STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235543	A. Building B. Wing	02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lincoln Haven Nursing and Rehabilitation Community	950 Barlow Rd Lincoln, MI 48742

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49302 Based on interview and record review, the facility failed to notify the physician of a change in condition related to blood glucose monitoring for one Resident (#5) of thirteen residents reviewed for a change in condition. Findings include: Resident #5 (R5): Review of R5's electronic medical record (EMR) revealed initial admission to the facility on [DATE] with diagnoses including Parkinson's disease, and type two diabetes mellitus. Review of R5's most recent Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 15, indicative of intact cognition. Review of R5's EMR revealed the following physician's order: Insulin lispro insulin pen; 100 unit/mL (millimeter); amt (amount): Per Sliding Scale; If Blood Sugar is 200 to 250 [milligrams/deciliter, mg/dL] give 2 Units. If Blood Sugar is 251 to 300, give 4 Units. If Blood Sugar is 301 to 350, give 6 Units. If Blood Sugar is 351 to 399, give 8 Units. If Blood Sugar is greater than 400, call MD (medical doctor). Subcutaneous (under the skin) Four Times A Day 05:00, 11:00, 16:00 [4:00 PM], 20:00 [8:00 PM]. (continued on next page)

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R5's blood glucose levels in the prior 3 months revealed the following elevated blood glucose levels: 1. 2/25/25 at 19:52 [7:52 PM]: 425 mg/dL 2. 2/10/25 at 16:22 [4:22 PM}: 450 mg/dL 3. 12/8/24 at 15:13 and 15:17 [3:13 PM and 3:17 PM]: 472 mg/dL 4. 12/3/24 at 11:13 AM: 470 mg/dL 5. 11/25/24 at 11:11 AM: 493 mg/dL 6. 11/24/24 at 10:11 AM: 475 mg/dL Review of R5's EMR revealed the physician had not been notified of the blood glucose levels out of the acceptable parameters. On 2/27/25 at 9:08 AM, an interview was conducted with Registered Nurse (RN) B regarding the facility's blood glucose monitoring protocol. RN B indicated if a blood glucose reading is out of range, either greater than 400 mg/dL or less than 70 mg/dL, the facility physician should be notified. RN B stated a corresponding progress note should be entered into the resident's EMR indicating the blood glucose level, the physician's response, any symptoms experienced by the resident, and the results of the follow-up monitoring. RN B identified the potential dangers of hyperglycemia [high blood glucose levels] as an accumulation of ketones in the blood which may lead to a diabetic coma and even death. On 2/27/25 at 11:33 AM an interview was conducted with the Director of Nursing (DON) regarding blood glucose monitoring expectations. The DON confirmed a physician should be notified if blood glucose levels are less than 70 mg/dL or greater than 400 mg/dL. Review of the facility's Physician Standing Orders read, in part: .Notify physician of any glucose above 400 [mg/dL] . Review of the facility policy, Notification of Change, reviewed 1/2025, read, in part: .the resident's physician .must be notified when an event involving the resident occurs or when the resident experiences a change in condition . Call the physician and document using the SBAR [Situation-Background-Assessment-Recommendation] Communication Form and/or Progress note . document physician's orders and implement .document the resident's condition change and new orders on the 24 hr [hour] report log .monitor and reassess the residents status and response to interventions . Review of the facility policy, Diabetic Management Program, reviewed 1/2025, read, in part: This policy is designed to provide standardized guidance for diabetic management and ensure appropriate treatment is initiated for hyperglycemic and hypoglycemic episodes . call the physician immediately if blood sugar is > [greater than] 300 [mg/dL], or as determined by a physician's order .

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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 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** 49302 Based on interview and record review, the facility failed to monitor and assess 2 Residents (#5 & #177) of 13 residents reviewed for quality of care. Findings include: Resident #5 (R5): Review of R5's electronic medical record (EMR) revealed initial admission to the facility on [DATE] with diagnoses including Parkinson's disease, and type two diabetes mellitus. Review of R5's most recent Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 15, indicative of intact cognition. Review of R5's EMR revealed the following physician's order in part: Insulin lispro insulin pen; 100 unit/mL (millimeter); amt (amount): Per Sliding Scale; . If Blood Sugar is greater than 400, call MD (medical doctor). . Four Times A Day 05:00, 11:00, 16:00 [4:00 PM], 20:00 [8:00 PM]. Review of R5's EMR revealed the following progress note written by Licensed Practical Nurse (LPN) C on 2/14/25 at 4:51 PM: Resident with blood sugar of 518 [mg/dL]; asymptomatic. [Nurse Practitioner] .made aware. Verbal order received to give 15 units of insulin lispro x 1 now and recheck blood sugar in one hour; if not under 400 [mg/dL] call back . Review of R5's EMR did not revealed a follow-up blood glucose level. On 2/27/25 at 10:53 AM, an interview was conducted with LPN C regarding R5's blood glucose level of 2/14/25. LPN C confirmed general protocol is to notify a physician if a blood glucose level is above 400 mg/dL or below 70 mg/dL. LPN C stated the physician typically orders a re-check of blood glucose levels within an hour to determine if the level is trending up or now and determine if further interventions are needed. LPN C was unsure why a re-check in blood glucose levels was not documented on 2/14/25. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/27/25 at 11:33 AM, an interview was conducted with the Director of Nursing (DON) regarding expectations on blood glucose monitoring. The DON stated R5's blood glucose levels should have been re-checked and documented in the EMR per physician's orders. Review of the facility policy, Notification of Change, reviewed 1/2025, read, in part: The Residents physician and responsible party must be notified when an event involving the resident occurs or when a resident experiences a change in condition . document physician's orders and implement .monitor and reassess the residents status and response to interventions . 45123 Resident #177 (R177) Review of R177's face sheet, dated 2/25/25, revealed R177 was admitted to the facility on [DATE] with medical diagnoses including, osteomyelitis of the right ankle and foot, peripheral vascular disease, hypertension, and diabetes mellitus. R177 was recently admitted for rehabilitation and was post-operative from an orthopedic surgery which included amputation of his right five toes and partial foot. Review of the EMR initial admission assessment for R177, dated 2/24/25, revealed arrival to the facility at 6:20 PM. There was no baseline care plan that could be located in the EMR for the date range of 2/24/25 through 2/27/25. On 2/27/25 at 10:00 AM, during an interview regarding R177's care plans, Licensed Practical Nurse (LPN) C was asked who creates the care plans, and where they are kept. LPN C replied, The admitting nurse does a baseline care plan and then either the Director of Nursing or the Minimum Data Set nurse builds a comprehensive care plan. (R177's) baseline care plan is in this folder right here along with other admission papers. R177's admission papers had not been fully completed and were not accessible to Certified Nursing Assistance. Review of R177's baseline care plan, was not dated. Review of R177's physician orders, dated 2/24/25, revealed an order for insulin glargine pen and to give 35 units subcutaneous in the morning between 6:30 AM and 10:30 AM, and a second order for finger stick blood sugar monitoring before meals and at bedtime to be checked at 6:00 AM, 11:00 AM, 4:00 PM, and 8:00 PM. Review of R177's medication administration record (MAR) and vital sign monitoring, dated 2/24/25 through 2/27/25, revealed no recorded blood glucose monitoring on 2/24/25 at 8:00 PM, 2/25/25 at 6:00 AM, 11:00 AM, 4:00 PM, or 8:00 PM, and 2/26/25 at 6:00 AM. R177 had no recorded vital signs for new admission monitoring on 2/25/25. On 2/27/25 at 11:00 AM, an interview was conducted with the DON who was asked about the new admission process, glucose monitoring, and vital signs. The DON replied, I have been busy and have not scanned in or started the comprehensive care plan yet. New admissions should be getting a full set of vital signs twice a day. If a resident is on insulin or is diabetic, then blood glucose monitoring should be completed, especially if they are on a sliding scale. (continued on next page)

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy, Diabetic Management Program, reviewed 1/2025, read, in part, This policy is designed to provide standardized guidance for diabetic management and ensure appropriate treatment is initiated for hyperglycemic and hypoglycemia .

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49302 Based on observation, interview, and record review, the facility failed to ensure interventions were implemented per physician's orders for one Resident (#16) of three residents reviewed for positioning and pressure ulcers. Findings include: Resident #16 (R16): Review of R16's electronic medical record (EMR) revealed initial admission to the facility on [DATE] with diagnoses including peripheral vascular disease (a disorder that causes narrowing or blocking of the blood vessels) and cellulitis of the left lower limb. Review of R16's most recent Minimum Data Set (MDS) assessment, dated 12/20/24, revealed a Brief Interview for Mental Status (BIMS) score of 15, indicative of intact cognition. On 2/25/25 at 1:03 PM, R16 was observed lying in bed. A pair of protective boots were observed placed on a recliner across the room. When R16 was asked if she wears the boots she replied, Sometimes. R16 indicated the staff did not always put them on. R16 denied refusing to wear the protective boots. On 2/26/25 at 11:44 AM, R16 was again observed resting in bed, with the pair of protective boots placed on a recliner across the room. Review of R16's EMR revealed the following physician order, initiated 9/30/24: Soft offloading boots to BLE [bilateral lower extremities] while in bed QS [every shift]. On 2/27/25 at 10:48 AM, an interview was conducted with Certified Nursing Assistant (CNA) A regarding R16's adaptive equipment needs. When asked if R16 wore the protective boots in her room, CNA A responded, Not very often. CNA A was asked if R16 was care planned to wear the protective boots to which she responded, I don't think so, but I can check. CNA A acknowledged they were unaware of the protective boots intervention for R16 because it wasn't listed in the care plan. On 2/27/25 at 11:05 AM an interview was conducted with Licensed Practical Nurse (LPN) C regarding R16's care plan. LPN C verified R16 had an existing physician's order to have soft boots applied at all times while in bed, however, it was not reflected in the care plan. LPN C indicated CNAs did not have access to residents' physician orders. Review of R16's EMR revealed the following progress note dated 9/30/24, which read in part: [R16's] bilateral heels are soft and slightly red/blanchable. Soft off-loading boots applied while in bed to help with pressure reduction . Review of R16's Braden Scale for Prediction of Pressure Sore Risk Assessment, dated 1/1/25, revealed a score of 14, indicative of a moderate risk. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/27/25 at 11:33 AM, an interview was conducted with the Director of Nursing (DON) regarding adaptive equipment expectations. The DON responded, At a bare minimum, splints should be entered into orders, but ideally they should be in the plan of care. The DON agreed CNAs would not know if a resident required adaptive equipment if it isn't in their plan of care. The DON stated, I'm going to add them right now [to the plan of care]. Review of the facility policy titled, Use of Assistive Devices, revised 1/2025, read, in part: .the use of assistive devices with be based on the resident's comprehensive assessment, in accordance with the resident's plan of care .a nurse with responsibility for the resident will monitor for the consistent use of the device .refusals of use .will be documented in the medical record .

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45123 Based on observation, interview, and record review, the facility failed to treat pain timely for one Resident (#177) of one resident reviewed for pain. Findings include: Resident #177 (R177) Review of R177's face sheet, dated 2/25/25, revealed admission to the facility on [DATE] with diagnoses including, osteomyelitis (bone infection) of the right ankle and foot, peripheral vascular disease, hypertension, and diabetes mellitus. R177 was recently admitted for rehabilitation and was post-operative from an orthopedic surgery which included amputation of his right five toes and partial foot. On 2/25/25 at 12:26 PM, R177 was observed lying in his bed with a dressing on his right foot. R177 was asked what kind of operation he had on his foot. R177 replied, I had an infection, and they had to removed part of my foot including my toes. R177 was asked about pain and stated that he was comfortable when he left the hospital and when he first got to the facility, but now he was very uncomfortable. R177 stated his current pain level was an 8-9 (pain scale 0-10). R177 further explained his primary doctor prescribed him oxycodone with acetaminophen 10/325 milligrams (mg) one every four hours as needed. R177 was asked when the last time he had his pain medication and replied, Yesterday, before I left the hospital. Review of discharge paperwork, dated 2/24/25, revealed R177 underwent surgical amputation of his right foot on 2/20/25 and was sent to the facility with an order for oxycodone with acetaminophen 10/325 mg, one tablet by mouth every six hours as needed. Review of the initial admission assessment, dated 2/24/25, revealed R177 arrived in the facility at 6:20 PM. On 2/25/25 at 12:30 PM, an interview was conducted with Medical Director (MD) G who was asked about R177 and his pain medication. MD G replied, The staff called me last night and I told them to fax it to me and I never got the fax. I got a call this morning from the Director of Nursing (DON), and so I told them again to fax it and never received it, so I came in to sign the C-2 [controlled substance-2] form. MD G expressed he was frustrated he did not receive the C-2 form sooner. On 2/27/25 at 11:35 AM, an interview was conducted with the DON who was asked how new admissions receive controlled substance pain medications. The DON replied, Nursing must fill out a C-2 form and fax it to the doctor for an authorization signature. Then after the C-2 is signed, it is faxed to pharmacy for an authorization code. After nursing receives the code from the pharmacy, the medication can be pulled from back-up medication box and given to the resident until the medication is sent from the pharmacy. The DON was asked why the C-2 form did not get sent to the doctor after R177 was admitted to the facility. The DON replied, I left that to the admitting night nurse who did not send it to the doctor. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/25/25 at 12:39 PM, an interview was conducted with Licensed Practical Nurse (LPN) D who confirmed that there was oxycodone with acetaminophen 10/325 mg in the back-up medication box. LPN D also confirmed the same process for obtaining medication from the back-up box as the DON described. LPN D stated that she just faxed the C-2 form for R177 to the pharmacy and was going to check if the pharmacy had sent a response back in a little while. Review of R177's medication administration record (MAR), dated February 2025, revealed that R177 received a dose of oxycodone with acetaminophen 10/325 mg on 2/25/25 at 1:54 PM, approximately 20 hours after being admitted to the facility. R177 also underwent a dressing change in the morning of 2/25/25 without pain medication. On 2/26/25 at 8:10 AM, an interview was conducted with R177 who was asked how his pain management was going. R177 replied, I am so happy to finally get pain medication now. On 2/26/25 at 2:35 PM, an observation was made of R177 receiving a wound dressing change. R177 was asked to compare yesterday's wound dressing change to today's wound dressing change. R177 replied, Today went much better because I now have may pain medication. Review of policy, tilted, Pain Management, dated 01/2025, read in part Purpose: to provide an approach to pain management that provides the resident with optimal comfort, dignity and quality of life .7. The provider will be notified if comfort is not achieved following pain management interventions, for changes in pain characteristics, and/or with new onset pain or breakthrough pain.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45123 Based on observation, interview, and record review, the facility failed to ensure proper storage of medications in two of two medication carts reviewed for pharmacy services. Findings include: On [DATE] at 10:30 AM, the [NAME] medication cart was observed, which was found to have three controlled substance medications that had been discontinued and remained in the medication cart as follows: a.) One blister pack from Resident #19 of tramadol 50 mg tablets that was ordered on [DATE] and discontinued on [DATE] with 9 of 15 remaining. b.) One blister pack from Resident #180 of lorazepam 0.5 mg tablets ordered on [DATE] and who was discharged from the facility on [DATE] with 15 of 15 remaining. c.) One blister pack from Resident #181 of lorazepam 1 mg tablets ordered on [DATE] and who was discharged from the facility on [DATE] with 11 of 13 remaining. On [DATE] at 1:24 PM, an interview was conducted with the Nursing Home Administrator (NHA) who was asked about the destruction of controlled substances. The NHA replied, The nurses give them to the Director of Nursing (DON) and that nurse, and the DON destroy them at that time. Pharmacy destruction policy is followed by the two of them. The NHA was unclear as to how often this occurs. On [DATE] at 10:15 AM, an observation was made of the East medication cart, which revealed two loose tabs of alendronate 10 milligrams (mg) and a blister pack of the same medication that held 7 tabs of alendronate 10 mg that were to be dispensed every Tuesday to an unidentified resident. Registered Nurse B confirmed via the medication administration record (MAR) that the unidentified resident was given the medication on [DATE] at 5:42 AM by the night shift nurse, RN H. On [DATE] at 2:30 PM, an observation was made of the [NAME] medication cart-controlled substance log and the three controlled substances remained in the active medication cart supply. On [DATE] at 10:35 AM, and interview was conducted with the Director of Nursing (DON) who was asked how long discontinued controlled substances should be left in the active medication cart supply. The DON replied, I have been very busy lately and have not had time to destroy them. They should be destroyed as soon as possible if they have been discontinued so there is no concern for misappropriation. When asked about the loose pill in the medication cart, the DON explained they should not have loose pills, and stated the carts were just cleaned. The DON replied, It sounds like the resident did not get their full dose of the medication prescribed. I will look into this. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 10:50 AM, and interview was conducted with the NHA who was asked how often and when the last time the medication carts were cleaned out. The NHA replied, I just did them with Licensed Practical Nurse (LPN) E on Monday morning, the 24th of this week. The NHA was asked if loose pills should be left in the medication carts. The NHA replied, No, there should not be any loose pills in the carts, they were just cleaned out. Review of policy, Control Substances Discontinued/Disposal of Medications, dated ,d+[DATE], read in part Policy: When medications are discontinued by the Physician or if a resident is transferred / discharged and medications are not taken with him / her, or in the event of resident's death and the medication require destruction / disposal or if the prepared medication was refused or contaminated (dropped on the floor) the following procedures will be followed, all changes will be in accordance with state or pharmacological regulations. Procedure: 1. Reason for Destruction: Facility will remove medication(s) from the medication cart to be destroyed for the following reasons: a.) When an order to discontinue a medication is received. b.) The resident has been discharged from the facility; including transfer and expiration . Review of policy, Disposal / Destruction of Expired or Discontinued Medication, dated [DATE], read in part .2. Once an order to discontinue a medication is received, facility staff should remove this medication from the resident's medication supply . Review of policy, Maintenance of Medication Storage Areas, dated ,d+[DATE], read in part .A. Cart: 1. Clean inside and out, including crushing devices .