STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235367	A. Building B. Wing	08/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Norlite Nursing Center	701 Homestead St Marquette, MI 49855

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35103 Based on interview and record review, the facility failed to assess and/or prevent or a significant weight loss for one Resident (R2), of three residents reviewed for nutrition. This deficient practice resulted in a significant weight loss of 12.9% within three weeks of admission to the facility for R2. Findings include: Review of R2's Face Sheet revealed the Resident was admitted on [DATE] from an acute care hospital with the following diagnoses, in part: fracture of lower end of right femur, orthopedic aftercare, cellulitis of right lower limb, fall on same level from slipping, tripping, and stumbling without subsequent striking against object, and pressure ulcer of unspecified buttock, Stage 2 . Review of R2's Minimum Data Set (MDS) Admission assessment, dated 7/18/24, revealed R2 had one Stage II pressure injury present upon admission, as well as a surgical wound. R2 scored 14 of 15 on the Brief Interview for Mental Status (BIMS) reflective of intact cognition. The Resident's height and weight were documented as 63 inches and 155 pounds, respectively. During a telephone interview on 8/15/24 at 4:25 p.m., Complainant M said R2 was transferred out of the facility because they were not satisfied with the care provided. Complainant M said [R2] lost weight while they were in the facility. Review of R2's weight vitals, revealed the following documentation of their weight while in the facility: 7/11/24 (Date of Admission): Weight 155 pounds, BMI 27.45 7/12/24: Weight 155 pounds, BMI 27.45 7/29/24: Weight 135 pounds, BMI 23.91 8/2/24: Weight 140 pounds, BMI 24.8 There was no evidence to show R2 was re-weighed to verify the significant 20 pound, 12.9% body weight reduction between 7/12/24 and 7/29/24. Review of R2's Electronic Medical Record (EMR) found no dietary progress notes, completed by Certified Dietary Manager (CDM) K, or Consultant Registered Dietitian (RD) L, available for review. (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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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/20/24 at 2:35 p.m., when asked about the completion of any dietary progress notes related to [R2], Assistant Dietary Manager (Staff) J said she was not responsible for any dietary progress notes and referred this Surveyor to CDM K. When asked if there was a dietitian that provided assessments for facility residents, Staff J stated, The dietitian doesn't come when I am here. She shows up, because she drops off paperwork. I don't know her name. She never introduced herself to me. During an interview on 8/20/24 at 2:40 p.m., the Director of Nursing (DON) was asked about the lack of dietary progress notes for R2. The DON said she would look into the matter and find whatever dietary information was available related to R2's significant weight loss. During an interview on 8/20/24 at 2:50 p.m., when asked about R2's significant weight loss, CDM K stated, What I was told is that it was an error from the hospital. It looks like weight loss like I have never seen before. They (nursing) sent me a note and they would send the physician a note as well. A copy of the note from nursing to CDM K was requested at that time. When asked what happens if someone experiences a significant weight loss. CDM said nursing would put it in a progress notes. When asked why there was not a progress note related to R2's significant weight loss, CDM K stated, Good question. CDM K said that he did not write a note about R2's significant weight loss because of the Significant Weight Loss policy, which required a referral to the dietitian, per CDM K. CDM K continued, Every month there is a dietary referral sheet. Nursing is responsible to put all the new admits on there for the dietitian. She (RD) comes about 2 weekends a month. CDM K was unaware if R2's significant weight loss had been assessed and/or addressed by Consultant RD L. During a telephone interview on 8/20/24 at 3:24 p.m., Consultant RD L was asked about assessment of R2's significant weight loss during the first few weeks in the facility. RD L stated, I will check my referral sheet. Usually, they put her on a list in the DON's office. There is a chance that she (R2) is on there (the list), and I didn't get to her yet. RD L stated, I don't even know how she could have lost that much weight. During an interview on 8/20/24 at 3:45 p.m., the DON acknowledged there was no progress note documentation in the Electronic Medical Record (EMR) for R2's significant weight loss. RN A, also present during the interview, provided a list of dietitian referrals for July 2024, revealing R2's name at the bottom of the list, documented as a New Admission. R2's name was not crossed off, indicating RD L had not completed a new admission dietary assessment of the Resident. No reference or indication of the 20-pound documented significant weight loss was present on the referral information line. The DON confirmed RD L had last been in the building on 8/7/24, but no dietary assessment based on the referral had been completed. The DON also acknowledged R2 had not received an RD or CDM dietary consult during the course of their stay in the facility (7/11/24 - 8/8/24) to address the significant weight loss or any other new admission concerns. Review of the Weight Management policy, last revision 11/2/16, revealed the following, in part: I. POLICY: To ensure proper weight measurement, prompt dietary notification and assessment of changes. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	II. PROCEDURE . The Skin Assessment sheets will already have the resident's prior weight noted on it by the Bath Nurse, so if a discrepancy of five (5) pounds or more is noted, the resident is to be re-weighed immediately. Both weights are to be recorded on the Skin Assessment sheet . The Bath Nurse will document the resident's weight and vital signs in Matrix, and make notifications, if necessary, as follows: 1. If resident's documented weight is more than a five (5) pound loss or gain, the Dietary Department will be notified by completing a Dietary Slip and forwarding it to the Food Service Director.

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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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35103 Based on interview and record review, the facility failed to provide pain management as prescribed by the physician consistent with professional standards of practice for one Resident (R2), of three residents reviewed for pain management. This deficient practice resulted in the consistent late administration of prescribed pain medication and non-administration of available PRN (as needed) pain medication to address R2's pain. Findings include: Review of R2's Face Sheet revealed the Resident was admitted on [DATE] from an acute care hospital with the following diagnoses, in part: fracture of lower end of right femur, orthopedic aftercare, cellulitis of right lower limb, fall on same level from slipping, tripping, and stumbling without subsequent striking against object, and pressure ulcer of unspecified buttock, Stage 2 . Review of R2's Minimum Data Set (MDS) assessment, dated 7/18/24, revealed R2 had one Stage II pressure injury that was present upon admission, as well as a surgical wound. R2 scored 14 of 15 on the Brief Interview for Mental Status (BIMS) reflective of intact cognition. Review of R2's Discharge, Return not Anticipated MDS assessment, dated 8/8/24, revealed the following documentation of pain: almost constant pain in the last five days, with the worst level of pain in the last five days noted as 10 (highest rating on pain scale). During a telephone interview on 8/15/24 at 4:25 p.m., Complainant M said R2 was transferred out of the facility because they were not satisfied with the care provided. Complainant M stated, [R2] went so long between her pain medications . Pain medication concern was expressed many times. I would call the nurses' station and ask to talk to the nurse on duty. [R2] would call me crying in pain, and it would take two hours after that to get the pain medication . the afternoon shift nurse was the problem with (getting) the pain medication. Review of R2's Physician Orders, retrieved 8/20/24 at 11:48 a.m., revealed the following prescribed pain medications: 1. Acetaminophen, 500 mg, every 6 Hours - PRN, Start Date: 7/11/24. 2. Cyclobenzaprine, (muscle relaxer) 10 mg, Three Times a Day - PRN. Start Date 7/11/24. 3. Fentanyl, Schedule II patch 72 hours; 50 mcg/hr (micrograms per hour), transdermal, Once a Day Every 3 days. Start Date 7/13/24. 4. Gabapentin, 500 mg, Three Times a Day. Start Date 7/11/24. 5. Hydrocodone-acetaminophen, Schedule II tablet; 7.5-325 mg; Special Instructions: To be given prior to therapy, therapy to work with resident between 8:00 am - 11:00 am correlate with therapy department to give medication appropriately. Once a Day 08:00 - 11:00 (8:00 a.m. to 11:00 a.m.). 6. Hydrocodone-acetaminophen, 7.5 - 325 mg, 1 tablet, oral, Every 4 Hours PRN. Start Date: 7/11/24. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R2's Progress Notes, retrieved 8/20/24 at 1:50 p.m., revealed the following, in part: 7/11/24 22:32 (10:32 p.m.) . Pain? Yes (Pain Scale) 10/10. 7/13/24 23:54 (11:54 p.m.) . Pain? Yes (Pain Scale) 5 . 7/14/24 18:15 (6:15 p.m.) . Pain? Yes (Pain Scale) (no rating documented) . 7/15/24 2:16 a.m., Res (resident) requested Norco at 2300 (11:00 p.m.) for pain. 7/15/24 13:42 (1:42 p.m.), A Care Conference was held for [R2] .[R2] did state that she would like to have her pain medication scheduled as she is waiting too long to receive them. She is wondering if she can have it scheduled to receive her pain meds before therapy . 7/17/24 0:00 (midnight), Res requested Norco at 2200 (10:00 p.m.). 7/22/24 16:34 (4:34 p.m.), Experiencing pain? Yes (pain scale) 10/10. 7/23/24 15:40 (3:40 p.m.), Experiencing pain? Yes (pain scale) 10. 7/23/24 23:31 (11:31 p.m.), At approximately 1915 (7:15 p.m.), staff was called in to see the resident to ask her if she would get up to the toilet to attempt to relieve herself of hard stool rather than on a bedpan. She (R2) adamantly declined, and stated, It takes so long to be seen around here, and my pain medication is late! 7/24/24 0:50 (12:50 a.m.), Pain? Yes (Pain Scale) 7/10 . 7/24/24 16:58 (4:58 p.m.), Pain? Yes (Pain Scale) 9/10 . 7/24/24 19:56 (7:56 p.m.), Pain? Yes (Pain Scale) 9 . 7/25/24 22:00 (10:00 p.m.), Pain? Yes (Pain Scale) 7 . 7/27/24 17:40 (5:40 p.m.), Pain? Yes (Pain Scale) 8/10 . 7/28/24 19:36 (7:36 p.m.), Pain? Yes (Pain Scale) 8/10 . 7/29/24 16:16 (4:16 p.m.), Pain? Yes (Pain Scale) 8/10 . 7/30/24 16:43 (4:43 p.m.), Pain? Yes (Pain Scale) 6/10 . 8/5/24 18:44 (6:44 p.m.), Pain? Yes (Pain Scale) 8/10 . 8/7/24 18:57 (6: 57 p.m.), Pain? Yes (Pain Scale) 7/10 . Review of R2's Medication History Report, for the duration of R2's facility stay (7/11/24 - 8/8/24) revealed the following pain medication documentation: (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. Gabapentin, Not Administered: Drug/Item Unavailable on 7/11/24 and 7/12/24 at 14:00 (2:00 p.m.) 2. Gabapentin, Late Administration, every day of stay, with the exception of 7/13, 7/18, 7/19, and 8/5/24. 3. Hydrocodone/acetaminophen, 7.5-325 mg, 1 tablet, once daily: Special Instructions: To be given prior to therapy, therapy to work with resident between 11:00 a.m. - 12:00 p.m., correlate with therapy department to give medication appropriately. Late Administration (given after 12:00 p.m.) on 7/16, 7/17, 7/22, 7/24, 7/28, and 7/29/24. 4. Acetaminophen tablet, 500 mg, every 6 Hours PRN; only administered one time, on the day of admission 7/11/24 at 12:02 p.m., for pain. 5. Cyclobenzaprine, 10 mg, Three Times a Day PRN, for Pain, was only administered one time daily, on 7/11, 7/12, 7/13, 7/18, and 7/25/24. 6. Hydrocodone/acetaminophen (Norco) tablet, 7.5-325, 1 tablet, every 4 Hours PRN for pain was administered, as follows: PRN 1: Administered on 7/11, 7/12, 7/13, 7/14, 7/15, 7/16, 7/17, 7/18, 7/20, 7/21 7/23, 7/24, 7/25, 7/26, 7/28, and 7/29/24. PRN2: Administered on 7/12, 7/13, 7/14, 7/15, 7/16, 7/18, 7/20, 7/24, 7/25, and 7/28. PRN3: Administered on 7/14/24. No Administration of PRN Norco was documented on 7/19, 7/22, 7/27, 7/30, 7/31, 8/1, 8/2, 8/3, 8/4, 8/5, 8/6, 8/7, or 8/8/24. Review of R2's Pain Care Plan, revealed the following: Problem Start Date: 7/25/24. Category: Pain, I have been having pain at times 10/10 since my fall and hospital stay. Goal . I would like my pain to be around a 2/10 at worst 5/10. Approach Start Date: 07/26/2024. Evaluate effectiveness of pain management interventions. Adjust if ineffective or adverse side effects emerge. Resident wears a fentanyl patch and is taking gabapentin. She can have PRN Tylenol and Hydrocodone . Approach Start Date: 7/25/2024. Encourage resident to request pain medication before pain becomes unbearable. Encourage resident to ask for pain medication when pain is around 5/10 and not wait until pain reaches 10/10 . Approach Start Date: 07/25/2024. Position for comfort with physical support as necessary . Review of the Pain Management policy, last revision 3/16/15, revealed the following, in part: (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	I. Policy: To ensure and provide pain management to residents in a consistent, timely, and safe manner that produces resident, family/representative, physician and caregiver satisfaction with resident comfort level. To assure effective communication between residents, nurses, caregivers, families/representatives, and physician through the use of pain assessment/management tools, resulting in optimal pain management. II. Procedure: A. A Pain Assessment will be performed by licensed staff: 1. Upon admission to the facility . 2. Quarterly, 3. Upon significant change(s) in condition, and 4. When the resident and/or family reports current or new pain. B. Resident preferences will be respected when determining methods to be used for pain management. C. Family members and/or resident representatives will be involved with pain management as appropriate. D. Pain will be re-assessed at: . 2. Each new report of pain by resident . The single, most reliable indicator of the existence and intensity of pain, and any resulting distress, is the resident's own verbalizations and/or behaviors. That is the basis of pain management. E. F. Re-Assessments of Pain 1. Continual assessment of pain is crucial. Changes in pain intensity and duration should trigger evaluation and modification of the treatment plan . Review of the Medications policy, last revision date of 9/20/19, revealed the following, in part: .D. must be given within one (1) hour of scheduled time . During an interview on 8/20/24 at 2:40 p.m., the Director of Nursing (DON) acknowledged awareness of R2's and Family Member N's concern with the late administration of Norco (pain medication). The DON stated, I got a phone call from the Ombudsman, and I spoke with [FM N]. [RN Supervisor A] and I had a conference call with [FM N], and I told her that I took full accountability (for the late administration of pain medication), and I would speak with her (R2's) nursing) staff. It continued to be late.