

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  235407	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/19/2025
NAME OF PROVIDER OR SUPPLIER  Kalkaska Memorial Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE  419 S Coral St Kalkaska, MI 49646	

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)
<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 49397</p> <p>This citation pertains to intake MI00150384.</p> <p>Based on record review and interview, the facility failed to notify the legal guardian of one Resident (#6) of one resident reviewed for notification of change in condition.</p> <p>Findings Include:</p> <p>Resident #6 (R6)</p> <p>A review of the medical record indicated R6 had a court appointed guardian, who was listed as the #1 emergency contact and a private caretaker who was listed as #2 emergency contact.</p> <p>A nurse's note on [DATE] at 6:33 PM charted by Registered Nurse (RN) A read in part: . (R6) deceased at 1333 (1:33 PM) today. (R6) had a bed bath at 1100. (R6) was wearing O2 (Oxygen) at 4 LPM (Liters Per Minute) via nasal cannula. (R6) was not awake during bath. (R6) resp (respiratory) were reg (regular) but he was blue when HOB (Head of Bed) was flat. O2 sat 72 on 4 LPM (R6) is on Hospice care for Pulmonary Hypertension. (R6) was bladder scanned at 1015 this am for 275 cc (cubic centimeters). (R6) was not (straight) cathed (catheterized) (a tube placed in body to drain urine). at 1330 (1:30 PM) Nurse and CENA (Certified Evaluated Nursing Assistant) went into (R6) room and found him sitting on the floor beside the bed leaning against the bed with O2 off. no resp rate or HR (Heart Rate) noted. (R6) was pronounced Dead at 1333. (R6) bed was in the lowest position and there was a mattress beside his bed that he was care planned to have due to his climbing out of bed and crawling to the door. the mattress was moved out of the way by him we think when he got out of bed. he was put back to bed with a hoyer lift and caregiver, guardian and sister called. Hospice also called. Guardian here to see him. organ donation called and they checked to see if tissue or eyes could be donated. they called back late afternoon and denied them. medical examiner called and told per hospice Dr. Medical examiner released the body. Morge (sic) called, and body picked released with glasses, stuffed cat and FBI hat at 1830(6:30 PM). belongings will be picked up by . his care giver on another day.</p> <p>While conducting an interview with RN A on [DATE] at 1:41 PM, RN A stated they had called the private caretaker, but was not the one who had contacted the guardian. RN A stated they believed it was nurse B who had called the guardian. This contradicts the nursing note that RN A had charted on [DATE].</p> <p>(continued on next page)</p>

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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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a phone interview on [DATE] at 1:43 PM, with R6's guardian C stated that the facility had not called to alert her to R6's death. Guardian C stated they had received a text message from the NHA that had said sorry for your loss, but the text didn't state who it was for, causing confusion to Guardian C. Guardian C stated the caregiver then texted asking if guardian C had received a phone call, to which guardian C responded they had not. The caregiver then asked guardian C to call them, at which time the caregiver notified guardian C of R6's death.</p> <p>On [DATE] at 2:02 PM a phone interview was conducted with nurse B regarding the death of R6. Nurse B stated they were a nurse float on [DATE]. Nurse B stated they were told not to call the guardian by someone, that person would call the guardian. Nurse B could not remember who that was. This revealed that there was no clear protocol in place to ensure responsible parties were contacted upon a resident's death.</p> <p>On [DATE] at 3:45 PM, the facility provided a Transfer and Discharge policy, that did not include protocols to perform upon a resident's death. The NHA (Nursing Home Administrator) and the Director of Compliance and Quality Assurance, Staff D, could not locate a policy related to notifications of a death. However, the NHA and Staff D provided a Death Checklist of Procedure. The NHA and Staff D indicated the nurses were expected to follow this procedure guide. The fifth task in the Death Checklist of Procedure stated: Charge nurse to notify and ask emergency contact located in My Unity under census, resident information and then related parties if he/she plans to come in, would like body released to funeral home and if belongings should be left in room or proved to the funeral home.</p>		