STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235407	A. Building B. Wing	07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kalkaska Memorial Health Center	419 South Coral Street 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)
F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure written consent and education was provided prior to administration of psychotropic medications for 5 Residents (#3, #8, #9, #40, & #72) of 5 residents reviewed for psychotropic consents. Findings include:Resident #9 (R9) A review of R9’s Electronic Medical Record (EMR) indicated R9 was admitted to the facility on [DATE] with diagnosis including dementia with behavioral disturbance. Review of R9’s orders indicated a physician order on 12/1/25 for “RisperiDONE (an atypical antipsychotic thought to work on certain parts of the brain) 0.5 mg (milligrams) Give 1 tablet by mouth two times a day for dementia w(with)/ BPSD (Behavioral and Psychological Symptoms of Dementia) replaces 1 tab daily d/t (due to) failed GDR (Gradual Dose Reduction) w/ relapsed verbal/physical agitation.” Further review of R9’s EMR indicated R40 had a legal guardian (a person appointed by a court to make decisions and care for another individual who is unable to do so themselves, whether due to age (minor) or incapacity (due to disability or other reasons)) responsible for her care within the facility. The EMR revealed psychotropic medications were initiated or continued without documentation of signed informed consents. There was no evidence in the EMR indicating risks, benefits, and alternatives to this medication were discussed with R9 and/or their guardian, and no consent forms were present in the clinical records. Resident #40 (R40) A review of R40’s EMR indicated R40 was admitted to the facility on [DATE] with diagnosis including dementia with behavioral disturbance. Review of R40’s orders indicated a physician order on 7/22/25 for “RisperiDONE Tablet 0.25 MG Give 1 tablet by mouth in the morning for dementia w/ bpsd replaces 0.5mg d/t stable bpsd and weakness w/ dysphagia ADR (Adverse Drug Reaction) AND Give 3 tablet by mouth at bedtime for dementia w/ bpsd give 0.75mg total.” Further review of R40’s EMR indicated a Durable Power of Attorney (DPOA, a legal document that allows a person to designate another person to make medical decisions on their behalf if they become unable to do so themselves due to illness, injury, or other circumstances.) was activated and in place for decision making in R40’s care within the facility. The EMR revealed psychotropic medications were initiated or continued without documentation of signed informed consents. There was no evidence in the EMR indicating risks, benefits, and alternatives to this medication were discussed with R40 and/or their DPOA, and no consent forms were present in the clinical records. On 7/30/25 at 10:32 AM, requested medication consents for R9 and R40 from the NHA (Nursing Home Administrator) and the DON (Director of Nursing), no medication consents were provided. (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
	235407	A. Building B. Wing	07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kalkaska Memorial Health Center	419 South Coral Street 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)
F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #8 (R8) Review of R8’s Minimum Data Set (MDS) assessment, submitted 5/2/2025, revealed initial admission to the facility 8/3/2020 with diagnoses including dementia with behavioral disturbance, anxiety disorder, and major depressive disorder. Review of R8’s July 2025 medication administration record (MAR) revealed the resident was actively prescribed and receiving the following medications Cymbalta Oral Capsule Delayed Release Particles [an anti-depressant medication], 20 mg [milligrams] with a start date of 11/7/24. Alprazolam 0.25 mg tablet [an anti-anxiety medication] with a start date of 4/22/25. Olanzapine 15 mg tablet [an antipsychotic medication] with a start date of 3/18/24. A review of R8’s EMR revealed no informed consent for Cymbalta, Alprazolam, nor Olanzapine. On 7/30/25 at 10:32 AM, psychotropic medication consents were requested for R8 from the NHA (Nursing Home Administrator) and the DON (Director of Nursing). No medication consents were provided by the time of survey exit. Resident #72 (R72) Review of the EMR revealed R72 was admitted to the facility on [DATE] and had diagnoses including Parkinson’s disease, dementia with psychotic disturbances, and major depressive disorder. Review of R72’s July 2025 MAR revealed the resident was actively prescribed and receiving the following medications: Wellbutrin XL (anti-depressant medication) 300 mg daily. Start date: 4/1/2024. Nuplazid (anti-psychotic medication) 34 mg daily at bedtime. Start date: 3/11/2025 Trazodone HCL (anti-depressant medication) 100 mg daily at bedtime. Start date: 1/27/2025 During review of R72’s EMR no informed consent for the Wellbutrin, Nuplazid or Trazodone could be located. Review of the physician’s progress note revealed no indication the medication regimen was discussed with the resident nor were there any informed consents completed for R72’s actively prescribed psychotropic medications to the resident/resident representative Resident #3 (R3) Review of the MDS assessment, submitted 5/16/2025, revealed R3 was admitted to the facility on [DATE] with diagnoses including psychotic disorder with delusions and major depressive disorder. Review of R3’s July 2025 MAR (medication administration record) revealed the resident was actively prescribed and receiving the following medications: Effexor XR (anti-depressant medication)150 milligram (mg) daily. Start date: 4/01/2024. Effexor XR 75 mg daily, give with Effexor XR 150 mg for total of 225 mg. Start date: 7/02/2025. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235407	A. Building B. Wing	07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kalkaska Memorial Health Center	419 South Coral Street 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)
F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Lurasidone HCL (anti-psychotic medication) 80 mg daily. Start date: 4/01/2024. Trazodone HCL (anti-depressant medication) 25 mg daily at bedtime. Start date: 7/01/2025. During review of R3’s EMR no informed consent for the Effexor, lurasidone or trazodone could be located. On 7/30/2025 at 2:41 p.m., the Nursing Home Administrator (NHA) presented a physician’s medication review, dated 4/02/2024. Review of the physician’s progress note revealed no indication the medication regimen was discussed with the resident or of informed consent for R3’s actively prescribed Effexor, lurasidone or trazodone being provided to the resident or her representative. During an interview on 7/30/2025 at 2:26 p.m., the Director of Nursing (DON) and the NHA were asked what the facility’s procedure was for obtaining informed consent for psychotropic medications. The NHA reported the facility had no formal process related to informed consent and discussions with resident and/or resident representatives related to medications were not consistently documented. The NHA confirmed no informed consent was obtained prior to starting psychotropic medications and no information was consistently being provided to residents in writing of the need for psychotropic medications, the potential side effects of the medications or alternative treatments available.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235407	A. Building B. Wing	07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kalkaska Memorial Health Center	419 South Coral Street 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)
F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235407	A. Building B. Wing	07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kalkaska Memorial Health Center	419 South Coral Street 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)
F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to follow physician orders for an upper extremity orthotic for one Resident (#1) of two residents reviewed for range of motion, positioning, and mobility. Findings include:Resident #1 (R1)Review of R1's electronic medical record (EMR) revealed a most recent admission to the facility on 5/24/25 with diagnoses including cerebral infarction (stroke) and hemiplegia (paralysis) affecting the left side. Review of R1s Minimum Data Set (MDS), dated [DATE], revealed a score of 14 on the Brief Interview for Mental Status (BIMS) assessment, indicative of intact cognition.On 7/29/2025 at 10:59 AM, an interview was conducted with R1 who confirmed he suffered a stroke with resulting deficits to the left side of his body. R1's left hand appeared to be edematous with minimal active movement. When asked about interventions for his left arm, R1 stated he was prescribed a left shoulder sling when out of bed for pain management due to a history of shoulder subluxation (when the head of the upper arm bone slips partially out of the shoulder socket).Review of R1's EMR revealed the following physician order, initiated 5/29/25: [Brand name] Sling should be worn when out of bed only.On 7/30/2025 at 11:47 AM, R1 was observed propelling himself in a wheelchair through the hall with his right arm and leg. R1's left arm was observed laying in his lap, without a sling, appearing edematous. When R1 was asked where his sling was, R1 stated, She [certified nursing assistant (CNA)] didn't put it on me. On 7/30/2025 at 3:09 PM, a follow-up interview was conducted with R1 regarding the location of the sling. R1 stated he hadn't seen this sling since he moved from a different unit on the facility approximately a month prior. When asked if R1 refused to wear the sling he admitted , I don't particularly like it, but I wouldn't refuse it. R1 confirmed he had continued discomfort in the left shoulder.On 7/31/2025 at approximately 7:23 AM, R1 was again observed wheeling down to the dining room for breakfast without a sling applied to his left upper extremity. R1's left arm was laying his lap, appearing edematous. On 7/31/2025 at 9:21 AM, an interview was conducted with Nurse Practitioner (NP) E regarding R1's left upper extremity sling. NP E verified she prescribed the left shoulder sling for increased comfort and support due to the flaccidity of R1's arm. When asked the potential outcomes of not wearing the sling when out of bed, NP E stated, increased pain in the left shoulder, for one. On 7/31/2025 at 9:52 AM, an interview was conducted with CNA F regarding orthotic care needs for R1. CNA F stated R1 had a left arm rest on his wheelchair but was unaware of any other care planned interventions for R1's left upper extremity. On 7/31/2025 at 9:55 AM, an interview was conducted with CNA G who was unaware of any care planned interventions for R1's left upper extremity.On 7/31/2025 at 9:56 AM, an interview was conducted with Registered Nurse (RN) H who stated she was unaware of any care planned interventions or orders for R1's left upper extremity.Review of R1's plan of care revealed no interventions for his left upper extremity.Review of R1's EMR revealed the following progress notes:5/21/25 at 1:20 PM: . Patient may benefit [NAME] [sic] shoulder sling on the left upper extremity.5/28/25 at 10:23 AM: .[R1] is having pain in the left shoulder for which he finds wearing his sling helpful .On 7/31/2025 at 11:14 AM, an interview was conducted with the Nursing Home Administrator (NHA) and Director of Nursing (DON) who verified orthotics should be provided as indicated by the physician order. The NHA and DON were also made aware the sling was not care planned properly, and the NHA and DON acknowledged it should have been. Review of the facility policy titled, Safety Device Use in Long Term Care, revised 2/18/25, read, in part: Purpose: To provide a process for safety devices used to maximize the independence and the maintenance of health and safety of an individual by reducing the risk of falls and injuries associated with the resident's medical symptoms. Posture devices:. these devices are used to enable a resident maintain proper body alignment. since most of the residents who will have a need for enablers are somewhat dependent on staff and restorative measures to maintain their current level of function, it is important that residents are visually checked regularly.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235407	A. Building B. Wing	07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kalkaska Memorial Health Center	419 South Coral Street 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)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview and record review, the facility failed to follow nursing standards of practice for wound care for one Resident (R5) of two Residents reviewed for pressure injuries. Findings include: Review of R5's Electronic Medical Record (EMR) revealed admission to the facility on 1/22/25 with diagnosis including peripheral vascular disease, unstageable pressure ulcer to left heel, and type 2 diabetes. R5 received a 15/15 on the Brief Interview for Mental Status (BIMS) score, indicating she was cognitively intact. On 7/29/25 at 11:05 a.m., R5 was observed sitting in her recliner chair with her left leg placed on top of a folded pillow and a blanket covering her. R5 stated that she was feeling well and confirmed that she had a pressure ulcer on her left heel and was heading to a doctor's appointment at 2:45 p.m. for the wound.On 7/30/25 at 9:54 a.m. an interview was conducted with Registered Nurse (RN) I who stated that R5 will be receiving a wound dressing change at 3:00 p.m. today. An interview with R5 confirmed this Surveyor could observe the wound dressing change. On 7/30/25 at 3:45 p.m. this Surveyor observed the wound dressing change for R5 with RN I and Nurse Technician/Staff J. RN I stated Staff J would be performing the wound dressing change. Staff J confirmed the physician order for R5, gathered supplies and sanitized prior to donning Personal Protective Equipment (PPE) which included gloves and a gown. Staff J entered R5's room and placed a barrier pad underneath residents left lower leg/foot area, removed R5's left shoe, and removed the wrap covering R5's wound placing it in the trash can. It was observed that gauze was still attached to the wound area on R5's left foot. Staff J then took a syringe with saline solution and began to soak the gauze and slowly began to peel it back exposing the wound bed. Once the gauze was fully off the wound bed, Staff J placed it in the trash can and began to apply the new gauze soaked with betadine on the wound. Staff J did not remove her soiled gloves or sanitize hands during the wound observation. After the observation, an interview was conducted with Staff J who confirmed her gloves should have been replaced after taking off R5's shoe and old gauze pad.An interview was conducted with the Nursing Home Administrator (NHA) on 7/31/25 at 10:30 a.m. who confirmed the observation of Staff J not removing soiled gloves was not the facility's standard of practice. Review of the Center for Disease Control and Prevention (CDC) Clinical Safety: Hand Hygiene for Healthcare Workers dated 2/26/24 read, in part, .When to change gloves and clean hands.If moving from work on a soiled body site to a clean body site on the same patient or if a clinical indication for hand hygiene occurs.