STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235432	A. Building B. Wing	01/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grayling Nursing & Rehab Community	331 Meadows Drive Grayling, MI 49738

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 - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49302 Based on interview and record review, the facility failed to obtain consent for a psychotropic medication prior to initiation for one Resident (#31) of five residents reviewed for psychoactive medications. Findings include: Resident #31 (R31) Review of R31's electronic medical record (EMR) revealed initial admission to the facility on [DATE] with diagnoses including cerebral infarction (stroke) and cognitive communication deficit. Review of R31's most recent Minimum Data Set (MDS) assessment, dated 1/9/25, revealed a Brief Interview for Mental Status (BIMS) score of 3, indicative of severe cognitive impairment. Review of R31's EMR revealed the following pharmacy order, initiated 1/10/25: Venlafaxine oral capsule [an antidepressant (psychotropic) medication], 112.5 mg (milligram), give 1 capsule, one time per day. On 1/15/25 at 8:37 AM, a phone interview was conducted with R31's legal guardian [Guardian D] who stated she had not signed a consent for psychotropic medication use nor was she educated on the risk and benefits. On 1/16/25 at 10:31 AM, an interview was conducted with Social Worker C who confirmed a psychotropic consent form for R31 had been, missed. On 1/16/25 at 1:00 PM, an interview was conducted with the Nursing Home Administrator (NHA) who confirmed residents who are prescribed a psychotropic medication should have a signed consent. Review of the facility policy titled, Psychotropic Medication Use, reviewed 1/2025, read, in part: .Residents and/or representatives will be educated on the risks and benefits of psychotropic medication use, as well as alternative treatments/non-pharmacological interventions .

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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49302 Based on interview and record review, the facility failed to notify the resident and/or resident representative in writing with the reason for a transfer out of the facility for one Resident (#35) of five residents reviewed for transfer and/or discharge. Findings include: Resident #35 (R35) Review of R35's electronic medical record (EMR) revealed initial admission to the facility on [DATE] with diagnoses including dementia and cognitive communication deficit. Review of R35's most recent Minimum Data Set (MDS) assessment, dated 1/5/25, revealed a Brief Interview for Mental Status (BIMS) score of 7, indicative of severe cognitive impairment. Review of the facility census report revealed R35 was hospitalized from 12/26/24 - 12/27/24 following a fall at the facility. On 1/16/25 at 10:38 AM, an interview was conducted with Business Office Manager (BOM) E who verified she was responsible for completing the necessary paperwork in the event a resident was transferred or discharged . BOM E confirmed R35 was hospitalized from 12/26/24 - 12/27/24 after a fall in the facility. BOM E stated a transfer notification had not completed for R35 as she was unaware of this requirement. On 1/16/25 at 1:00 PM, an interview was conducted with the Nursing Home Administrator (NHA) who verified the transfer notification process was not conducted in the facility as she was unfamiliar with the requirement. Review of the facility policy titled, Transfer and Discharge, reviewed 1/2025, read, in part: .when the transfer is initiated for the right reason, proper written notice will be provided to the resident. Written notice will contain the following content: Date notice is given to the Resident and Resident Representative, date of anticipated move, reason for the move, where the resident is to be moved, name, address, and telephone number of the ombudsman or other protection and advocacy agency as required or indicated by diagnosis, explanation of their right to appeal the transfer .

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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 - Minimal harm or potential for 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** 34568 Based on observation, interview and record review, the facility failed to provide a physician order, care plan, and implement interventions to aide with edema (swelling due to excess fluid trapped in the body tissues) for one Resident (#12) of two residents reviewed for non-pressure related skin conditions. This deficient practice resulted in the potential for increase pain, swelling, and increase risk of skin ulcers. Findings include: Review of R12's Electronic Medical Record (EMR) revealed admission to the facility on [DATE] with readmission on 8/29/24 and diagnosis including acute respiratory failure, type 2 diabetes, kidney failure, and muscle weakness. Review of R12's 12/15/24 Minimum Data Set (MDS) assessment revealed a score of 12/15 on the Brief Interview for Mental Status (BIMS) score indicating R12 was cognitively intact. In Section M of R12's 12/15/24 MDS assessment, R12 was marked as having Moisture Associated Skin Damage (MASD). An observation on 1/14/25 at 11:34 a.m. revealed R12 sitting in his recliner chair with his feet elevated using the footrest. R12's lower legs and shins were noted to be deep purple in color and swollen. An interview with R12 was conducted to which he stated that his legs can become very swollen and painful. There was no type of wrapping noted on his lower legs. An observation on 1/15/25 at 9:32 a.m. revealed R12 sitting in his recliner chair with his feet elevated watching television. R12's lower legs were a deep purple color and swollen. There was no wrapping noted on his lower legs. An observation on 1/16/25 at 11:00 a.m. revealed R12 sitting in his recliner chair with his feet elevated. R12 had an ACE wrap on his right lower leg and his left leg had no wrap and was deep purple and swollen. An interview was conducted with R12 who stated that sometimes the nurses will wrap his legs, but it doesn't happen very often. An interview was conducted with Licensed Practical Nurse (LPN) F on 1/16/25 at 11:10 a.m. LPN F stated that she did wrap R12's right leg as it appeared swollen. When asked if there was a physician order to wrap R12's legs with ACE wraps, LPN F reviewed R12's EMR and stated that there was not. Review of R12's Care Plans read, in part, .Problem Start Date: 12/21/23 Potential for fluid imbalance, fluctuating weights and edema r/t (related to) diuretic medication . There were no interventions to wrap R12's legs using ACE wraps. An interview was conducted with the Director of Nursing (DON) on 1/16/25 at 12:59 p.m. The DON confirmed that R12's legs should be wrapped daily with ACE wraps to help with his lower leg edema.

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F 0689 Level of Harm - Minimal harm or potential for 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** 49302 Based on observation, interview, and record review, the facility failed to ensure appropriate assessment, interventions, and supervision were in place after a hot liquid spill for one Resident (#48) of 7 residents reviewed for accidents and hazards. This deficient practice resulted in the potential for continued spills and subsequent burns. Findings include: Resident #48 (R48) Review of R48's electronic medical record (EMR) revealed initial admission to the facility on [DATE] with diagnoses including stroke, dementia, and osteoarthritis of both the left and right hands. Review of R48's most recent Minimum Data Set (MDS) assessment, dated 9/25/24, revealed a Brief Interview for Mental Status (BIMS) score of 10, indicative of moderate cognitive impairment. On 1/14/25 at 12:22 PM, R48 was observed at the lunch time meal consuming hot coffee out of a mug without a lid. Review of R48's EMR revealed the following progress note written by Registered Nurse (RN) G on 1/6/25 at 3:54 PM: Resident spilt hot coffee on his abdomen at breakfast . Abdomen slightly red . On 1/15/25 at 12:32 PM, R48 was observed at the lunch meal drinking coffee out of a mug without lid. R48 experienced difficulty grasping the mug handle as well as the fork, dropping yellow cake to the floor. On 1/16/25, at 8:40 AM, R48 was again observed drinking coffee out of a mug at the breakfast meal without a lid. On 1/16/25 at 10:48 AM, a telephone interview was conducted with RN G who verified she was working on 1/6/25 when R48 spilled hot coffee on his abdomen. When asked about typical facility procedure following a hot beverage spill, RN G stated, I should have completed an accident and incident report. RN G continued that typically, when a resident experiences a spill, a hot beverage assessment is conducted to assess if they require a lid or any other adaptive equipment to prevent future burns. When asked if this was completed after R48 experienced a spill, RN G replied, Not that I'm aware. Review of R48's EMR revealed the most recent Hot Food/Liquid Assessment was completed on 12/27/24. Review of R48's Occupational Therapy (OT) Evaluation, dated 1/8/25, revealed the following goal: (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Patient will exhibit improved fine motor coordination skills to facilitate patient's ability to perform functional grasp/release of daily living items .in order to facilitate follow-through with techniques and strategies and perform UB [upper body] ADLs [activities of daily living] with increased independence and safety with a baseline assistance level of, partial/moderate assistance. On 1/16/25 at 11:05 AM, an interview was conducted with the Director of Rehabilitation (DOR) H regarding R48's OT goals. DOR H stated R48 has really arthritic hands which contributed to R48 difficulty grasping and releasing daily living items including eating utensils, buttons, as well as cups and coffee mugs. On 1/16/25 at 11:26 AM, an interview with conducted with R48 who verified he experienced a coffee spill on 1/6/25. R48 stated, I have arthritis .my hands don't work! R48 confirmed he had difficulty holding on to eating utensils and coffee mugs stating, It's so painful. On 1/16/25 at 11:15 AM, an interview was conducted with the Director of Nursing (DON) who stated an accident and incident report was not completed because no injury occurred following the hot beverage spill despite the documented presence of skin redness. The DON confirmed R48 was not re-evaluated with a Hot Food/Liquid Assessment following the incident. After review of the OT assessment dated [DATE], the DON stated, He [R48] should probably have a lid. On 1/16/25 at approximately 1:00 PM, an interview was conducted with the Nursing Home Administrator (NHA) regarding R48's future safety with hot beverages. The NHA stated a Hot Food/Liquid Assessment was not completed following the coffee spill on 1/6/25 because the event was a, one-off. When asked how R48 was determined to not be at further risk of burn if a follow-up assessment was not completed, the NHA replied, It was discussed in IDT [interdisciplinary team meetings]. IDT meeting notes regarding R48's coffee spill incident was not provided to this Surveyor by survey exit. Review of the facility policy titled, Hot/Liquid Food Management, reviewed 1/2025, read, in part: It is the policy of this facility to manage resident consumption of hot liquids in order to prevent burns or resident injury . Residents will be evaluated upon admission, quarterly, and with change in condition for hot liquids and food spills . In the event of a burn event the following actions will be followed: . complete a 'Skin Incident Event' observation in the electronic medical record .