T not hearing a reply from multiple attempts to MD regarding Wound Care Consult, reached out to supervisor who will be contacting MD directly to discuss referral which family and treatment team is in favor of. Review of R113's Wound Care Consultation, dated 5/28/24, 14 days after initial identification of R113's wound progression, read, in part: .Wound #1 is located on left lower leg (distal shin). The aide with the patient is not sure how long the wound has been present for, just states that per [facility] nurses, that since developing the wound it has worsened . Wound #2 is located on left heel. The aide with the patient again is not sure how long this wound has been present for. This wound was not even listed on the paperwork brought in by the CNA [certified nursing assistant] from the facility . The aide wasn't sure with that (sic) the wound has been treated with; there is no mention in the accompanying documentation of what it's been being treated with .Wound #1/left distal shin .I suspect this is an arterial ulcer .non-pressure chronic ulcer .with unspecified severity . On 6/5/24 at 12:15 PM, an interview was conducted with the Director of Nursing (DON) regarding expectations for interdisciplinary communication regarding wound care/management. The DON stated the physician should be notified and should respond to progression of a wound in terms of size and signs and symptoms of infection including odor. The DON stated she was unsure why Physician R did not respond to the Wound Care Consult request despite rounding on R113 on 5/14/24. The DON was questioned regarding the facility protocol if the interdisciplinary team was unsatisfied with the physician's response. The DON stated, the medical director would be responsible for assisting but indicated the medical director was not notified in this case. The DON confirmed the 14-day lapse from the initial wound care consultation request on 5/14/24 to the wound care consult visit on 5/28/24 was considered a delay in treatment. Review of facility policy titled, Significant Change Notification, dated 1/4/23, read, in part: STANDARD: To ensure that a system exists for immediate notification for the resident's physician and legal representative when there is a change in psychosocial status, life threatening conditions, clinical complications, or a need to alter treatment significantly . The RN Supervisor/Charge Nurse may at any time prompt a clarification of orders. If the RN Supervisor or Charge Nurse is not satisfied that the physician's response will meet the resident's needs, then he/she may move up the chain of command: a. On-call RN b. DON/ADON [assistant director of nursing] or designee c. Medical Director d. Administrator . Review of facility policy titled, Skin Integrity Program, dated 7/18/23, read, in part: (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	.This facility is committed to reducing the risk of pressure injuries and the promotion of healing of existing pressure injuries . The MD [medical doctor] will be updated, following a nursing assessment, for changes in preexisting or new onset of co-morbid conditions affecting skin integrity . The attending physician will be notified of the presence or lack of healing of any pressure injuries .

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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** 34568 Based on observation, interview, and record review the facility failed to implement, update and revise comprehensive care plans to prevent falls for three Residents (#9, #26, #29) of three residents reviewed for falls. This deficient practice resulted in falls with major injury. Findings include: Resident #26 (R26) Review of R26's Electronic Medical Record (EMR) revealed admission to the facility on [DATE] with diagnoses including dementia, left femur fracture, and history of falling. Review of R26's 9/21/23 Minimum Data Set (MDS) assessment revealed a Brief Interview for Mental Status (BIMS) score of 11/15, indicative of mild cognitive impairment. Further review of R26's MDS revealed she had a fall with fracture prior to admission to the facility. Review of R26's Fall Risk Assessment, dated 9/15/23 and completed on 9/20/23 revealed R26 scored a 19 presenting as a high risk for falls. Plan of Care for R26 read, in part, Resident has a fall risk score of 19. She has a history of 1 fall within the past month resulting in current fracture. No falls since admission, she has not shown any impulsive behaviors. She is working with skilled therapy and remains capable of making her own independent decisions. She will be changed from a risk closely monitor, to a potential monitor for falls. Care plan updated. Review of R26's Plan of Care in October 2023 revealed the following problems: Alteration in cognition secondary to some underlying memory loss that is present - start date: 9/18/23. Potential Alteration in performing activities of daily living resulting in risk of self-care deficit and potential falls . start date: 9/15/23. Approaches for R26 included the following interventions: I am known to self-transfer despite reminders and encouragement to call for assistance - start date 10/5/23. Potential for falls, monitor - start date 9/20/23. Review of R26's Incident and Accident Reports revealed the following entry: (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	10/14/23 .Floor staff heard resident yelling for help while they were assisting another resident. Upon entering the room res (resident) was laying on the floor on her left side with her head towards the door and her legs toward her bed. WC (wheelchair) was next to armoire and walker was next to the foot of her bed. Res had been noted to be ambulating without walker this shift .Res ROM (Range of Motion) WNL (within normal limits) with all extremities with the exception of her LLE (Left Lower Extremity), LLE rotated outward and shortened. Res unable to move without pain and was guarding the lateral side of her left thigh about her knee where a mass was felt by writer upon assessment .Res agreed to be sent out to hospital for further evaluation . Review of R26's Hospital Discharge Summary dated 10/19/23 read, in part, Discharge Diagnosis: Oblique left periprosthetic distal femur fracture, s/p (status post) ORIF (open reduction internal fixation [surgical repair method]) on 10/15/23 . R26 returned to the facility on [DATE]. Review of R26's Current Plan of Care revealed the following problems: Alteration in cognition secondary to diagnosis of dementia with a recent progression of disease progress. Worsening insight, judgment and recall ability's .start date: 9/18/23. Alteration in performing activities of daily living resulting in risk of self-care deficit and potential falls .start date: 9/15/23. Approaches for R26 included the following interventions: Transfers and ambulates independently with a walker. Please encourage walker usage if seen walking without her assistive devices .start date: 4/19/24. Potential for falls, monitors, signs to encourage resident to use her walker by TV and bed in room .start date: 4/19/24. An interview was conducted with R26 and her daughter on 6/3/24 at 3:29 p.m. R26 stated that she has attempted most recently to not use her walker when getting out of bed to see if she, still can do it. An interview was conducted with the Director of Nursing (DON) on 6/5/24 at 11:17 a.m. The DON confirmed that when R26 had returned to the facility after her fall in October 2023, the facility's fall watch program was either not initiated or not documented correctly. The DON stated that the facility would normally do more interventions for residents who are at high risk for falls which would include 15-minute checks stating, They could have done more. The DON agreed that the pre and post fall interventions for R26 were not appropriate or adequate. 49735 Resident 9 (R9) Review of R9's Minimum Data Set (MDS) assessment, dated 5/9/24, revealed an admission to the facility on [DATE], with active diagnoses that included: urinary tract infection, dementia, anxiety, chronic obstructive pulmonary disease (COPD), and chronic kidney disease. R9 scored 11 of 15 on the Brief Interview for Mental Status (BIMS) reflective of moderate cognitive impairment. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of Resident Incident Report, dated 4/29/24, reflected R9 was found sitting on the bathroom toilet at 1:15 a.m. The staff were alerted by roommate that R9 had fallen and assisted self to a standing position and ambulated to the bathroom. R9 sustained a skin tear to left arm. A review of R9's care plan, revealed no interventions to reduce accidents/falls were added to R9's care plan. During an interview on 6/5/24 at 8:45 a.m., RN (Registered Nurse)/Rehab Coordinator K stated, The care plan was not updated as it was a Urinary Tract Infection (UTI) that caused the fall ., We don't update with each fall. During an interview on 6/5/24 at 11:25 a.m., the Director of Nursing (DON) acknowledged the care plan was not revised after R9's fall to prevent further accidents. Resident 29 (R29) Review of R29's MDS assessment, dated 3/14/24, revealed an admission to the facility on [DATE], with active diagnoses that included: diabetes mellitus, hypertension, heart failure, chronic kidney disease, and depression. R29 scored a 13 of 15 on the BIMS reflective of intact cognition. Review of R29's Incident Report, dated 2/12/24, revealed R29 was found on the floor in her room, and she fell trying to get out of bed. A review of R29's care plan, revealed no intervention to reduce accidents was added to R29's care plan. During an interview on 6/5/24 at 8:03 a.m., RN/Rehab coordinator K confirmed no interventions were added to R29's care plan . Review of R29's Incident Report, dated 4/16/24, revealed R29 rang call light and stated that R29 slid out of bed and fell to the floor. During an interview on 6/5/24 at 8:03 a.m., RN/Rehab Coordinator K stated, a treatment was added . and should have been added to her care plan, but it was not done. Review of Resident Incident Report, dated 4/23/24, revealed R29 fell in the doorway of another resident's room. R29 reported a head injury and a bump was noted to the back of R29's head. A review of R29's care plan, revealed no intervention to reduce accidents was added to R29's care plan. During an interview on 6/5/24 at 8:03 a.m., RN/Rehab coordinator K said, Changes are in the notes but not in the care plan. During an interview on 6/5/24 at 11:25 a.m., the DON acknowledged the care plan was not revised after R29's multiple falls to prevent further accidents. Review of policy titled, Fall/Fall Risk Program, read in part, .The facility will identify residents at risk for falls and develop interventions along with a plan of care to prevent falls. The facility will respond to resident's experiencing a fall by analysis/assessment, establishment of a plan of care, and monitoring of the effectiveness of the care plan. The Rehab Coordinator/designee will identify and initiate fall interventions with staff, resident, and or family input which will be reflected in the plan of care. Interventions will be monitored for effectiveness and adjusted as necessary .