STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235450	A. Building B. Wing	01/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Allendale Nursing and Rehabilitation Community	11007 Radcliff Dr Allendale, MI 49401

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39056 Based on interview and record review, the facility failed to administer and document the administration of controlled substances for 4 residents (Resident #39, #25, #50 and #24), reviewed for medication administration, resulting in medication errors and inaccurate documentation of controlled drugs. Findings: Resident #39 Review of an Admission Record revealed R39 was a [AGE] year-old female, admitted to the facility on [DATE], with pertinent diagnoses which included: pain. Review of R39's Order Summary dated 12/5/24 revealed oxycodone 15mg 1 tablet by mouth every 4 hours as needed for pain. Review of R39's Controlled Substances Proof of Use log revealed: *On 1/1/25 a dose of oxycodone was administered at 4:45 AM. *On 1/3/25 a dose of oxycodone was administered at 4:15 AM. *On 1/4/25 a dose of oxycodone was administered at 8:00 AM. *On 1/4/25 a dose of oxycodone was administered at 2:00 PM. *On 1/5/25 a dose of oxycodone was administered at 8:34 AM. Review of R39's Medication Administration Record revealed the above listed oxycodone administrations were not documented in R39's Electronic Medical Record. (Accurate documentation of pain medication administration is essential for ensuring adequate pain control as well as ensuring narcotics are not diverted.) Resident #25 Review of an Admission Record revealed R25 was a [AGE] year-old male, admitted to the facility on [DATE], with pertinent diagnoses which included: pain. (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: 235450	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/10/2025

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R25's Order Summary dated 1/21/21 revealed Norco (hydrocodone-acetaminophen) 7.5/325 mg 1 tablet three times a day. Review of R25's Controlled Substances Proof of Use log revealed that on 1/5/25 the evening dose of Norco was not administered. Review of R25's Medication Administration Record revealed on 1/5/25 the evening dose of Norco was not administered for Not Administered: Drug/Item Unavailable despite there being 24 tablets available for R25. Review of R25's Electronic Medical Record revealed no documentation regarding the withholding of R25's Norco or that the provider was notified that the prescribed medication was not administered. Resident #50 Review of an Admission Record revealed R50 was a [AGE] year-old female, admitted to the facility on [DATE], with pertinent diagnoses which included: anxiety and osteoporosis. Review of R50's Order Summary dated 11/17/24 revealed, clonazepam 0.5 mg; Give 1 tablet by mouth daily at bedtime. Review of R50's Controlled Substances Proof of Use log revealed that on 1/4/25 R50's clonazepam was not documented as administered. Review of R50's Medication Administration Record revealed that on 1/4/25 R50's clonazepam was documented as administered. Review of R50's Order Summary dated 10/23/24 revealed, oxycodone 5 mg; 1/2 tablet = 2.5mg; oral Twice A Day . Review of R50's Controlled Substances Proof of Use log revealed that on 1/5/25 R50's evening dose of oxycodone was not documented as administered. Review of R50's Medication Administration Record revealed that on 1/5/25 R50's evening dose of oxycodone was documented as administered. Resident #24 Review of an Admission Record revealed R24 was a [AGE] year-old male, admitted to the facility on [DATE], with pertinent diagnoses which included: insomnia. Review of R24's Order Summary dated 11/12/24 revealed, Belsomra (suvorexant) 15 mg; 1 tablet; oral At Bedtime. Belsomra is a hypnotic used to treat insomnia. Review of R24's Controlled Substances Proof of Use log revealed: *On 1/4/25 a dose of belsomra was administered at 1200 (unable to determine if it was 12:00 AM or 12:00 PM). (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Allendale Nursing and Rehabilitation Community		STREET ADDRESS, CITY, STATE, ZIP CODE 11007 Radcliff Dr Allendale, MI 49401	

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*On 1/4/25 or 1/5/25 (a 4 and 5 were written on top of each other) a dose of belsomra was administered at 11:30 PM *On 1/5/25 a dose of belsomra was administered at 1145 (presumably 11:45 PM at the time it was due). Indicating 2 doses of belsomra was administered on either 1/4/25 or 1/5/25. Review of R24's Electronic Health Record revealed no documentation regarding the additional dose of belsomra or physician notification of the double dose. During an interview on 01/10/25 at 10:21 AM, Regional Clinical Director (RCD) B confirmed the medication/documentation errors for R39, R25, R50 and R24 and reported licensed nurses are expected to administer medications following professional standards of practice. Review of the facility policy Control Substances Standards of Practice last updated 9/2022 revealed, .Nurses removing controlled substances from the narcotic storage require documentation on the Proof-of-Use Sheet the amount removed using a full last name signature. Nurse documentation of inventory balance on Proof-of Use sheet MUST be made as soon as the controlled substance is removed from the package/cart. Avoid waiting until the end of med pass or end of shift. Once the nurse completes the administration, then the nurse is to document on the MAR paper record or E0Mar electronic record. If PRN medication is administered, additional documentation regarding reason, result, time and initials are required . Review of Fundamentals of Nursing ([NAME] and [NAME]) 10th edition revealed, The National Coordinating Council for Medication Error Reporting and Prevention (2018) defines a medication error as any preventable event that may cause inappropriate medication use or jeopardize patient safety. Medication errors include inaccurate prescribing, administering the wrong medication, giving the medication using the wrong route or time interval, administering extra doses, and/ or failing to administer a medication. Preventing medication errors is essential. [NAME], [NAME] A.; [NAME], [NAME] Griffin; Stockert, [NAME] A.; Hall, [NAME]. Fundamentals of Nursing - E-Book (p. 605). Elsevier Health Sciences. Kindle Edition.

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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 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39056 Based on interview and record review, the facility failed to ensure appropriate treatment and services to maintain and carry out communication for 1 of 8 residents (R25) reviewed for activities of daily living, resulting in R25 feeling frustrated and isolated. Findings: Resident #25 Review of an Admission Record revealed R25 was a [AGE] year-old male, admitted to the facility on [DATE], with pertinent diagnoses which included: contracture right hand, stroke affecting dominant right side, and expressive aphasia. Review of Fundamentals of Nursing ([NAME] and [NAME]) 11th edition revealed, Expressive aphasia, a motor type of aphasia, is the inability to name common objects or express simple ideas in words or writing. For example, a patient understands a question but is unable to express an answer .The temporary or permanent loss of the ability to speak is extremely traumatic to an individual .Determine whether the patient has developed a sign-language system or symbols to communicate needs. [NAME], [NAME] A.; [NAME], [NAME] G.; Stockert, [NAME] A.; Hall, [NAME]. Fundamentals of Nursing - E-Book (p. 1396). Elsevier Health Sciences. Kindle Edition. Review of R25's Progress Notes revealed: 10/5/24 Resident is alert and oriented 12/20/24 Resident in bed upon arrival, alert and oriented . Confirming R25 was cognitively intact. Review of R25's Speech Therapy-SLP Evaluation and Plan of Treatment documentation from 6/6/23-7/5/23 revealed, .Caregiver Goals: want pt (patient) to communicate more with them about pt needs/wants/desires/etc .Was referred to ST (speech therapy) for evaluation of aphasia and communication d/t (due to) decrease in communication with caregivers and staff after losing communication book .Prior Level of Function: Previously was using communication board provided by SLP (speech language pathology), however has since misplaced it and requires a new one . Pt presets with severe expressive aphasia and moderate receptive aphasia. Pt demonstrates ability to understand and correctly respond to simple yes/no questions (both verbally and non-verbally). Pt is mostly nonverbal, with the only verbalizations made during evaluation being yes no take me home and what . (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In order to facilitate return to prior level of living, patient requires continued ST services in order to analyze communication abilities and improve ability to communicate self-care and/or medical needs in order to enhance patient's quality of life by an improved ability to communicate basic wants/needs and improve expressive communication. Due to the documented physical impairments and associated functional deficits, without skilled therapeutic intervention, the patient is at risk for: anxiety, social isolation and decreased participation with functional tasks . Discharge recommendations: To facilitate optimal cognitive-communicative performance, the following strategies are recommended: consistent words/verbal directions to increase comprehension, concrete, one step directions by speak to increase comprehension and slower rate of speech to facilitate communication request clarification. Use communication book (AAC) as often as possible . During an observation and interview on 01/07/25 at 11:49 AM, R25 was sitting up awake in his room. R25 was able to answer yes or no questions but became visibly frustrated (rolling eyes, refusing to make eye contact, grunting) when he was unable to make his needs and thoughts known and this writer was unable to determine what he was attempting to express. R25 was asked if he utilized any tools such as a communication board or electronic device to communicate his needs/wants with staff and he responded by shaking his head no. When asked if the facility staff knew him well enough to understand/identify what he needed he shook his head no. When asked if he was frustrated that staff could not understand his needs, he shook his head yes. R25 then pointed behind his bed towards the nightstand that was not within his reach. Underneath a stuffed animal and a positioning pillow were a few paper flashcards with sign language and a word in poor condition (dirty, ripped, difficult to see) and a hard cover 3 ring binder with keep next to (R25) at all times written on it. Inside of the binder was large printouts of communication forms (example: the first page was a large yes and a large no, sports teams, etc.). R25 was asked if the communication binder was helpful in communicating his needs, he responded by shaking his head no. R25 did not have the use of his right arm/hand and when asked if it was difficult to turn pages and navigate the book with the use of only his left hand, he shook his head yes. When asked if the staff would attempt to use the communication binder when they could not identify his needs, he shook his head no. When asked if he was ever questioned about changing to a different communication style, he shook his head no. At that time Certified Nursing Assistant (CNA) D entered the room and told R25 it was time to get up for a weight. She did not attempt to utilize the communication binder or flash cards. CNA D was asked how she determined R25's wants/needs and she reported the communication binder was not utilized but the facility staff would ask him yes or no questions until they could figure it out. R25 became visibly frustrated and was saying incoherent words over and over and shaking his head no. This surveyor asked R25 if we could use the communication binder, and he aggressively shook his head no. CNA D reported that she could tell by his frustration that he wanted this writer out of the room. R25 then grabbed my right hand with his left hand and shook his head no. R25 was asked if he wanted an assessment/evaluation into a new style of communication he shook his head yes emphatically. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 01/09/25 at 09:09 AM, R25 was sitting up in his bed with the communication binder on his nightstand out of reach. R25 was asked if he used his iPad as a communication tool and he shook his head no. R25 was asked if he participated in care conferences with his wife/legal guardian and facility staff and he shook his head no. R25 was asked if he would join care conferences if he had a way to communicate easily/efficiently so he could have a say in his care and he shook his head yes. R25 was shown different forms of communication boards, tools, and flashcards on the computer and he appeared excited and started shaking his head yes vigorously. R25 pointed to sad on a communication board on the computer. When asked if he would be less sad if he could communicate more efficiently, he shook his head yes. During an interview on 01/09/25 at 09:24 AM, Licensed Practical Nurse (LPN) J confirmed that R25 was cognitively intact but suffered from expressive aphasia. LPN J reported that R25's iPad was locked in the medication room on the unit and would be brought to R25 when he requested it. LPN J reported that the iPad was not used as a form of communication and was only used by R25 to watch movies. During an interview on 01/09/25 at 01:31 PM, Social Services (SS) I reported that R25's wife was his legal guardian and would attend the care conferences. SS I reported that R25 did not consistently attend. SS I reported she did not know the last time ST/OT (speech therapy and occupational therapy) evaluated him for communication needs and/or tools and was not aware that staff were not using the communication binder. SS I confirmed that R25's stroke affected his dominant hand, and the communication binder may be difficult for R25 to maneuver. SS I reported that R25 would get frustrated and quit interacting with staff when staff could not identify what he needed. SS I reported that she was not aware that the iPad was care planned for his communication tool and confirmed it was not used for that purpose. SS I reported that she would meet with R25 and identify a more suitable communication tool for him to utilize. During an interview on 01/09/25 at 03:12 PM, Legal Guardian (LG) C reported that communication tools and his frustrations with communication had not been discussed in care conferences. LG C stated that R25 might have something in one of his drawers be he can't use it referring to the communication binder. LG C reported that R25 would communicate by pointing and shaking his head yes or no, but he would often get frustrated and refuse to answer after he's asked a few questions and the staff could not identify what he needed/wanted. LG C reported that a communication tool would be beneficial for him so he could participate in his care and have more autonomy and not shut down when he's frustrated. Review of R25's contracted psychiatric Progress Note dated 12/23/24 revealed, .Long-Term Memory: Unable to assess due to communication deficit . Indicating a more in-depth psychiatric evaluation could have been completed had R25 been able to communicate effectively. There was no documentation the communication binder was utilized or refused. Review of R25's March 2024 Care Conference revealed R25 had not been invited to the care conference. Is this resident able to express choice? No. wife has noted residents depression has increased since she was discharged from the facility, resident has voiced wanting to go home, wife reminds him that he cannot go home d/t needing 24-hour care, he understands once he talks to wife . There was no documentation that R25's communication had been addressed despite R25 being cognitively intact and documenting that he was unable to express himself. (continued on next page)

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	235450	A. Building B. Wing	01/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Allendale Nursing and Rehabilitation Community	11007 Radcliff Dr Allendale, MI 49401

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R25's June 2024 Care Conference revealed R25 had not been invited to the care conference. Is this resident able to express choice? No. Resident is bed bound mostly, no changes in participation with activities . There was no documentation that R25's communication had been addressed. Review of R25's September 2024 Care Conference revealed, Is this resident able to express choice? No. There was no documentation that R25's communication had been addressed. Review of R25's December 2024 Care Conference revealed R25 had not been invited to the care conference. Is this resident able to express choice? No. There was no documentation that R25's communication had been addressed. Review of R25's Care Plan revealed Communication Resident experiences a communication deficit r/t (related to) CVA (stroke), impaired cognition, aphasia, limited speech, rarely/never understood but understands others. Review of the interventions dated 4/9/18 revealed: Resident use IPAD/tablet and gestures to assist with communication . Address resident's emotional needs: Use IPAD/tablet and gestures to determine resident's needs, resident is aphasic and easily frustrated when not able to communicate needs . Staff to encourage resident to use gestures, motions, communication board . Encourage resident to not become frustrated if at first staff does not understand what it is they are trying to say. Seek assistance from other staff PRN (as needed) . ST (speech therapy) referral as needed . R25's Care Plan did not include the use of the communication binder/book despite speech therapy recommendation but instead reflected the us of the iPad as a communication device although not utilized for that purpose. Review of R25's Electronic Medical Record revealed no recent assessments or SLP evaluations for the use of a more appropriate communication tool or documentation of steps taken to improve R25's ability to communicate with staff despite R25's noted dissatisfaction and difficulty utilizing the communication binder.

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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** 28101 This citation pertains to intake #: MI00148539 Based on observations, interview and record review the facility failed to assess residents with new medical conditions in a timely manner, accurately assess pain and address pain in a timely manner, follow physician orders for wound treatment for 3 Residents of 3 Residents sampled (R20, R36, and R57), resulting in delay of physician notification of culture results and wound treatment, and uncontrolled pain. Findings included: R20 Review of R20's face sheet, no date revealed he was a [AGE] year-old male admitted to the facility on [DATE] and had diagnoses that included: end stage renal disease (kidney failure), unsteady on feet, need for assistance with personal care, cervical disc disorder myelopathy (muscle disorder) and diabetes mellitus with diabetic neuropathy (nerve disease). R20 was his own responsible party. During an interview with R20 on 1/8/25 at 10:19 AM, R20 reported that he went to the podiatrist yesterday and his great toe treatment caused it to bleed, and he was very concerned about his follow up care. He also reports that he feels ignored and upset that the facility is not addressing his pain. He said he asked to see the doctor again this week about his pain and he witnessed the physician assistant being here that day and the physician assistant left without talking to him. He said when he is in dialysis 3 days a week his pain always gets to 10/10. Today prior to being given his narcotic pain medication his pain was 9 and currently it was 8/10. He knows he will always have pain but feels that there is room for improvement, but no one listens to him. During an interview with Licensed Practical Nurse (LPN) K on 1825 at 12:29 PM, LPN K said she recorded a 0 for R20's pain that morning when she gave his morning medication because he did not complain of pain. When LPN K was asked if she asked R20 to rate his pain she said no she did not ask him. During an interview with the Director of Nursing (DON) on 1/8/25 at 12:32 PM in R20's room with R20 present. R20 repeated the information he told the surveyor at 10:19 AM about the podiatrist, feeling ignored, the wound on his right great toe, and his pain concerns. During an interview with the Director of Nursing (DON) on 1/8/25 at 2:07 PM the DON confirmed that R20 had an outside Podiatry (foot doctor) appointment on 1/7/25. The DON was not able to locate any new orders or documents from the podiatrist. The DON could not locate any nursing notes or message to R20 physician about follow up care related to R20' nail removal on 1/7/25. The DON confirmed that R20 had a dressing on his right great toe and nursing staff should have noted that on his return, she was getting documents from the pediatrist and placed him on the list to be seen by the medical staff. The DON removed the dressing, contacted the podiatrist and notified the medical staff of the condition of R20's right great toe. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/10/25, Regional Clinical Director (RCD) B said she interviewed R20 about his pain and he reports it is consistently around 8/10. She reported the physician assistant increased one pain medication yesterday. They are in the process of educating the nurses to properly assess pain and they are adding an additional assessment for pain after his narcotic pain medication to assess if that medication is effective. Review of R20's January 2025 Medication Administration Record (MAR) revealed he was to have pain assessments 3 times a day. Most entries were 0 for no pain. On 1/8/25 the morning assessment was 0. There was no pain assessment for the morning of 1/7/25. For 1/5/25 morning pain was recorded as 9. See interviews above. Record does not reflect interviews. Review of R20's progress notes revealed no documentation of R20 having a podiatry appointment or a procedure requiring a dressing done on 1/7/25. Record review revealed treatment orders for R20's right great toe started on 1/7/25 when he had the nail partially removed on that toe by the podiatrist. Review of R20's progress note dated 1/8/25 at 1:14 PM revealed the DON charted, physician notified of resident's pain level. Physician increasing Lyrica to 100 mg BID (pain medication increased to twice a day). States not appropriate to perform two med (medication) adjustments at once. (name of PA) stated she will meet with him next week to review his pain and increase his Norco (narcotic pain medication) this if he feels his pain is still not controlled. Resident notified of plan. R36 Review of R36's face sheet, no date, revealed she was a [AGE] year-old female admitted to the facility on [DATE] and had diagnoses that included: lymphedema (swollen legs), rheumatoid arthritis, and severe morbid obesity. R36 was her own responsible party. Review of R36's physician orders revealed an order dated 1/3/25 right anterior and posterior lower leg. Cleanse with NS (normal saline). Apply Gentle blue ready to wound beds. Cover with silicone superabsorbent dressing. Every other day as needed. 3:00 PM to 11:00 PM. During an interview with R36 on 1/7/25 at 10:01 AM, R36 complained of the dressing on the back of her right leg not getting changed on Saturday. R36 said there were no supplies. R36 said she asked again last night at 8:30 PM and again was told there were no supplies. The dressing on the back of R36's right leg did not have a date noted. On 1/7/25 at 10:40 AM the Director of Nursing (DON) changed the dressing on the back of R36's leg. The DON confirmed that there was no date on dressing and confirmed that the dressing on the back of R36's leg did not have the Gentle Blue as ordered. The DON confirmed the nurses are to date and initial dressings when they replace them. The pillowcase under R36 right leg was soiled (dry brown large spot). The DON removed the soiled pillowcase and assured R36 she would look into what happened with wound treatments. 39056 Resident #57 (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of an Admission Record revealed R57 was a [AGE] year-old female, admitted to the facility on [DATE]. Review of R57's hospital After Visit Summary dated 10/6/24 revealed .START taking: ceftriaxone (ROCEPHIN) (and) cefuroxime (CEFTIN) . Review of R57's Order Summary revealed: 10/7/24-10/8/24: cefuroxime 500mg tablet; Take 1 tablet twice daily x 7 days for UTI 10/8/24-10/14/24: cefuroxime 500mg tablet; Take 1 tablet daily x 7 days for UTI Review of R57's Electronic Medical Record revealed no culture results or documentation that the provider reviewed culture results to ensure the correct and/or most effective antibiotic was ordered/administered. During an interview via email on 01/10/2025 at 11:54 AM, Regional Clinical Director (RCD) B confirmed that there was no follow-up culture available for review. Review of Fundamentals of Nursing ([NAME] and [NAME]) 11th edition revealed, .resistance to key antibiotics are becoming more common in all health care settings .The increased resistance is associated with the frequent and sometimes inappropriate use of antibiotics over the years in all settings (i.e., acute care, ambulatory care, clinics, and long-term care) .A culture result may show growth of an organism in the absence of infection. For example, in the older adult bacterial growth in urine without clinical symptoms does not always indicate the presence of a UTI .Many laboratory studies are often necessary when a patient is suspected of having an infectious or communicable disease (Box 28.14). You collect body fluids and secretions suspected of containing infectious organisms for culture and sensitivity tests. After a specimen is sent to a laboratory, the laboratory technologist identifies the microorganisms growing in the culture. Additional test results indicate the antibiotics to which the organisms are resistant or sensitive. Sensitivity reports determine which antibiotics used in treatment are effective and need to be ordered for treatment. [NAME], [NAME] A.; [NAME], [NAME] Griffin; Stockert, [NAME] A.; Hall, [NAME]. Fundamentals of Nursing - E-Book (pgs. 425-443). Elsevier Health Sciences. Kindle Edition.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235450	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/10/2025
NAME OF PROVIDER OR SUPPLIER: Allendale Nursing and Rehabilitation Community		STREET ADDRESS, CITY, STATE, ZIP CODE: 11007 Radcliff Dr Allendale, MI 49401	

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28101 Based on observations, interviews and record review, the facility failed to keep the 100-hall medication refrigerator in the safe temperature storage range, resulting in the potential for medication to became ineffective. Findings included: On 1/8/25 at 8:09 AM the 100-hall medication refrigerator was observed to be stuffed full of medications. There were no shelves to put the medications on. The thermometer was stuffed into the middle of the medications. There was no freezer door, and the freezer had approximately 1 inch of ice build up in it. Licensed Practical Nurse (LPN) K had to dig around in the refrigerator to locate the thermometer. The thermometer read 32 degrees Fahrenheit. LPN K went with the Surveyor to notify the Director of Nursing (DON). At approximately 9:00 AM the DON said pharmacy said to destroy the medications and they were shipping new medications. They notified the physician about any medications that would be late due to having to destroy the current medications. The Surveyor requested an inventory of all medications that were in the refrigerator that need to be destroyed. Review of the 100-hall medication temperature log revealed the temperature was to be kept between 36 degrees Fahrenheit and 46 degrees Fahrenheit. If it was not in this range action should be taken. The log indicated the temperatures were to be taken every AM and every PM. The boxes for January 1 to [DATE], were all marked as being 38 degrees Fahrenheit. The AM temperature on 1/8/25 was marked as 39 degrees Fahrenheit. Review of the facility 100 hall medication refrigerator revealed 9 Residents had medications stored in the refrigerator. The medications included insulin, Trulicity (medication used to control blood sugar) and pain medications. The medications require storage in a safe temperature as indicated on the refrigerator log sheet or they can become ineffective. Total number of vials, pens or amount of liquid was not included in the inventory.

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	235450	A. Building B. Wing	01/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Allendale Nursing and Rehabilitation Community	11007 Radcliff Dr Allendale, MI 49401

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37573 Based on interview and record review, the facility failed to follow and implement policies and procedures for hospice care and implement communication, coordination of cares and services, and have complete hospice medical records readily available for one (R41) of 3 residents reviewed for hospice services. Findings include: Review of a policy titled End of Life Care last reviewed 1/2025 revealed: 6a. Hospice must designate a registered nurse from hospice to coordinate the implementation of the plan of care. b. The coordinated plan of care must identify the care and services, which the facility and hospice will provide in order to be responsive to the unique needs of the resident and his/her, expressed desire for hospice care. d. When a resident participates in the hospice program, a coordinated plan of care between the facility, hospice agency and resident/family/resident representative will be developed and shall include directives for managing pain and other uncomfortable symptoms. The care plan shall be revised and updated as necessary to reflect the resident's status. e. The facility and hospice are responsible for performing each other their respective functions that have been agreed upon and included in the plan of care. g. The hospice and facility are aware of each other's responsibilities in implementing the plan of care to include hospice personnel schedules. h. All hospice services are provided under contractual arrangement. Complete details outline the responsibilities of the facility and the hospice agency are contained in this agreement. A copy of this agreement is available upon request from the administrator/or the hospice agency. i. The agreement with the hospice provider must be signed by a representative from this facility and a representative from the hospice agency before hospice services are furnished to any resident. Resident #41 (R41) Review of a Face Sheet revealed R41 admitted to the facility on [DATE] and has pertinent diagnoses of hospice, cerebral infarction (stroke), and dementia without behavioral disturbances, psychotic disturbance, mood disturbance, and anxiety. Review of the Hospice Care plan revealed 12/10/24 hospice services were implemented. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Allendale Nursing and Rehabilitation Community		STREET ADDRESS, CITY, STATE, ZIP CODE 11007 Radcliff Dr Allendale, MI 49401	

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and an interview on 1/7/25 at 10:45 AM, R41 had complaints of chronic pain and the inability to sleep due to his past military life. He rated his pain at a 5 on a 1-10 scale. R41 randomly removed his slippers, and his toenails were very long and reported the staff will file and clip the nails on his hands, but not on his feet. He reported he is receiving hospice services. Review of the electronic medical records (EMR) for R41 revealed no hospice agreement, no hospice orders, no hospice communications, no hospice visitations and services were documented. In an interview on 1/8/25 at 12:25 PM, R41 reported the hospice nurse visited him this morning. Review of the EMR revealed no documentation documenting this visit or services provided this day. In an interview on 1/8/25 at 12:44 PM, the Regional Clinical Consultant (RCC) reported the hospice documentation should be in the EMR and verified there is no documentation. In an interview on 1/8/25 at 12:53 PM, Licensed Practical Nurse (LPN) J reported some residents have paper binders with hospice communications at the nursing station, and confirmed R41 did not have any paper binders with hospice communications, services, or visitations. In an interview on 1/8/25 at 2:09 PM, Social Worker (SW) I reported she and the Director of Nursing (DON) are responsible for hospice coordination. SW I reported R41 did not have any hospice documentation or communication at the facility. She reported this day she requested documentation from hospice that was sent via email this day and forwarded them to the DON. The hospice records sent via email was not available to the front-line staff who provided nursing services to R41 at this time. In an interview on 1/8/25 at 2:48 PM, the DON reported the facility did not have all the information needed from the hospice agency regarding the contract/agreement, visits, progress notes, and orders. The DON reported it was a work in progress. Review of a Hospice Certification document provided in paper form from the facility before the end of this survey for R41 dated 12/9/24 revealed he was certified for hospice from 11/22/24 to 2/19/25.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28101 Based on observations, interviews and record review, the facility failed to properly clean 1 Resident's (R20) BiPap (breathing machine) for 1 Resident reviewed for respiratory equipment. Findings included: Review of R20's face sheet, no date revealed he was a [AGE] year-old male admitted to the facility on [DATE] and had diagnoses that included: end stage renal disease (kidney failure), unsteady on feet, need for assistance with personal care, cervical disc disorder myelopathy (muscle disorder) and diabetes mellitus with diabetic neuropathy (nerve disease). R20 was his own responsible party. On 1/8/25 at 10:14 AM R20 was observed in bed, and he had a BiPap (breathing assistance machine used during sleep) on his nightstand. The mask was still attached to the hose and there was no cleaning equipment observed in the room. R20 said no one had cleaned his BiPap equipment since admission. During an interview with the Director of Nursing (DON) on 1/8/25 at 12:04 PM she confirmed that she did some checking into the cleaning of R20's BiPap machine, she could not confirm that it had ever been cleaned and she was not sure who had checked the boxes on R20's Medication Administration Recorded indicating they had cleaned his BiPap machine. The DON said she had to get the supplies so they would be available for the staff to use and would start training the staff. Review of R20's Medication Administration Record (MAR) for January 2025 revealed, BIPAP WEEKLY Cleaning: Wash mask, headgear with warm water & mild dish detergent, rinse well, air dry. Wipe foam cushion with damp cloth, DO NOT submerse foam in water. Ensure completely dry prior to use. Wash humidifier with water & mild dish detergent, rinse well. The box for Sunday January 5th was marked as completed. Review of R20's Medication Administration Record (MAR) for January 2025 revealed, Bipap DAILY Cleaning: Wipe mask with damp cloth, rinse out humidifier, refill with distilled water. Every box was marked as completed.