STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235499	A. Building B. Wing	11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grand Oaks Nursing Center	600 Denmark St Baldwin, MI 49304

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37573 This citation pertains to intake M100147971. Past non-compliance was accepted for this citation. Plan identified below. Based on interview and record review, the facility failed to ensure 11 residents (R3, R4, R5, R6, R7, R8, R9, R11, R12, R13, and R14) of 16 residents reviewed, were provided medications as ordered, resulting in medication not given as ordered. Findings include: Review of a Facility Reported Incident (FRI) revealed 15 residents received all their medications for the day at one time on the morning of 10/31/24 by Licensed Practical Nurse (LPN) E. Through the facility's investigation, Licensed Practical Nurse (LPN) A went to R7s room at 10:15 AM and the resident had a blank stare and could not speak. R7 was not aroused with physical stimulation and was brought out to the nurse's station for an assessment. LPN E was R7s assigned nurse this day. The Director of Nursing (DON) was notified of R7's change of condition and checked the medication cart to find R7's medications were not there for the 8 AM, 12 PM, or the 6 PM orders. The DON reviewed all the medication carts and saw missing medications for the residents in LPN E's care for the day. The facility report reflected LPN E later confessed to giving all medications scheduled during her shift at once to the residents in her care on 10/31/24. LPN E reported she did it for time management but denied giving R7 medications. R7 was sent to the hospital for evaluation. The FRI report also mentioned R14 receiving 10 units of short acting insulin at 7:15 AM, and she was symptomatic at 8:30 AM at the nursing station. Her blood sugar was checked, and it was 48 (normal is 60-100 for non-diabetics). The LPN A immediately walked the resident to the dining room for breakfast. Resident #7 (R7) Review of a Face Sheet for R7 revealed she admitted to the facility on [DATE] with pertinent diagnoses of Parkinsons disease, psychotic disorder, and dementia. (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 11/19/24 at 11:00 AM, LPN A reported she went to visit R7 in her room on 10/31/24 around 10:00 AM and saw R7 in her room, not responsive with her eyes opened and tears coming out of her eyes. LPN A reported she had never seen her like that and started to assess her. LPN A reported she was prompted to have the DON check the medication carts to see if the daily medications were in the cart because of an incident on 10/23/24 when LPN A took over the medication cart from LPN E who had already given a resident all her daily medications. LPN A said she did not tell the DON about the incident but did educate LPN E on the potential harm of giving resident medications all at once. When the DON checked the medication carts on 10/31/24, there were no day shift medications in the cart for the residents in LPN E's care and they had to call the physicians to let them know. Review of the Hospital Medical Record for R7 dated 10/31/24 revealed she had a diagnosis of an accidental overdose and acute cystitis (inflammation of the bladder). It seems the nurse this morning gave all of her daily medications rather than just her morning dosages. she seemed a bit more tired than usual. after completing evaluation the dosage of medication that you took beyond your normally prescribed dosage is not particularly harmful in these quantities . In addition we do see you have a urinary tract infection. (sic) Review of the October Medication Administration Record (MAR) for R7 revealed on 10/31/24, LPN E signed off giving all her 8:00 AM medications. The Carbidopa-Levodopa (to treat tremors associated with Parkinsons disease) 25/100 mg (milligrams) is ordered to be given at 8:00 AM, 12:00 PM and 6:00 PM but documented as not receiving the 12:00 PM or 6:00 PM doses. Pramipexole Dihydrochloride (for restless leg associated with Parkinsons disease) is ordered to be given at 8:00 MA, 12:00 PM, and 6:00 PM, and is documented as not given at 12:00 PM and the 6:00 PM. Resident #14 (R14) Review of a Face Sheet for R14 revealed she admitted to the facility on [DATE] with pertinent diagnoses of diabetes and schizoaffective disorder. In an interview on 11/20/24 at 12:07 PM, LPN A was questioned about the incident on 10/31/24 with R14. LPN A reported R14 came out to the nursing station around 8:15 AM with complaints of feeling dizzy. LPN A knew she was diabetic, and she did not receive her breakfast tray yet. LPN A checked R14's blood sugar and it was 43, so she immediately took the resident to the dining room to get her some food. LPN A reported she educated LPN E and told the Director of Nursing (DON) about it. Review of the October MAR for R14 revealed on 10/31/24 she received her 8:00 AM medications but did not receive her Gabapentin (for walking difficulty) 200 mg at 4:00 PM, Metformin 1000 mg (for diabetes) at 4:00 PM, Sodium Chloride at 4:00 PM, Humalog (insulin) 10 units at 5:00 PM, Seroquel (for schizoaffective disorder) 200 mg at 4:00 PM. The Humalog is documented as given at 7:14 AM. Breakfast trays start at 8:00 AM. Resident #3 (R3) Review of the October MAR for R3 revealed on 10/31/24 he received all his 8:00 AM medications including his Coreg (Carvedilol) (blood pressure medication) 4:00 PM dose was documented as not given. Resident #4 (R4) (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the October MAR for R4 revealed on 10/31/24 she received all her 8:00 AM medications including acetaminophen 500 mg and the 4:00 PM dose is documented as not given. Senna-Docusate tablet 8.6-50 mg, give 2 tablets twice a day for constipation is documented as given at 8:00 AM, and documented not given at 4:00 PM. Resident #5 (R5) Review of the October MAR for R5 revealed on 10/31/24 he received all his 8:00 AM morning medications and his Atorvastatin 40 mg (for high cholesterol) is documented as not given at 6:00 PM, Apixaban (anticoagulant) 5 mg ordered twice a day is documented as not given at 4:00 PM, PreserVision (multivitamin with minerals for macular degeneration) ordered twice a day and documented as not given at 4:00 PM. Bumetanide 1 mg (diuretic) ordered twice a day and the 1:00 PM dose is documented as not given. Resident #6 (R6) Review of the October MAR for R6 revealed on 10/31/24 he received all his 7:00 AM and 8:00 AM medications. His Metformin (diabetic medication) 1000 mg tablets ordered twice a day is his 4:00 PM dose is documented as not given. Benztropine Mesylate (for extrapyramidal symptoms and movement disorder) 2 mg ordered three times a day and documented as not given at 12:00 PM. Resident #8 (R8) Review of the October MAR for R8 revealed on 10/31/24 she received all her 8:00 AM medications. Her Metoprolol Tartrate (for blood pressure) ordered twice day, was documented as not given at 4:00 PM. Pantoprazole (antiulcer) 40 mg ordered twice a day and was documented as not given at 4:00 PM. Resident #9 (R9) Review of the October MAR for R9 revealed on 10/31/24 he received his 7:00 AM and 8:00 AM medications. He was ordered Preservision 2 caps twice a day the 4:00 PM dose is documented as not given. Systane eye drops is ordered three times a day and the 12:00 PM dose is documented as not given. Resident #11 (R11) Review of the October MAR for R11 revealed on 10/31/24 he received his 8:00 AM morning medications. He was ordered Furosemide (diuretic) 40 mg twice a day and his 1:00 PM dose is documented as not given. Potassium Chloride 10 milliequivalents (mEq) ordered twice a day and his 1:00 PM dose is documented as not given for the 1:00 PM dose. Buspirone 10 mg (for anxiety) ordered three times a day and the 2:00 PM dose is documented as not given. Resident #12 (R12) (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the October MAR for R12 revealed on 10/31/24 she received her 8:00 AM medications but her Tylenol 650 mg is documented as not given at 11:00 AM and 3:00 PM. Resident #13 (R13) Review of the October MAR for R13 revealed on 10/31/24 she received her 8:00 AM medications. Her Potassium Chloride 10 mEq at 4:00 PM and her Bumetanide 1 mg (diuretic) at 4:00 PM is documented as not given. During an observation and an interview on 11/19/24 at 2:15 PM, LPN B reported medications come from the pharmacy in packages with the ordered times of the medications in one package. If a person gets 8:00 AM medication, all those medications would be in one package. Some residents will have more than one package of medications because they get medications at different times of the day. LPN B reported she is the nurse for R14 and reported short acting insulin (Humalog) should not be given until at least 15 minutes before meals. Anytime longer than that is too long, and the residents would need a snack or something if meals are delayed. Breakfast trays will start getting served at the dining room at 8:00 AM. In a telephone interview on 11/20/24 at 11:17 AM, LPN E reported she did make a medication error on 10/31/24 by giving a resident more than the amount of medication than she should have. She felt the best way to avoid this from happening again was to remove herself and so she resigned. When asked if she gave more medications than she should have to more than one resident, she reported I won't answer that, then said there may be more than one resident. She could not remember the residents she gave more than the ordered number of medications. LPN E admitted she was wrong for giving those medications but said it was not with malicious intent. In an interview on 11/20/24 at 1:00 PM, the DON reported she was not made aware of LPN E giving a resident a full day of medications at once on 10/23/24 until the incident on 10/31/24 when R7 had a change in condition. LPN A suggested checking the medication cart to see if all her medications for the day were given. The DON checked the medication carts and the daily medications for the residents in LPN E's care were gone. She could not find them and confirmed the pharmacy did deliver them to the facility. She had LPN E sit in her room while she investigated it. At first LPN E denied giving the residents their afternoon medications early but then admitted she did do it for time management. During the onsite survey, past noncompliance (PNC) was cited after the facility implemented actions to correct the noncompliance which included .: 1. On 10/31/24 the facility identified a concern with a staff member giving all day shift medications in the morning to several residents. 2. R7 was transferred to the hospital for evaluation. 3. The DON audited all 4 medication carts in the facility on 10/31/24 and found 14 residents' who were in LPN E's care had afternoon medications missing in the cart . 4. The Medical Director was notified and ordered the monitoring of residents and their vital signs. (continued on next page)

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