STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235464	A. Building B. Wing	03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
North Woods Nursing Center	2532 Cadillac Dr Farwell, MI 48622

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 - Few	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 obtain and document vital signs prior to medication administration for 2 of 6 residents (Resident #6 and #51) reviewed for professional standards of practice. Findings: Resident #6 (R6) Review of an Admission Record revealed R6 was a [AGE] year-old female, admitted to the facility on [DATE], with pertinent diagnoses which included: Review of R6's Order Summary dated 9/11/24 revealed, Insulin Lispro Injection Solution 100 UNIT/ML (Insulin Lispro)-Inject 5 unit subcutaneously with meals for DM (diabetes mellitus) hold if BS <110 (blood sugars less than 110). Blood sugars were to be obtained prior to the insulin administration to ensure R6's blood sugar was not less than 110. This was to be completed prior to the 8:00 AM, 12:00 PM, and 5:00 PM insulin administration. Review of R6's Blood Sugar Summary revealed: *On 01/14/2025 at 9:59 AM R6's blood sugar was 182. There was no blood sugar assessment completed prior to the 8:00 AM lispro administration. Indicating R6's blood sugar was not assessed prior to the administration of lispro insulin. *On 01/22/2025 at 11:59 AM R6's blood sugar was 166. There was no blood sugar assessment completed prior to the 8:00 AM lispro administration. *On 02/24/2025 at 10:35 AM R6's blood sugar was 172. There was no blood sugar assessment completed prior to the 8:00 AM lispro administration. Review of R6's January Medication Administration Record revealed *On 01/14/2025 R6's insulin was documented as administered at 8:00 AM with a blood sugar of 182 and was documented as administered at 12:00 PM with a blood sugar of 182. (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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*On 01/22/2025 R6's insulin was documented as administered at 8:00 AM with a blood sugar of 166 and was documented as administered at 12:00 PM with a blood sugar of 166. Review of R6's February Medication Administration Record *On 01/22/2025 R6's insulin was documented as administered at 8:00 AM with a blood sugar of 172 and was documented as administered at 12:00 PM with a blood sugar of 172. Review of R6's Electronic Medical Record revealed no documentation for the lack of the blood sugar assessments with the administration of lispro. During an interview on 03/06/2025 at 9:10 AM, Director of Nursing (DON) reported that she spoke with the nurse that administered the lispro insulin on 01/14/2025 and 01/22/2025 and it was reported to her that R6 had refused the morning lispro but instead of documenting the refusal on the Medication Administration Record, the nurse put in the 12:00 PM blood sugar assessment and documented the morning lispro as administered. DON was unable to provide a rationale for the lack of blood sugar assessment for R6 on 02/24/2025. Resident #51 (R51) Review of an Admission Record revealed R51 was a [AGE] year-old male, admitted to the facility on [DATE], with pertinent diagnoses which included: hypertension. Review of R51's Order Summary dated 12/21/24 revealed, Bisoprolol Fumarate Oral Tablet 10 MG (Bisoprolol Fumarate)-Give 1 tablet by mouth one time a day related to ESSENTIAL (PRIMARY) HYPERTENSION (I10) hold if HR (heart rate) < (less than) 60, or SBP (systolic blood pressure) < 90 AND Give 0.5 tablet by mouth in the evening related to ESSENTIAL (PRIMARY) HYPERTENSION (I10) Hold if HR<60 or SBP <90. To be administered at 8:00 AM and 4:00 PM. Review of R51's Blood Pressure Summary revealed: *On 01/04/2025 at 08:34 AM R51's blood pressure was 116/65. R51's blood pressure was not reassessed until 11:41 PM. *On 01/14/2025 at 07:43 AM R51's blood pressure was 162/70. R51's blood pressure was not reassessed until 8:30 PM. *On 01/22/2025 at 07:43 AM R51's blood pressure was 126/70. R51's blood pressure was not reassessed until 01/23/2025. Review of R51's January Medication Administration Record revealed: *On 01/04/2025 R51's antihypertensive medication was documented as administered at 8:00 AM with a blood pressure of 116/65 and was documented as administered at 4:00 PM with a blood pressure of 116/65. (Indicating R51's blood pressure was not assessed prior to the administration of the Bisoprolol Fumarate at 4:00 PM.) (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*On 01/14/2025 R51's antihypertensive medication was documented as administered at 8:00 AM with a blood pressure of 162/70 and was documented as administered at 4:00 PM with a blood pressure of 162/70. *On 01/22/2025 R51's antihypertensive medication was documented as administered at 8:00 AM with a blood pressure of 126/70 and was documented as administered at 4:00 PM with a blood pressure of 126/70. Review of R51's Blood Pressure Summary revealed: *On 02/03/2025 at 08:07 AM R51's blood pressure was 142/75. R51's blood pressure was not reassessed until 02/04/2025 at 12:30 AM. *On 02/04/2025 at 12:30 AM R51's blood pressure was 138/65. R51's blood pressure was not reassessed until 02/04/2025 12:43 PM. *On 02/18/2025 at 07:55 AM R51's blood pressure was 122/64. R51's blood pressure was not reassessed until 02/19/2025 at 12:57 AM. Review of R51's February Medication Administration Record revealed: *On 02/03/2025 R51's antihypertensive medication was documented as administered at 8:00 AM with a blood pressure of 142/75 and was documented as administered at 4:00 PM with a blood pressure of 142/75. *On 02/04/2025 R51's antihypertensive medication was documented as administered at 8:00 AM with a blood pressure of 138/65. R51's blood pressure result was from approximately 7.5 hours prior. *On 02/18/2025 R51's antihypertensive medication was documented as administered at 8:00 AM with a blood pressure of 122/64 and was documented as administered at 4:00 PM with a blood pressure of 122/64. Review of R51's Electronic Medical Record revealed no documentation for the lack of the blood pressure assessments prior to the administration of Bisoprolol Fumarate. During an interview on 03/06/2025 at 10:30 AM, Nursing Home Administrator (NHA) reported she had confirmed with DON that there was no additional or supporting documentation for the lack of R51's blood pressure assessments. During an interview on 03/05/25 at 07:50 AM, Registered Nurse (RN) M reported that both the CNAs (Certified Nursing Assistants) and licensed nurses can obtain vital signs. If the CNA doesn't get the vitals prior to the medication administration she will grab her own if there are ordered parameters. RN M reported that the electronic medical record prompts the licensed nurse to input the vital signs. RN M reported that the vital sign assessments are to be made prior to medication administration. Review of the facility policy Medication Administration by the Various Routes dated December 2024 revealed, .13. General Preparation .e. Take vital signs as indicated if the medication administration is contingent upon the results .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37577 Based on observation, interview, and record review, the facility failed to follow infection control practices when providing peri-care for two residents (Resident #46 and Resident #2) of four reviewed for infection control, and when preparing medications for administration to residents. Findings: Resident #46 (R46) Review of an Admission Record revealed R46 was a [AGE] year old male, last admitted to the facility on [DATE], with pertinent diagnoses of profound intellectual disabilities, seizure disorder, muscle wasting, dependent on tube feeding for hydration and nutrition, and dependent on total assistance from staff for all care needs. During an observation on 03/04/25 at 10:19 AM, CNA's (certified nurse aides) N and O provided peri care to R46 and the following was noted: (a) R46 was incontinent of urine and two wash clothes were used to clean the residents genitalia and then placed on the residents over bed table, (b) after peri-care was completed CNA N did not remove the contaminated gloves and touched the broda chair, gait belt, R46s clothing, the foot rest on the broda chair, and bed linens, (c) with the same contaminated gloves on. CNA N closed the top of the tube feed and positioned R46's abdominal binder over the tube feed port, and (d) the over bed table was not sanitized after the two contaminated wash clothes were removed. Resident #2 (R2) Review of an Admission Record revealed R2 was a [AGE] year old female with pertinent diagnoses of spastic quadriplegic (affecting all four extremities) cerebral palsy, severe intellectual disabilities, and a history of urinary tract infections. R2 depended completely on staff to attend to her care needs. During an observation on 03/05/25 at 8:37 AM, CNA I and CNA J provided peri care to R2 and the following was noted: (a) R2 had some stool present, (b) CNA J used a wash cloth to remove the stool, wiping R2's bottom three separate times with the same wash cloth, (c) the wash cloth had visible stool on it, (d) CNA J did not remove the gloves worn to remove the stool and hold the contaminated wash cloth, (e) with the same gloves on, CNA J opened a cupboard in R2's room, removed a small bottle of baby powder, dispensed baby powder onto R2's skin, and returned the bottle of baby powder to the cupboard, (f) CNA I handed CNA J a single use unopened packet of remedy protect zinc oxide, CNA J received the packet with the same gloves used to provide peri care to R2 and placed the packet in the front pocket of her scrubs, (g) CNA J then opened another cupboard in R2's room with the contaminated gloves on, (h) CNA J removed the contaminated gloves and performed hand hygiene, and (i) CNA J removed the contaminated packet of remedy protect zinc oxide from her scrub pocket with a bare hand, showed the surveyor the packet, and stated that it will get used later on another resident because the packet cannot be left in the room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 03/06/25 at 8:05 AM, Registered Nurse (RN) M did not perform hand hygiene, removed a medication card from the controlled substance locked drawer, popped out a pill into her bare hand, and then placed the pill in a medication cup that contained other pills. RN M repeated the process with a second medication card and pill without performing hand hygiene. RN M took the medication cup to the resident residing in bed 116-1 and administered them to the resident. During an interview on 03/06/25 at 8:16 AM, RN M indicated that she was not aware that dispensing pills into her bare hand was not an acceptable practice at this facility. During an interview on 03/06/25 at 8:43 AM, the Director of Nursing stated that dispensing pills into a bare hand and placing that medication in a cup with the intention of administering the pills to a resident, was not the facilities practice nor a standard of practice.