STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235460	A. Building B. Wing	05/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Paul Oliver Memorial Hospital Ltcu	224 Park Avenue Frankfort, MI 49635

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview, and record review the facility failed to ensure medication reconciliation was completed shift to shift per standards of practice for two of two medication carts and one of one medication rooms reviewed for pharmaceutical services.Findings include:On 5/4/26 at 1:15 PM, an observation was made of the medication storage room and was found to be out of compliance with the back-up narcotic box not being double locked and lying on the top of the medication counter with two plastic zip locks. During this time the narcotic sign-off sheet was observed and found to have missing shift to shift signatures confirming the narcotic box maintained the same lock numbers. During an interview on 5/4/26 at 1:20 PM, Registered Nurse (RN) C was asked about the box and why it was not behind a locked key cupboard and replied, It has always been that way. The Director of Nursing (DON) was asked on 5/4/26 at 1:25 PM, if the narcotic box locked with the two plastic zip locks was then why was it not checked after every shift like it is supposed to be and did not have an answer. On 5/5/26 at 8:20 AM, the DON was asked about signing off on narcotic sheets and agreed that his expectation was for two nurses to sign off from shift to shift and there are typically only two shifts. On 5/5/26 at 1:03 PM, an audit was conducted with the front hall medication cart of the narcotic book and was found to be out of compliance with the following nurse signature dates blank:Blank on 12/30/25 for one nurse signature and a time,Blank on 1/6/25 (time omitted) and 1/7/26 for one nurse signatures,Blank on 1/20/26 and 1/21/26 for time and signature,Blank on 1/23/26 for one nurse signature,No signatures for first shift on 1/28/26,Blank time and missing one signature on 1/29/26 evening shift,On 1/29/26 no date for evening shift and missing time and nurse signature,Blank signature for one nurse on 1/30/26 day shift,On 2/5/26 and 2/6/26 no time indicated for day or evening shift,On 2/7/26 no time, missing one nurse signature and no second entry for signing off count of narcotic medication,Blank on 2/8/26 for time and one nurse signature missing,Blank on 2/9/26 for day shift nurse signing off on count,On 2/10/26 blank time entry for second shift and missing nurse second signature for signing of count of narcotics,On 2/15/26 no second nurse signature signing off narcotic count,Blank signature on 3/12/26 for one nurse on evening shift for narcotic count,On 3/26/26 to 3/27/26 blank signature for narcotic count from day shift to evening shift,Blank on 4/23/26 and 4/24/26 for night shift nurse not signing off on narcotic count,No times indicated on dates 4/25/26 or 5/1/26,Blank signature on 5/5/26 for midnight shift change on one nurse signature for narcotic count. On 5/5/26 at 1:13 PM, an audit was conducted with the back hall medication cart of the narcotic book and was found to be out of compliance with the following nurse signature dates blank:On 2/2/26 only one nurse signed off on narcotic count sheet,One nurse signed off on narcotic count for evening shift on 2/5/26,On 2/6/26 and 2/7/26 only one nurse signed off on the narcotic count sheet and no time on 2/7/26,Only one nurse signed off on narcotic count for 2/12/26 day shift and 2/12/26 evening shift for narcotic count,On 2/21/26 only one nurse signed off on narcotic count,Blank nurse signature on 3/5/26 for morning narcotic count, During an interview with the Pharmacist Q on 5/5/26 at 3:20 PM who was asked what his expectation were for narcotic back-up storage, medication reconciliation, and medication storage and replied, All narcotics need to be under double lock and key. The same way as the medication carts is set up. No (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	loose medications should be in the medication carts. Nurses need to be counted and signed off after each shift. No missing signatures should be on the sign off sheet. Blank areas on the reconciliation sheet are unacceptable. Review of policy titled, Controlled Medication - Security, undated, read in part Policy: Medications listed in Schedule 2 through 5 of the Controlled Substances Act possess high abuse potential and are subject handling, storage, disposal, and record keeping. Procedures.2. Medications listed in scheduled 2 thru 5 must be stored in a double-locked container designated for that purpose. (Note: This includes Scheduled drugs present as part of the Emergency Drug Kit.).

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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** Based on observation, interview, and record review the facility failed to store medications in a safe manner for two of two medication carts and one of one medication rooms reviewed for medication storage.Findings include:During an inspection of the medication cart for the front hall on [DATE] at 1:03 PM, the medication cart was found to be out of compliance with medication storage. The front medication cart had two insulin pens that had an open date but lacked an expiration date. The front hall medication cart also had one loose pill in the second drawer with multiple paper debris. The medication was a round white pill with imprints of EP 117 and identified as furosemide 40 milligrams (mg). Registered Nurse (RN) E was asked if the pens should have an expiration date and if any loose medication should be left in the medication cart and replied, I did not know the insulin pens needed an expiration date and no loose medications should be left in the cart.On [DATE] at 1:10 PM, an inspection was made of the back medication cart and was found to have two loose pills in the second drawer with paper debris. The loose medication was a half tablet oblong orange pill with imprint of 766 and an A on the opposite side and identified as a warfarin sodium 5 mg. A second loose medication was an oblong yellow tablet with imprints of H 126 and blank on the other side identified as pantoprazole 40 mg extended release. RN C was asked about the cleaning of medication carts and replied, Pharmacy does it once a month. There should not be any loose medications floating around.During an observation of the single medication room on [DATE] at 1:15 PM, an observation was made of the medication storage room and was found to be out of compliance with the backup narcotic box being left out on top of the counter and not double locked. RN C stated It has always been that way and just left out on the counter.On [DATE] at 1:20 PM, an interview was conducted with the Director of Nursing (DON), who was asked about the narcotic back-up box and replied, We are getting a different storage unit soon. We have always just left it on the counter and nurses do a check to ensure the same lock is on it each shift. The DON was asked if the nurses are signing off each shift, then why are there holes in the sign off sheet and could not provide an answer.On [DATE] at 8:20 AM, an interview was conducted with the DON who was asked about signing off on narcotic sheets and agreed that his expectation was for two nurses to sign off from shift to shift and there are typically only two shifts. During an interview with the Pharmacist Q on [DATE] at 3:20 PM who was asked what his expectation were for narcotic backup storage, medication reconciliation, and medication storage and replied, All narcotics need to be under double lock and key. The same way as the medication carts is set up. No loose medications should be in the medication carts. Nurses need to be counted and signed off after each shift. No missing signatures should be on the sign off sheet. Blank areas on the reconciliation sheet are unacceptable.Review of policy titled, Controlled Medication - Security, no date, read in part Policy: Medications listed in Schedule 2 through 5 of the Controlled Substances Act possess high abuse potential and are subject handling, storage, disposal, and record keeping. Procedures.2. Medications listed in scheduled 2 thru 5 must be stored in a double-locked container designated for that purpose. (Note: This includes Scheduled drugs present as part of the Emergency Drug Kit.).Review of policy titled, Medication Expiration, no date, read in part Policy: All pharmaceuticals dispensed will bear an expiration date or expiration date information as required by State and Federal Law.Expiration dating will be considered expired on the last day of the month if only a month and year are specified on the label.4. Insulins will expire 28 days after opening.Review of policy titled, Equipment and Supplies, no date, read in part Policy: The facility will maintain equipment and supplies that are necessary for the provision of pharmaceutical services and the administration and documentation of medications. Procedures.1. The nurse on duty has the responsibility to assure equipment and supplies relating to drug storage and use are clean, functional, orderly, and in sufficient supply.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities Based on interview and record review, the facility failed to ensure a Level II PASARR (Preadmission Screening and Annual Record Review) evaluation was completed on 1 Resident (#7) of 1 sampled residents for preadmission screening and annual record review for mental health needs or intellectual disabilities.Findings include: Resident #7 (R7)A review of R7's electronic record indicated admission to the facility with diagnosis including bipolar disorder on 6/4/24. R41's EMR indicated PASARR II was completed on 8/5/24. The PASARR II stated, if the above-named individual remains in the nursing facility, a Level II Evaluation is needed by August 4, 2025.On 5/5/26 at 11:40 AM, during an interview, the Director of Nursing (DON) stated Registered Nurse (RN) J is responsible for the facility's social services. The DON stated RN J would also be responsible for monitoring and obtaining requests for the PASARR process.At 1:11 PM on 5/5/26, an interview was conducted with RN J, who stated a request for the PASARR would have been her responsibility. She stated it was her fault it had not been completed. RN J continued to state that since R7 was already seeing Behavioral Care Solutions, she had not thought about the PASARR system in regard to R7.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on observation, interview, and record review the facility failed to prevent the development of a pressure ulcer and document measurements per standards of practice for one Resident (#4) of three residents reviewed for pressure ulcer development.Findings include: Resident #4 (R4)On 5/4/26 at 11:43 AM, an interview was conducted with R4 in her room. R4 was asked if she had a pressure ulcer on her buttocks and replied, Yes, it comes and goes.On 5/5/26 at 10:45 AM, an observation was made of R4's dressing change with Registered Nurse (RN) G. It was noted to have a padded dressing over her left and right buttock and another padded dressing between her knees on the inner side of her right knee. After removing the dressings on R4's buttocks there was another area that was open just above the original pressure ulcer on R4's right buttocks. The new upper open area was noted to be 1.0 centimeters (cm) by 1.0 cm. Measurements of R4's right lower buttocks were 2.5 cm x 1.5 cm.Review of R4's electronic medical record (EMR), revealed an order dated 3/27/26 to document assessment of skin/wound areas and follow-up actions in a clinical nurse note, Subcategory Skin Condition and to monitor right and left ischial tuberosity and between knees dated 1/31/26.R4's progress note, dated 3/9/26, read in part .Blanchable redness noted to coccyx.R (right) ischial tuberosity with stage II measuring 2.25 cm x 2 cm.Progress noted for R4, dated 3/27/26, read in part .Coccyx continues with non-blanchable redness.Foam dressing applied to L (left) ischial tuberosity for protection. Xeroform and foam dressing applied to R ischial tuberosity d/t (due to) open area measuring 2 cm x 5.25 cm. Patient c/o (complained of) pain to ?my butt'.R4's EMR was reviewed from 3/9/26 through 5/5/26, to ensure documentation of R4's skin/wound was monitored for her pressure ulcer. R4's documentation lacked measurements on weeks: 3/23/26, 4/13/26, 4/20/26, and 4/27/26. R4's skin/wound documentation failed to provide any measurements describing the depth of her stage II pressure ulcer. On 5/5/26 at 11:40 AM, an interview was conducted with the Assistant Director of Nursing (ADON) who was asked what her expectation was for nurses to document measurements of pressure ulcers. The ADON replied, Ideally with every dressing change, but at least once a week. The ADON was asked why there were missing measurements for R4 and replied, We definitely have some gaps in documenting weekly measurements, and it looks like we missed a couple of weeks in a row. The ADON confirmed R4 had missing pressure ulcer measurements and R4's pressure ulcer developed on 3/9/26.Review of policy titled, Pressure Injury Prevention and Management, dated 6/27/25, read in part Purpose: The facility is committed to the prevention of pressure injuries, unless clinically unavoidable, and to provide treatment and services to promote healing, prevent infection, and prevent the development of additional pressure injuries.Assessment of Pressure Injury Risk and Skin Assessment. A. Licensed nurses will conduct skin assessments on admission, weekly, or upon a significant condition change using the admission Skin Assessment form or Weekly Skin Assessment form.Identified pressure injuries will be assessed weekly by the DON and/or designee.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observations, interview, and record review, the facility failed to ensure respiratory equipment was stored in a clean and sanitary manner between resident use for three Residents (#5, # 37, #38) of four residents reviewed for respiratory care.Findings include:Resident #5 (R5) On 5/4/26 at 12:32 PM an observation was made that noted a CPAP (Continuous Positive Airway Pressure) machine mask was draped across a small dresser next to R5's bed. The mask was open to air, not in a plastic bag. At 9:25 AM on 5/5/26 the CPAP mask was again noted to be draped across a small dresser next to R5's bed, with the mask open to air, not in a plastic bag. Resident #37 (R37) On 5/4/26 at 12:35 PM, an observation was made of R37's room and was found to have an intact nebulizer on his nightstand with condensation in the medication cup. R37 also had a bubbler on his nightstand with oxygen tubing coiled up around the bubbler. Neither of R37's respiratory equipment was stored in a bag as R37 was not utilizing either piece of respiratory equipment. At 9:52 AM on 5/5/26, R37's nebulizer was observed intact lying on his nightstand with condensation in the medication cup and his oxygen tubing was coiled around the bubbler and regulator device in the oxygen wall port. Resident #38 (R38) On 5/4/26 at 12:40 PM, an observation was made of R38's room and was found to have a nebulizer intact with condensation inside the medication cup lying on his nightstand. R38's nebulizer lacked a date. At 9:50 AM on 5/5/26, R38's nebulizer was observed intact, without a date, and coiled around the regulator device in the oxygen wall port. On 5/5/26 at 10:00 AM, an interview was conducted with the Assistant Director of Nursing (ADON) regarding the storage of oxygen equipment while not in use and replied, It should be stored in a bag and nebulizers are to be rinsed, dried, and then placed in a bag until the next use. Review of facility provided document titled, Inhalers-Nebulizers, undated, read in part .Treatment is complete when medication cup is empty. Rinse mouthpiece, with water, allow to dry, store in a clean location.