

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235447	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/21/2025
NAME OF PROVIDER OR SUPPLIER Douglas Cove Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 243 Wiley Road Douglas, MI 49406	

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 0908</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Keep all essential equipment working safely.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement regular device checks, monitor battery status, and complete functionality tests for their AED (automatic external defibrillator) machine in 1 of 3 residents (Resident #101) reviewed for essential equipment in safe operating condition, resulting in an inoperable device at the time of Resident #101's critical cardiac arrest emergency and the potential for essential equipment to not be operable in a time of need.</p> <p>Findings include:</p> <p>Review of an admission Record revealed Resident #101 was a female, with pertinent diagnoses which included: atherosclerotic heart disease of native coronary artery without angina pectoris (heart disease), other pulmonary embolism (blood clot in the lungs) without acute cor pulmonale (right-sided heart failure), and malignant neoplasm of anterior mediastinum (cancer in the space between the lungs in the chest).</p> <p>Review of Resident #101's Nursing Note dated [DATE] at 6:22 PM revealed, Note Text: Around 1758 (5:58 PM) CNA (Certified Nurse Aide N and M) called out at the N Hall nurses station that resident is not breathing, not responding to any stimuli. Code Blue (medical emergency, cardiac or respiratory arrest) called, and 911 called. 1800 (6:00 PM) Chest compressions started. 1803 (6:03 PM) First responder arrived, 1807 (6:07 PM) Paramedic arrived. 1808 (6:08 PM) Attach to lucas (a chest compression machine), 1810 (6:10 PM) more paramedics arrived .</p> <p>Review of Resident #101's Nursing Note dated [DATE] at 7:12 PM revealed, Note Text: Around 1850 (6:50 PM) resident out to (hospital name omitted) with paramedics, EMS. Husband was following the ambulance going to the (hospital name omitted).</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 0908</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on [DATE] at 1:45 PM, Director of Nursing (DON) B reported on [DATE] she had been in her office getting ready to leave for the day when she saw a CNA hurrying past the door. DON B reported Licensed Practical Nurse (LPN) G then called a Code Blue for Resident #101. DON B reported staff had confirmed that Resident #101 was a full code (cardio-pulmonary resuscitation (CPR) desired). DON B reported LPN Q had grabbed the crash cart (a cart with emergency supplies to respond to a medical emergency and code blue event) and LPN O grabbed the AED (a device used to shock the heart back into normal rhythm). DON B reported LPN Q and Registered Nurse (RN) F were performing CPR. DON B reported when they hooked the AED up to Resident #101, it did not turn on. DON B reported the first responding police officer had an AED that was then used on the resident. DON B reported the facility AED did not work because the battery was dead. DON B reported, at the time, the facility did not have a backup battery to install in the AED machine. DON B reported facility staff were supposed to check the AED machine every Sunday when they checked the crash carts and was not sure if there had been a disconnect on checking the AED machine.</p> <p>In an interview on [DATE] at 3:40 PM, RN F reported she had been performing CPR on Resident #101 with another nurse. RN F reported she and another nurse had put the AED contact pads on Resident #101 and when she (RN F) went to turn on the AED, it wouldn't turn on.</p> <p>In an interview on [DATE] at 12:55 PM, LPN O reported she was giving report around 6:00 PM on [DATE] when 2 CNAs yelled that Resident #101 was a Code Blue. LPN O reported another nurse had been performing CPR when she arrived and then she (LPN O) had switched off with that nurse and started performing CPR. LPN O confirmed that the facility AED machine did not work when they turned it on.</p> <p>On [DATE] at 1:47 PM, this surveyor requested evidence of AED functionality checks and backup battery availability from DON B. DON B looked at the Crash Cart Checklist (a listing of what items nursing staff was to check for the crash carts) and reported there was not a place on the checklist directing nurses to check the AED functionality. DON B suggested checking with the maintenance department to see if they had a record of the AED functionality checks.</p> <p>In an interview on [DATE] at 1:55 PM, Maintenance Director (MD) P reported he had been working at the facility for 3.5 months and had not been involved in checking the functionality of the AED and did not have evidence of functionality checks.</p> <p>In a follow-up interview on [DATE] at 2:03 PM, DON B confirmed that there was no documentation that the AED machine had been checked for functionality but assured this surveyor it would be added to the Crash Cart Checklist.</p> <p>In an interview on [DATE] at 2:39 PM, Nursing Home Administrator (NHA) A showed this surveyor an AED Inspection Log with the last entry of the AED being inspected on [DATE]. There was also a copy of a battery tag on the AED Inspection Log with the date of 3/2026 for the INSTL DATE and [DATE] for the EXP. DATE. NHA A reported she thought the date of [DATE] was when a battery had been installed in the AED machine and the date of 3/2026 was when the battery would be expired.</p>		