STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235447	A. Building B. Wing	07/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Douglas Cove Health and Rehabilitation	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)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46999 Based on observation, interview, and record review, the facility failed to provide equipment maintenance services in a dignified manner for 1 (Resident #29) of 5 residents reviewed for dignity, resulting in a potential for feelings of fear, frustration, and dehumanization. Findings include: Review of Dignity and It's Related Factors Among Older Adults in Long-Term Care Facilities Die [NAME], 8/21/21, published by the National Library of Medicine, revealed: Personal dignity is a type of dignity that relates to a sense of worthiness, individualistic, tied to personal goals and social circumstances, and can be taken away or enhanced by circumstances or acts from others . Personal dignity is important to understand, assess and preserve within the context of health care. Resident #29 Review of an Admission Record revealed Resident #29, was originally admitted to the facility on [DATE] with pertinent diagnoses which included: major depressive disorder, alzheimer's disease, cognitive communication deficit, and encephalopathy (a broad term for any brain disease that alters brain function). Review of a Minimum Data Set (MDS) assessment for Resident #29, with a reference date of 4/9/24 revealed the resident could sometimes make herself understood, and sometimes understood others. Review of a Care Plan for Resident # 29, with a reference date of 1/4/24, revealed a focus/goal/interventions: (Resident #29) has a communication problem r/t (related to) HOH (hard of hearing). Goal: (Resident #29) will be able to make basic needs known on a daily basis. Interventions: allow adequate time to respond, do not rush .ask simple yes/no questions . (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 7/16/24 at 9:41am, Resident #29 slept in her bed. Maintenance Assistant (MA) LL entered Resident #29's room without knocking, did not ask for permission and began working on Resident #29's bed as the resident slept. MA LL laid on the floor parallel to Resident #29's bed with the bed remote in hand, and remotely adjusted Resident #29's bed into several positions. MA LL elevated the head of the bed, then the lower half of the bed, then raised the height of the bed before ultimately lowering the bed back into a low, flat position. This process continued for 2 minutes. MA LL did not acknowledge Resident #29's presence throughout this process. Registered Nurse (RN) P came to the doorway of Resident #29's room and she and MA LL laughed about MA LL laying on the resident's floor. In an interview on 7/17/24 at 9:06am, Resident #29 reported she liked to be in her room, that the staff were friendly, and that she did not like to have her bed moved when she was in it. In an interview on 7/17/24 at 9:08am, Certified Nursing Assistant (CNA) BB reported it was important to support the dignity of each resident. When further queried, CNA BB reported maintenance work should never be completed on a resident's bed while they were in it, unless the resident approved it, because doing so would compromise the resident's dignity. In an interview on 6/17/24, at 10:40am, Maintenance Assistant (MA) LL reported she tried to work on resident beds when they were not in them but couldn't always get to it(maintenance work) when the resident was not in bed. MA LL reported some residents didn't mind having their bed worked on while they were in it and others were not aware enough to voice a concern. MA LL reported she at times completed maintenance work on resident's beds even while they slept in the beds if she felt they would sleep through anything. MA LL reported she did not always ask the resident for permission if they were cognitively impaired. Applying the reasonable person concept, though Resident #29 had decreased ability to verbally express her thoughts, MA LL actions resulted in Resident #29 being treated as an inanimate object, or has having no emotions or sensations, and these actions resulted the potential for Resident #29 to experience feelings of frustration, fear, and dehumanization.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47659 This citation pertains to intake number MI00143228 Based on interviews and record review, the facility failed to develop and/or implement policies and procedures for ensuring the reporting of a reasonable suspicion of a crime in accordance with section 1150B of the Act for 1 (Resident #195) of 1 residents reviewed for abuse resulting in an allegation of misappropriation not being thoroughly investigated. Findings include: Resident #195 Review of an Admission Record revealed Resident #195 was originally admitted to the facility on [DATE] with pertinent diagnoses which included diabetes. Review of Facility Reported Incident Investigation Guide dated 2/27/24 indicated that On 2/17/24, Resident #195 received notification from his bank (name redacted) to verify a purchase of $290 at (local store). Resident #195 reported that his wallet was missing to Registered Nurse (RN) P. RN P immediately reported the missing wallet to the Nursing Home Administrator (NHA) A. NHA A reported the missing wallet to the (local) police department.On 2/18/24, an officer from the (local) police department notified NHA A that he would be closing the case since the allegation took place in a different county and would need to be investigated by the police department of the county where the allegation occurred. During an interview on 7/18/24 at 12:49 PM, NHA A reported that she did not contact the police department in the county which the allegation occurred to open a new case. NHA A reported that she chose not to not contact the police department to open a new investigation because Resident #195's wallet had been found. NHA A confirmed that she was not able to determine if misappropriation had occurred because the investigation was closed by the (local) police department and not further investigated.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 41982 Based on interview and record review, the facility failed to identify and implement person-centered, non-pharmacological interventions for a resident receiving a psychotropic medication for 1 (Resident #17) of 5 residents reviewed for high-risk medication care planning, resulting in and the potential for unmet psychosocial needs. Findings include: Resident #17 Review of an Admission Record revealed Resident #17 was a female, with pertinent diagnoses which included: anxiety disorder, major depressive disorder, and dementia. Review of a current Physician's Order for Resident #17 revealed, FLUoxetine HCl Oral Capsule 10 MG (Fluoxetine HCl) Give 1 capsule by mouth one time a day for depression Pharmacy Active 8/7/2023 Review of a current Physician's Order for Resident #17 revealed, FLUoxetine HCl Oral Capsule 20 MG (Fluoxetine HCl) Give 1 capsule by mouth one time a day for depression Pharmacy Active 8/7/2023 Review of Resident #17's current Care Plan revealed a focus of (Resident #17) uses antidepressant medication r/t (related to) Depression with a revision date of 7/11/24; a goal of (Resident #17) will be free from discomfort or adverse reactions related to antidepressant therapy through the review date with a revision date of 1/24/24; and a total of 2 interventions which included Administer ANTIDEPRESSANT medications as ordered by physician. Monitor/document side effects and effectiveness Q-SHIFT (every shift) with a date initiated of 11/21/23 and Educate (Resident #17)/family/caregivers about risks, benefits and the side effects and/or toxic symptoms with a revision date of 11/21/23. In an interview on 7/18/24 at 2:36 PM, Social Services Director (SSD) F reported she was responsible for developing the care plans for residents who were prescribed antipsychotics, antidepressants, and antianxiety medications. SSD F reported person-centered, non-pharmacological approaches would be on the resident care plans listed as interventions. SSD F reported it would depend on the person as to what the interventions were, and that the interventions could be added to or revised as the staff learned new information about the resident. SSD F was queried about person-centered, non-pharmacological interventions to address Resident #17's depression. SSD F reviewed Resident #17's care plan with this surveyor and reported it definitely needed to be more individualized.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47659 Based on observation, interview, and record review the facility failed to ensure residents received ordered medications as scheduled for 1 (Resident #245) of 3 residents reviewed for medication administration and standards of practice, resulting in the potential for worsening of health conditions. Findings include: Review of an Admission Record revealed Resident #245 was originally admitted to the facility on [DATE] with pertinent diagnoses which included chronic obstructive pulmonary disease (COPD). Review of Resident #245's Orders revealed, .Xifaxan Oral Tablet 550 MG (Rifaximin) Give 1 tablet by mouth two times a day for diarrhea for 30 Days . During an observation and interview on 7/17/24 at 8:36 AM, Licensed Practical Nurse (LPN) N reported that the facility did not have Resident #245's Xifaxan medication, and therefore he would not receive the medication as ordered. LPN N reported that the medication that the medication had not been re-ordered, and the facility would need to wait for the pharmacy to deliver the medication. LPN N reported that the nursing staff were responsible for re-ordering medications. LPN N reported that she was not aware of why the medication had not been re-ordered for Resident #245. LPN N reported that the facility did not have this medication in back up stock, and the pharmacy would need to be contacted to get the medication delivered. Review of Resident #245's Medication Administration Report indicated that Resident #245 had missed two doses of the Xifaxan medication on 7/16/24 and one missed dose on 7/17/24. During an interview on 7/18/24 at 11:43 AM, Assistant Director of Nursing (ADON) D reported that nurses were responsible for ordering medications prior to the medication running out. ADON D reported that each medication blister pack had a blue column which indicated that the nurse would need to order the medication once they reached that column. ADON D reported that it was her expectation for nurses to reorder medications before they ran out, and for the nurses to contact the pharmacy promptly if they were missing a medication to ensure it was delivered. During an interview on 7/17/24 at 3:04 PM, LPN L reported that nursing staff were responsible for reordering medications and notifying the pharmacy and provider if a resident missed a medication and as ordered. LPN L reported that he discovered Resident #245 was missing his Xifaxan medication on 7/16/24 and was not able to administer his scheduled morning dose. LPN L reported that he had not contacted the pharmacy or physician about Resident #245's missing medication. Review of the Facility's Medication Reordering Policy last revised 12/2023 revealed, Policy: (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	It is the policy of this facility to accurately and safely provide or obtain pharmaceutical services including the provision of routine and emergency medications and biologicals in a timely manner to meet the needs of each resident .Policy Explanation and Compliance Guidelines: 1. The facility will utilize a systematic approach to provide or obtain routine and emergency medications and biologicals in order to meet the needs of each resident. 2. Acquisition of medications should be completed in a timely manner to ensure medications are administered in a timely manner. 3. Each time a nurse is administering medications and observes (6) or less doses left of one kind, that nurse will reorder the medication, time permitting .

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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** 46999 Based on interview and record review, the facility failed to ensure timely and consistent nutrition/hydration status assessment, monitoring, or reassessment in 1 (Resident #1) of 5 residents reviewed for nutritional care and services, resulting in unassessed nutritional status, inadequate monitoring and follow-up of resident deemed to be at nutritional risk, and the potential for unidentified weight loss, nutritional status decline, and unmet nutritional needs. Findings include: Review of Prevention and Treatment of Malnutrition in Older Adults Living in Long-Term Care, [NAME], PhD, RDN, CDN, published on 4/5/24 by the Journal of the Academy of Nutrition and Dietetics, revealed: Malnutrition in older adults can decrease quality of life and increase risk of morbidities and mortality. Accurate and timely identification of malnutrition, as well as subsequent implementation of effective interventions, are essential to decrease poor outcomes associated with malnutrition in older adults. Resident #1 Review of an Admission Record revealed Resident #1, was originally admitted to the facility on [DATE] with pertinent diagnoses which included: anoxic brain damage (brain damage that results when brain cells are deprived of oxygen), quadriplegia (loss of movement affecting all four extremities), and dysphagia (difficulty swallowing). Review of a Minimum Data Set (MDS) assessment for Resident #1, with a reference date of 6/25/24 revealed a Brief Interview for Mental Status (BIMS) score of 15/15 which indicated Resident #1 was cognitively intact. Section K of the MDS revealed Resident #1 was on a mechanically altered diet. Section M of the MDS revealed Resident #1 was deemed at risk for the developing pressure ulcers. Review of a Care Plan for Resident # 1, with a reference date of 4/4/23, revealed a focus/goal/intervention of: Focus: (Resident #1) has unplanned weight loss r/t (related to) variable meal intake, refusals of supplements .Goal: (Resident #1) will remain stable with no significant weight changes through next review. Interventions .if weight decline persists, contact physician .monitor and evaluate weight loss .monitor food intake .RD (Registered Dietitian) to evaluate and make diet change recommendations . Review of a facility policy titled Nutritional Management with a reference date of 12/23 revealed: A comprehensive nutritional assessment will be completed by a dietitian within 72 hours of admission, annually, and upon significant change in condition. Follow-up assessments will be completed as needed. Review of the Nutritional Status Review assessments completed for Resident #1 in the last twelve months revealed Resident #1's nutritional needs were assessed on 9/1/23, 3/15/24 and 6/24/24. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 7/17/24, at 1:44pm, Registered Dietitian (RD) GG reported a Nutritional Status Review should be done for each resident on a quarterly basis at a minimum to ensure their nutritional needs are being met. RD GG reported during quarterly nutritional assessments, the dietitian evaluates a resident's need for change in a therapeutic diet, need for dietary supplements related to weight loss and/or wound healing, as well as the resident's food intake. When further queried about the nutritional assessments completed for Resident #1 in the last 12 months, RD GG reported an assessment should have been completed for Resident #1 in December 2023 but did not appear to have been done. RD GG reported the lack of assessment resulted in a potential for unmet nutritional needs, unaddressed weight loss, and ultimately a worsening of the resident's overall health.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41982 Based on interview and record review, the facility failed to ensure the attending physician reviewed and responded to the consultant pharmacist's monthly medication regimen review (MRR) irregularity report recommendations for 2 (Resident #17, Resident #8) of 5 residents reviewed for medication regimen review, resulting in the registered pharmacist's recommendations not being addressed and the potential for negative medication side effects resulting from unaddressed recommendations. Findings include: Review of the policy Addressing Medication Regimen Review Irregularities with a Date Implemented of 12/2023 revealed, Policy: It is the policy of this facility to provide a Medication Regimen Review (MRR) for each resident in order to identify irregularities and respond to those irregularities in a timely manner to prevent the occurrence of an adverse drug event .Policy Explanation and Compliance Guidelines .4. The pharmacist must report any irregularities to the attending physician, the facility's medical director and director of nursing, and the reports must be acted upon .b. Any irregularities noted by the pharmacist during this review must be documented on a separate, written report which may be in paper or electronic form .d. The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record . Resident #17 Review of an Admission Record revealed Resident #17 was a female, with pertinent diagnoses which included: anxiety disorder, major depressive disorder, and dementia. Review of a current Physician's Order for Resident #17 revealed, FLUoxetine HCl Oral Capsule 10 MG (Fluoxetine HCl) Give 1 capsule by mouth one time a day for depression Pharmacy Active 8/7/2023 Review of a current Physician's Order for Resident #17 revealed, FLUoxetine HCl Oral Capsule 20 MG (Fluoxetine HCl) Give 1 capsule by mouth one time a day for depression Pharmacy Active 8/7/2023 Review of Resident #17's Pharmacy Progress Note dated 3/7/24 at 9:47 PM revealed, Note Text: Monthly medication regimen reviewed performed: Comments /Recommendation noted - please see report. On 7/17/24 at approximately 10:30 AM, this surveyor reviewed Resident #17's electronic medical record for said pharmacy recommendation report. No report was found at which time Nursing Home Administrator (NHA) A was requested to provide the report to this surveyor. On 7/17/24 at 11:10 AM, NHA provided, electronically, Resident #17's pharmacy recommendation report. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the Resident #17's pharmacy recommendation report that was provided by NHA A revealed, Note To Attending Physician/Prescriber .MRR Date: 3/7/2024 .Medication: Fluoxetine for depression start 8/6/2023 .Federal guidelines state antipsychotic drugs should have an attempt at a gradual dose reduction (GDR) twice per year for the first year in 2 different quarters with at least 1 month between attempts, then annually thereafter. Please consider a GDR unless clinically contraindicated per documentation. The report provided an area for Physician/Prescriber Response with check boxes for Agree, Disagree, Other, lines for physician to document additional response information, physician signature, and date. The Physician/Prescriber Response area was left blank. In an interview on 7/17/24 at approximately 11:30 AM, NHA A was notified that the report that had been provided to this surveyor electronically was blank in the Physician/Prescriber Response area and that this surveyor would need to review the copy of the report that had been addressed by the physician. NHA A reported Medical Records Clerk (MRC) K would be the one to ask for that. In an interview on 7/17/24 at 11:37 AM, MRC K was requested to provide a copy of the Note To Attending Physician/Prescriber .MRR Date: 3/7/2024 report for Resident #17 that included the physician response. MRC K reported did not have that document. MRC K reported the doctors' stuff that needed to be scanned was put in the front office and she collected it daily during the week and scanned it into the resident electronic chart. MRC K reported she did not see any pharmacy recommendation reports for Resident #17 in her electronic medical record for that date. In an interview on 7/18/24 at 10:46 AM, Assistant Director of Nursing (ADON) D was queried about the process for physician response to pharmacy recommendations. ADON D reported that pharmacy submitted their reports to the facility, the facility printed the reports and put them into the physician box for review. ADON D reported the physician would then review the reports, would either approve (agree) or disagree with the recommendation on the report, and then hand it to a nurse who would then make any changes in the computer and put the signed report in the front office for collection by medical records to scan into the chart. In an interview on 7/18/24 at 12:45 PM, Consultant Pharmacist (CP) C was queried as to whether there had been a response to Resident #17's Note To Attending Physician/Prescriber .MRR Date: 3/7/2024 from the physician. CP C reported the 3/7/24 pharmacy recommendation for Resident #17 was still pending for pharmacy meaning that there had been no response noted. On 7/18/24 at 1:56 PM, facility NHA was again requested to provide this surveyor with evidence of the Physician/Prescriber Response to Resident #17's 3/7/24 Note To Attending Physician/Prescriber report. No documentation was provided to this surveyor prior to survey exit. 47659 Resident #8 Review of an Admission Record revealed Resident #8 was originally admitted to the facility on [DATE] with pertinent diagnoses which included schizophrenia and depression. Review of Resident #8's Orders revealed, Risperidone (Antipsychotic medication) oral 2 mg. Give 1 tablet by mouth one time a day related to schizophrenia . (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #8's Monthly Medication Review Recommendations dated 4/10/24 reveled, Medication: Risperidone. Antipsychotic medications may induce hyperlipidemia. Please consider obtaining a fasting lipid panel at next lab draw . The physician/prescriber response was noted to be incomplete. During an interview on 7/18/24 at 11:43 AM, Assistant Director of Nursing (ADON) D reported that she was not able to find any response in Resident #8's electronic health record (EHR) that indicated that the provider had reviewed and responded to the April 2024 pharmacy recommendation. ADON D reported that Resident #8 did not have orders for a fasting lipid panel lab to be completed. During an interview on 7/18/24 at 1:33 PM, Nurse Practitioner (NP) OO reported that Resident #8 did not have a fasting lipid panel lab completed. NP OO reported that if she or any other provider had been made aware of the pharmacy recommendation, their signature and response would have been on the form, and since there were no signatures or responses on the form, she could not confirm that the pharmacy recommendation had been reviewed. During an interview on 7/18/24 at 12:42 PM, Consulting Pharmacist (CP) C reported that the April 2024 monthly medication recommendation for Resident #8 had not been completed, and they did not receive a response back from the facility provider.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41982 Based on interview and record review, the facility failed to attempt a required Gradual Dose Reduction (GDR) of an antidepressant medication, in the absence of a documented contraindication, for 1 (Resident #17) of 5 residents reviewed for unnecessary medications, resulting in the potential that the resident is receiving the medication at an unnecessary dose or for an unnecessary length of time. Findings include: Resident #17 Review of an Admission Record revealed Resident #17 was a female, originally admitted to the facility on [DATE], with pertinent diagnoses which included: anxiety disorder, major depressive disorder, and dementia. Review of a current Physician's Order for Resident #17 revealed, FLUoxetine HCl Oral Capsule 10 MG (Fluoxetine HCl) Give 1 capsule by mouth one time a day for depression Pharmacy Active 8/7/2023 Review of a current Physician's Order for Resident #17 revealed, FLUoxetine HCl Oral Capsule 20 MG (Fluoxetine HCl) Give 1 capsule by mouth one time a day for depression Pharmacy Active 8/7/2023 A review of Resident #17's Medication Regimen Review (MRR) pharmacy recommendation report dated 3/7/24 revealed, Note To Attending Physician/Prescriber .MRR Date: 3/7/2024 .Medication: Fluoxetine for depression start 8/6/2023 .Federal guidelines state antipsychotic drugs should have an attempt at a gradual dose reduction (GDR) twice per year for the first year in 2 different quarters with at least 1 month between attempts, then annually thereafter. Please consider a GDR unless clinically contraindicated per documentation. In an interview on 7/17/24 at 10:06 AM, Social Services Director (SSD) F reported she provided the social work and admissions services for the facility. SSD F was queried on the GDR history of Resident #17's Fluoxetine HCl (an antidepressant) use. SSD F reviewed Resident #17's electronic medical record and physician's order history and reported it didn't appear that there had been a GDR attempted for Resident #17 but that there should have been. SSD F reported the Interdisciplinary Team (IDT) reviewed resident medications for needed GDRs during the Risk Meetings and that it was normally the contracted behavioral health service or the resident physician that would make the GDR recommendations. SSD F reported she did not track the resident medications for the required GDRs. SSD F reported Resident #17 was not seen by a contracted behavioral health service. In an interview on 7/18/24 at 10:46 AM, Assistant Director of Nursing (ADON) D was queried as to whether or not Resident #17 had received a required GDR for her antidepressant Fluoxetine. ADON D reviewed Resident #17's electronic medical record and reported she did not see a GDR for this resident. ADON D reported the IDT kept track of the GDRs and the physicians made the recommendations. ADON D reported GDRs were not something she had been a part of keeping track of. (continued on next page)

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	235447	A. Building B. Wing	07/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Douglas Cove Health and Rehabilitation	243 Wiley Road Douglas, MI 49406

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 7/18/24 at 12:19 PM, Nursing Home Administrator (NHA) A reported nursing (referring to the Director of Nursing (DON) and ADON) kept track of the GDRs and that they were reviewed during the IDT meeting. The Director of Nursing was not available for interview during the survey. On 7/18/24 at 12:56 PM, Resident #17's electronic medical record was reviewed for evidence of a documented contraindication to a GDR of Fluoxetine for this resident. No such documentation was found.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 41982 Based on observation, interview, and record review, the facility failed to ensure residents received the correct foods as outlined on the planned, posted menu resulting in the potential for dissatisfaction with meal service and feelings of frustration. This deficient practice has the potential to affect all residents who consume food from the kitchen, out of a total census of 49. Findings include: Review of the Resident Meal Menu for 7/16/24 revealed: Breakfast - Juice of Choice, Bacon, Cereal of Choice, French Toast, Milk of Choice, 8 oz (ounces), Coffee, Syrup / Margarine / Creamer Lunch - Ravioli Baked, Italian [NAME] Beans, Bread Sticks, Apple Crisp, Beverage of Choice Supper - Tuna Melt Grilled Sandwich, Sweet Potato Fries, Creamy Cucumbers, Mandarin Oranges, Beverage of Choice, Milk of Choice, 8 oz During a dining observation on 7/16/24 at 12:40 PM on the A Hall, noted that none of the meal trays contained breadsticks as was outlined on the posted menu for that meal. In an interview on 7/16/24 at 4:03 PM, Dietary Manager (DM) H confirmed that residents had not been served breadsticks at lunch because the breadsticks hadn't gotten pulled from the freezer. DM H also reported that a tuna melt sandwich was on the menu for the supper meal that evening but because those sandwiches didn't hold up well on meal trays, they were going to make tuna noodle casserole instead. (It should be noted that at the time of the interview, the posted menu had not been updated to reflect the planned change to tuna noodle casserole.) In an interview on 7/16/24 at 9:22 AM, Resident #39 reported he did not get bacon on his breakfast tray that morning but that the menu had listed bacon as part of the meal. Resident #39 reported he had received his French toast and oatmeal, but no bacon and he was concerned because he had not gotten a protein source for that meal. In a follow-up interview on 7/17/24 at 2:49 PM, Resident #39 reported he had not received milk for lunch the day before even though that had been his beverage of choice. Resident #39 reported staff had said there was only a little bit of milk left and they needed to conserve it for the breakfast the following morning. Resident #39 reported it was frustrating when he did not receive what he ordered and when he did not receive what was on the menu. In an interview on 7/17/24 at 2:53 PM, Resident #16 reported the kitchen had run out of things at times resulting in residents not being served what was on the menu. Review of Resident Council Meeting Minutes of 7/12/24, Comment revealed, The menu and food we are served are completely different. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	In a follow-up interview on 7/17/24 at 10:54 AM, DM H was queried on resident report of not receiving bacon for breakfast on 7/16/24 per the posted menu. DM H reported the cook had burned the bacon on Monday and, as a result, there was not enough bacon for breakfast on Tuesday. DM H was queried on resident report of staff needing to conserve milk for breakfast. DM H reported they were unable to purchase single-serve pints of milk and had to purchase gallons instead. DM H reported because he was new to the position, he was still trying to determine how many gallons of milk to purchase to have enough while not over-purchasing and wasting it. DM H reported he had told the staff if there was only enough milk for one meal service before the next milk delivery came, to save it for breakfast.

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 38905 Based on observation, interview, and record review, the facility failed to maintain sanitary conditions in the kitchen resulting in the potential to spread food borne illness to all residents that consume food from the kitchen. Findings Include: During the initial tour of the kitchen, at 9:15 AM on 7/16/24, it was found that the walk in coolers were dark and hard to see, especially in the back of the unit. When a flashlight was used, heavy accumulation of black debris was evident on the floor perimeter and especially around the wheels and rack legs of the storage shelves. When asked if he was aware of the black accumulation, Dietary Manager (DM) H stated it was hard to see until the flashlight was used. During the initial tour of the kitchen, at 9:50 AM on 7/16/24, it was observed that the clean utensil drawers, located under the preparation table, were found with excess crumb debris on the inside of the drawer. Staff were using parchment paper as a bottom barrier in the drawer. The paper looked old and discolored with no date to indicate when it was changed last. DM H was unsure when it had been changed. During a revisit to the kitchen, at 3:00 PM on 7/16/24, a Digital [NAME] meter was used to determine the amount of visible foot candles of light register in the walk-in cooler and freezer. Putting the Digital [NAME] meter 30 inches off of the floor, directly under the walk in cooler and freezer light, found they produced between 10.3-14.2 foot candles. When moved to the back of each walk-in unit and measured 30 inches off of the floor (near the condenser), the digital lux meter read between 0.5-2.1 foot candles of light. According to the 2017 FDA Food Code section 4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils. (A) EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be clean to sight and touch. (B) The FOOD-CONTACT SURFACES of cooking EQUIPMENT and pans shall be kept free of encrusted grease deposits and other soil accumulations. (C) NonFOOD-CONTACT SURFACES of EQUIPMENT shall be kept free of an accumulation of dust, dirt, FOOD residue, and other debris. According to the 2017 FDA Food Code section 6-501.12 Cleaning, Frequency and Restrictions. (A)PHYSICAL FACILITIES shall be cleaned as often as necessary to keep them clean . According to the 2017 FDA Food Code section 6-303.11 Intensity. The light intensity shall be: (A) At least 108 lux (10 foot candles) at a distance of 75 cm (30 inches) above the floor, in walk-in refrigeration units and dry FOOD storage areas and in other areas and rooms during periods of cleaning . (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview with DM H, at 9: 18 AM on 7/16 24, it was found that the facility does not cool food very often. At this time, observation of a gallon container of apple crisp was found stored in the walk-in cooler, tightly covered with a top, with heavy condensation on the inside of the container. Upon seeing the item cooling DM H opened the top to allow it to vent. When asked what the item was used for, DM H stated it was apple crisp from Breakfast this morning. A temperature was taken at this time and found the item to be 95. 5F. A return visit to the kitchen, at 12:01 PM on 7/16/24, found the apple crisp in the same position in the walk-in cooler with no apparent additional ways to help rapidly cool the product. At this time a temperature was taken with a rapid read thermometer and found the item to be 69.8F. An interview with DM H at this time found the item should have reached 70F within two hours of cooling. According to the 2017 FDA Food Code section 3-501.14 Cooling. (A) Cooked TIME/TEMPERATURE CONTROL FOR SAFETY FOOD shall be cooled: (1) Within 2 hours from 57 C (135 F) to 21 C (70 F); and (2) Within a total of 6 hours from 57 C (135 F) to 5 C (41 F) or less . According to the 2017 FDA Food Code section 3-501.15 Cooling Methods. (A) Cooling shall be accomplished in accordance with the time and temperature criteria specified under S 3-501.14 by using one or more of the following methods based on the type of FOOD being cooled: (1) Placing the FOOD in shallow pans; (2) Separating the FOOD into smaller or thinner portions; (3)Using rapid cooling EQUIPMENT; (4) Stirring the FOOD in a container placed in an ice water bath; (5) Using containers that facilitate heat transfer; (6) Adding ice as an ingredient; or (7) Other effective methods. (B) When placed in cooling or cold holding EQUIPMENT, FOOD containers in which FOOD is being cooled shall be: (1) Arranged in the EQUIPMENT to provide maximum heat transfer through the container walls; and (2) Loosely covered, or uncovered if protected from overhead contamination as specified under Subparagraph 3-305.11(A)(2), during the cooling period to facilitate heat transfer from the surface of the FOOD. During the initial tour of the kitchen, at 9:22 AM on 7/16/24, observation found that ice accumulation in the walk-in freezer door impedes the doors ability to fully close. An interview with DM H found that ice tends to building up around the door and inside the unit some. Staff must watch for and break down the ice in the corner of the door in order to get it to close properly. During the initial tour of the kitchen, at 9:44 AM on 7/16/24, it was observed that the gasket to the single door True cooler was found with large rips and tears in the gasket seal along the top and side of the door. During the initial tour of the kitchen, at 10:00 AM on 7/16/24, it was observed that the atmospheric vacuum breaker, on the back of the dish machine, was missing its top cap which compromises the integrity of the vacuum breaker. According to the 2017 FDA Food Code section 6-501.11 Repairing. PHYSICAL FACILITIES shall be maintained in good repair.

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F 0880

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Many

Provide and implement an infection prevention and control program.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 46999

Based on observation, interview, and record review the facility failed to properly implement enhanced barrier and contact isolation precautions and the use of personal protective equipment for 4 of 4 residents (Resident #33, Resident #8, Resident #9, and Resident #41) reviewed for infection control, resulting in the potential for cross contamination and spread of infection.

Findings include:

Resident #33

Review of an Admission Record revealed Resident #33, was originally admitted to the facility on [DATE] with pertinent diagnoses which included: hemiplegia (loss of movement on one side of the body).

Review of a Minimum Data Set (MDS) assessment for Resident #33, with a reference date of 6/24/24 revealed a Brief Interview for Mental Status (BIMS) score of 15/15 which indicated Resident #33 was cognitively intact.

Review of a Care Plan for Resident # 33, with a reference date of 5/24/24 , revealed a focus/goal/interventions of: Focus: (Resident #33) has an eye infection, conjunctivitis(common but very contagious infection) of left eye. Goal: (Resident #33's) infection will be resolved with complications. Interventions: Educate resident and direct care staff that the infection is contagious .

Review of physician orders for Resident #33 revealed an order placed on 7/14/24 for the resident to be in contact isolation precautions due to conjunctivitis (a common but very contagious infection of the conjunctiva of the eye).

During an observation on 7/16/24 at 12:57pm a sign that read: Stop. Contact Precautions, Providers and Staff must .: Put on gloves before room entry. Put on gown before room entry hung outside Resident #33's room.

During an observation on 7/18/24 at 9:39am, Activity Director (AD) J stood against Resident #33's bed, wore no personal protective equipment (PPE), held Resident #33's electronic device with her left hand and used her right index finger to tap on the touch screen of the device. AD J then handed the device back to Resident #33, exited the room and completed hand hygiene with hand sanitizer.

In an interview on 7/18/24, at 9:41am, AD J reported while in Resident #33's room, she took his electronic device from him and assisted him with completing a task on it. AD J reported she thought staff only needed to wear PPE when performing cares for Resident #33, but she was not really sure. When further queried, AD J confirmed she did not wear any PPE while in Resident #33's room, handled his electronic device that he uses frequently and cleansed her hands with hand sanitizer upon exiting.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	In an interview on 7/18/24 at 10:03am, Assistant Director of Nursing/Infection Preventionist (ADON) D reported Resident #33 was in contact precautions for conjunctivitis and all staff who entered his room and handled his belongings or performed care were required to wear a gown, gloves, and a mask to reduce the risk of infection. ADON D added that staff who handled Resident #33's belongings with their bare hands would need to wash their hands with soap and water to reduce the risk of cross contamination. When further queried, ADON D reported that failure to use the proper personal protective equipment while caring for Resident #33, or handlings items in his room, could result the potential spread of infection to other residents. Review of a facility policy titled Transmission Based Precautions with a reference date of 3/24 revealed: Contact Precautions- Intended to prevent transmission of pathogens that are spread by direct or indirect contact with the resident or the resident's environment Healthcare personnel caring for residents on Contact Precautions wear a gown and gloves for all interactions that may involve contact with the resident or potentially contaminated areas in the resident's environment. 47659 Resident #8 Review of an Admission Record revealed Resident #8 was originally admitted to the facility on [DATE] with pertinent diagnoses which included chronic obstructive pulmonary disease (COPD). Review of Resident #8's Orders did not reveal current or discontinued orders for enhanced barrier precautions. During an observation on 7/16/24 at 10:03 AM, Resident #8's room had a sign outside of the door that stated, enhanced barrier precautions. Inside of Resident #8's room, there was a cart full of personal protective equipment (PPE). During an observation on 7/17/24 at 9:09 AM, Resident #8's room had a sign outside of the door that stated, enhanced barrier precautions. Inside of Resident #8's room, there was a cart full of personal protective equipment (PPE). During an interview on 7/17/24 at 12:10 PM, Certified Nursing Assistant (CNA) U reported that Resident #8 was on enhanced barrier precautions because she had a catheter, but the catheter had recently been removed. CNA U reported that she did not know if staff were still following the enhanced barrier precautions for Resident #8. During an interview on 7/17/24 at 3:04 PM, Licensed Practical Nurse (LPN) L reported that he had removed Resident #8's catheter the previous week, and that Resident #8 no longer required enhanced barrier precautions. LPN L reported that he did not know who was responsible for initiating or discontinuing enhanced barrier precautions for residents. LPN U reported that he did not know if staff were still following enhanced barrier precautions for Resident #8. During an interview on 7/18/24 at 8:40 AM, LPN R reported that Resident #8 remained on enhanced barrier precautions. LPN R confirmed that she was aware that Resident #8 no longer had a catheter. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 7/18/24 at 11:00 AM, Registered Nurse (RN) P reported that the facility process for initiating and discontinuing enhanced barrier precautions was not clear and it caused confusion among the staff. RN P reported that nurses were able to initiate and discontinue enhanced barrier precautions, but not all nurses were aware of the process. During an interview on 7/18/24 at 11:43 AM, Assistant Director of Nursing (ADON) D reported that the nursing staff were responsible for initiating and discontinuing enhanced barrier and transmission-based precautions. ADON D reported that nurses were also responsible for communicating the precautions to the environmental services department so that they could place and/or remove the sign and cart from the resident's room. ADON D reported that all residents on enhanced barrier or transmission-based precautions should have an order in their electronic health record (EHR). ADON D reported that Resident #8 did not have an order in their EHR for initiating or discontinuing enhanced barrier precautions. ADON D reported that the staff missed completing initiation and discontinuation of enhanced barrier precautions for Resident #8. During an interview on 7/18/24 at 12:19 PM, Maintenance/Environmental Director (MD) G reported that he was responsible for communicating with nursing staff to know which residents were on enhanced barrier or transmission-based precautions. MD G reported that he had reviewed all residents the prior week to ensure that the correct signs and PPE were placed and removed as ordered. MD G reported that he could not recall if he had been notified that Resident #8 was no longer on enhanced barrier precautions. Resident # 9 Review of an Admission Record revealed Resident #9 was originally admitted to the facility on [DATE] with pertinent diagnoses which included dementia. Review of Resident #9's Orders did not reveal current or discontinued orders for transmission-based precautions. Review of Resident #9's Nursing Note dated 6/14/24 revealed, .Resident also to be on contact isolation . During an observation on 7/16/24 at 9:35 AM, Resident #9's room had a sign that stated Contact Precautions on the door. It was noted that there was not a PPE cart located outside or inside of Resident #9's room. During an interview on 7/16/24 at 10:18 AM, CNA T reported that staff were required to wear gloves and gowns when providing direct care to Resident #9. CNA T did not know why Resident #9 did not have a PPE cart in her room or how staff were putting on PPE when there was not a cart available. During an interview on 7/17/24at 12:10 PM, CNA U reported that Resident #9 was not on contact precautions anymore. CNA U was unaware of when the precautions were discontinued for Resident #9. During an interview on 7/17/24 at 3:04 PM, LPN L reported that he worked with Resident #9 regularly, but he did not know if Resident #9 was currently or had been on contact precautions. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 7/18/24 at 8:40 AM, LPN R reported that Resident #9 was removed from contact precautions on 6/24/24. LPN R did not know why Resident #9's room still had a sign that stated they were on contact precautions. During an interview on 7/18/24 at 11:43 AM, ADON D reported that Resident #9 did not have orders in their EHR for the initiation or discontinuation of contact precautions. During an interview on 7/18/24 at 12:19 PM, Maintenance/Environmental Director (MD) G reported that he could not recall when he was notified that Resident #9 was removed from contact precautions or when the PPE cart was removed from Resident #9's room. Resident #41 Review of an Admission Record revealed Resident #41 was originally admitted to the facility on [DATE] with pertinent diagnoses which included muscle weakness. Review of Resident #41's Orders did not reveal current or discontinued orders for enhanced barrier precautions. During an observation on 7/16/24 at 9:17 AM, A PPE cart was sitting in Resident #41's room. It was noted that Resident #41 did not have a sign on the door of their room to indicate what kind of precautions Resident #41 was on. During an interview on 7/18/24 at 11:43 AM, ADON D reported that Resident #41 was on enhanced barrier precautions. ADON D reported that Resident #41 was missing an order for the enhanced barrier precautions in their EHR. ADON D confirmed that Resident #41 should have had a sign on their door to indicate to staff what kind of precautions Resident #41 was on, as that would determine when and how staff should don and doff PPE when caring for Resident #41. During an interview on 7/18/24 at 12:19 PM, Maintenance/Environmental Director (MD) G reported that he did not know why Resident #41 was missing a sign on their room door to indicate what precautions staff should take when caring for Resident #41. During an observation and interview on 7/18/24 at 1:19 PM, Resident #41's room door was noted to have a sign that stated Contact Precautions on the door. LPN R reported that the sign was incorrect, and that Resident #41 was not on contact precautions. During an observation and interview on 7/18/24 at 1:54 PM, LPN R prepared medication to administer to Resident #41 via Resident 341's peg tube (a feeding tube that goes directly to the stomach). LPN R was observed entering Resident #41's room with the prepared medication. LPN R placed the medication on a tray table and applied gloves. After applying gloves, LPN R administered the medication to Resident #41 via the peg tube. It was noted that LPN R did not have any other form of PPE on during the medication administration. LPN R reported that staff were only required to wear gowns when caring for wounds. LPN R reported that she never wore PPE when administering medications via peg tubes. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the Facility's Enhanced Barrier Precautions last reviewed 9/2023 revealed, Policy: It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms .Policy Explanation and Compliance Guidelines: 1. Prompt recognition of need: A. All staff receive training on enhanced barrier precautions upon hire and at least annually and are expected to comply with all designated precautions. B. All staff receive training on high-risk activities and common organisms that require enhanced barrier precautions .2. Initiation of Enhanced Barrier Precautions: A. The facility will have the discretion in using EBP for residents who do not have a chronic wound or indwelling medical device and are infected or colonized with an MDRO that is not currently targeted by CDC but may be considered epidemiologically important. B. An order for enhanced barrier precautions will be obtained for residents with any of the following: I. Wounds (e.g., chronic wounds such as pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and chronic venous stasis ulcers) and/or indwelling medical devices (e.g., central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes, hemodialysis catheters, PICC lines, midline catheters) even if the resident is not known to be infected or colonized with a MDRO. (Peripheral IVs, continuous glucose monitors, insulin pumps, or ostomies without an associated indwelling medical device are not an indication for EBP.) . 3. Implementation of Enhanced Barrier Precautions: a. Make gowns and gloves available immediately near or outside of the resident's room. Note: face protection may also be needed if performing activity with risk of splash or spray (i.e., wound irrigation, tracheostomy care). B. PPE for enhanced barrier precautions is only necessary when performing high-contact care activities and may not need to be donned prior to entering the resident's room . 4. High-contact resident care activities include: a. Dressing. b. Bathing C. Transferring D. Providing hygiene E. Changing linens F. Changing briefs or assisting with toileting. G. Device care or use: central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes, hemodialysis catheters, PICC lines, midline catheters H. Wound care: any skin opening requiring a dressing .

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 07/18/2024
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)
F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46999 Based on interview and record review, the facility failed to ensure residents' medical records included documentation that residents/resident representatives were educated, offered and/or received timely, the COVID-19 immunization as recommended by the Centers for Disease Control and Prevention (CDC) for 1 resident (Resident #29) of 5 residents reviewed for immunizations, resulting in the resident not being offered the Covid-19 immunization per CDC guidelines, and the potential for serious illness and complications from COVID-19 (SARS-CoV-2). Findings include: Resident #29 Review of an Admission Record revealed Resident #29, was originally admitted to the facility on [DATE] with pertinent diagnoses which included: unspecified dementia, and age-related physical disability. Review of a Minimum Data Set (MDS) assessment for Resident #29, with a reference date of 6/4/24 revealed a Brief Interview for Mental Status (BIMS) score of 00/15 which indicated Resident #29 was severely cognitively impaired. Review of Resident #29's immunization records revealed she last received the COVID-19 immunization on 6/20/22. In an Infection Control interview on 7/18/24, at 10:03am, Assistant Director of Nursing/Infection Prevention (ADON) D reported residents should be offered a COVID-19 vaccination upon admission and annually thereafter. When further queried, ADON D reported Resident #29 should have been offered a COVID-19 vaccination when she admitted to the facility on [DATE] but was not and this was likely due to a mistake during the resident's initial nursing assessment. Review of a facility policy titled COVID-19 Vaccination with a reference date of 9/23 revealed: People ages [AGE] years and older should receive 1 additional dose of any updated (2023-2024 Formula) COVID-19 vaccine .at least 4 months following the previous dose of updated COVID-19 vaccine .COVID-19 vaccinations will be offered to residents unless such immunization is medically contraindicated, the individual has already been immunized during this time period, or refuses to receive the vaccine.