STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235574	A. Building B. Wing	06/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cascade Senior Care Center, LLC	2121 Robinson Rd Jackson, MI 49203

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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27306 Based on interview and record review, the facility failed to ensure that the Notice of Medicare Non-Coverage (NOMNC) and Skilled Nursing Facility Advanced Beneficiary Notice (SNF ABN) were provided accurately and timely to two Residents (R#25 and R#107) of three reviewed. Findings include: Resident #25 Review of the clinical record, including the Minimum Data Set (MDS) dated [DATE] revealed Resident 25 (R25) was a [AGE] year old admitted to the facility on [DATE] utilizing Medicare part A benefits. Review of the NOMNC for R25 reflected a last covered day under Medicare A would be 4/16/25. The NOMNC was signed by R25 on 4/15/25, thus not giving the required time frame for the notice . Review of the SNF ABN, also signed by R25 on 4/15/25 revealed R25 would be billed privately starting 4/18/25. Resident #107 Review of the clinical, including the Minimum Data Set (MDS) record reflected Resident 107 (R107) was admitted to the facility on [DATE]. Review of the NOMNC for R107 reflected a last covered day under Medicare A would be 2/19/25 the form was signed by R107 and dated 2/19/25. On 06/03/25 at 03:28 PM, during an interview with the facility Social Worker (SW) K she reported being responsible for issuing NOMNC and SNF ABN and always issued them with 3 days notice to ensure residents had adequate time to appeal. Review of R25's and R107's NOMNC, SNF ABN was completed with SW K whom offered no explanation for why the notices were issued late and inaccurate.

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 45038 Based on observation, interview, and record review the facility failed to develop and implement comprehensive care plans for one resident (#49) of 14 resident reviewed. Findings included: Resident #49 (R49) Review of the medical record demonstrated R49 was admitted to the facility 04/16/2025 with diagnoses that included fracture of right tibia (the larger of the two bones in the lower leg), infection at surgical site, cellulitis (bacterial infection) of left upper limb, chronic pain, osteoarthritis (degenerative joint) of right knee and right hip, hypertension, atrial fibrillation, malnutrition, depression, prediabetes, gastro-esophageal reflux, neurocognitive disorder with Lewy Bodies (Lewy Body Dementia), anxiety, and schizoaffective disorder. Review of the Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 04/22/2025, revealed R49 had a Brief Interview for Mental Status (BIMS) of 10 (moderate cognitive impairment) out of 15. During observation and interview on 06/02/2025 at 11:26 a.m. R49 was observed sitting up in a recliner chair at bedside. R49 explained that she was bored at the facility. It was inquired of R49 if the facility provided her with an activity calendar with activities that she could possibly attend. R49 explained that she was unaware of any Calander of activity programs. No activity Calander was observed posted in R49's room. Review of R49's medical record did not reveal any listed plan of care demonstrating what activity programs R49 may have been interested in attending or completing while at the facility. Review of R49's Life Enrichment Assessment, dated 04/17/2025, listed her activities as passive, centered almost entirely family activities, and solitary activities. R49's Life Enrichment Assessment , dated 04/17/2025 also revealed Will Activities- functional status be addressed in the care plan?, was answered yes. During observation and interview on 06/03/2025 at 01:31 p.m. R49 was observed sitting up in her recliner at bedside. R49 was asked if anyone invited her to facility activity? R49 explained that no one has ever invited her to any activities. R49 denied again that she had ever been provided an activity calendar. No activity calendar was observed in her room. R49 again expressed concern that she was bored at the facility. Review of R49's activity participation, in the medical record, for the last 30 days revealed an activity entitled conversation/reminiscing and documented participation 21 times. R49's activity participation for the last 30 days also revealed that seven times out of those 21 times were only conducted with R49 participating, not staff. The activity record did not demonstrate any group activity being offered to R49. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 06/03/2025 at 01:53 p.m. Nursing Home Administrator (NHA) A explained that it was her expectation that the Life Enrichment (Activity) Department provide a monthly activity Calender, of list activity programs, to all residents. NHA A also explained that it was her expectation that all residents plan of care included activity preferences. NHA A confirmed that R49 did not have a plan of care demonstrating her activity preferences. NHA A could not explain why no care plan was present for R49's activity preferences. In an interview on 06/04/2025 at 12:54 p.m. Activity Assistant (AA) L explained that activities are documented in the resident's records for each activity that residents are invited to attend or that the resident participates in. AA L explained that all residents are provided an activity calendar that is usually placed on the bathroom door of the residents' room. During observation and interview on 06/04/2025 at 01:08 p.m. R49 was observed sitting up in recliner chair. She was observed coloring with colored pencils. It was also observed that an activity calendar was hanging on the exterior of her bathroom door. R49 explained that someone from the activity program at the facility had come into her room and discussed June's activity calendar and hung it on her bathroom door. R49 also explained that the same person had given her colored pencils and coloring books at that time. R49 explained that she was happy and excited that she was able to color and had been given the option to attend other activities.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. 45038 During observation, interview, and record review the facility failed to provide failed to provide meaningful, individualized activities for one resident (#49) of one resident reviewed for activities. Findings included: Resident #49 (R49) Review of the medical record demonstrated R49 was admitted to the facility 04/16/2025 with diagnoses that included fracture of right tibia (the larger of the two bones in the lower leg), infection at surgical site, cellulitis (bacterial infection) of left upper limb, chronic pain, osteoarthritis (degenerative joint) of right knee and right hip, hypertension, atrial fibrillation, malnutrition, depression, prediabetes, gastro-esophageal reflux, neurocognitive disorder with Lewy Bodies (Lewy Body Dementia), anxiety, and schizoaffective disorder. Review of the Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 04/22/2025, revealed R49 had a Brief Interview for Mental Status (BIMS) of 10 (moderate cognitive impairment) out of 15. During observation and interview on 06/02/2025 at 11:26 a.m. R49 was observed sitting up in a recliner chair at bedside. R49 explained that she was bored at the facility. It was inquired of R49 if the facility provided her with an activity calendar with activities that she could possibly attend. R49 explained that she was unaware of any Calander of activity programs. No activity Calander was observed posted in R49's room. Review of R49's medical record did not reveal any listed plan of care demonstrating what activity programs R49 may have been interested in attending or completing while at the facility. Review of R49's Life Enrichment Assessment, dated 04/17/2025, listed her activities as passive, centered almost entirely family activities, and solitary activities. R49's Life Enrichment Assessment , dated 04/17/2025 also revealed Will Activities- functional status be addressed in the care plan?, was answered yes. During observation and interview on 06/03/2025 at 01:31 p.m. R49 was observed sitting up in her recliner at bedside. R49 was asked if anyone invited her to facility activity? R49 explained that no one has ever invited her to any activities. R49 denied again that she had ever been provided an activity calendar. No activity calendar was observed in her room. R49 again expressed concern that she was bored at the facility. Review of R49's activity participation, in the medical record, for the last 30 days revealed an activity entitled conversation/reminiscing and documented participation 21 times. R49's activity participation for the last 30 days also revealed that seven times out of those 21 times were only conducted with R49 participating, not staff. The activity record did not demonstrate any group activity being offered to R49. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 06/03/2025 at 01:53 p.m. Nursing Home Administrator (NHA) A explained that it was her expectation that the Life Enrichment (Activity) Department provide a monthly activity Calander, of list activity programs, to all residents. NHA A also explained that it was her expectation that all residents plan of care included activity preferences. NHA A confirmed that R49 did not have a plan of care demonstrating her activity preferences. NHA A could not explain why no care plan was present for R49's activity preferences. In an interview on 06/04/2025 at 12:54 p.m. Activity Assistant (AA) L explained that activities are documented in the resident's records for each activity that residents are invited to attend or that the resident participates in. AA L explained that all residents are provided an activity calendar that is usually placed on the bathroom door of the residents' room. During observation and interview on 06/04/2025 at 01:08 p.m. R49 was observed sitting up in recliner chair. She was observed coloring with colored pencils. It was also observed that an activity calendar was hanging on the exterior of her bathroom door. R49 explained that someone from the activity program at the facility had come into her room and discussed June's activity calendar and hung it on her bathroom door. R49 also explained that the same person had given her colored pencils and coloring books at that time. R49 explained that she was happy and excited that she was able to color and had been given the option to attend other activities.

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F 0684 Level of Harm - 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** 38383 Based on interview and record review, the facility failed to assess and monitor respiratory status for one (R51) of one reviewed, resulting in R51 being discovered unresponsive and pronounced deceased . Findings include: A Progress Note for [DATE] at 11:58 PM reflected R51 arrived to the facility, from the hospital, via ambulance, at 11:10 PM. The ambulance company reported R51 was hypoxic (low oxygen level), with an oxygen saturation level in the 70's. The note further reflected the ambulance company applied a non-rebreather mask (delivers high concentrations of oxygen) and gave instructions to begin BiPAP (Bilevel Positive Airway Pressure/machine that helps breathing) upon arrival to the facility. BiPAP was initiated with four liters of oxygen per minute. R51's oxygen saturation remained in the 70's, and their respiratory rate was 30 breaths per minute. R51's oxygen was increased to ten liters per minute. Their oxygen saturation increased to 82 percent (%), their respiratory rate was 34 breaths per minute, and they were using their accessory muscles to breathe. The note reflected R51 was unable to converse due to increased work of breathing. The provider was notified, and R51 was transferred back to the hospital at 11:50 PM. Review of the medical record reflected R51 admitted to the facility on [DATE], with diagnoses that included respiratory failure with hypercapnia (high levels of carbon dioxide in the blood), chronic obstructive pulmonary disease, obstructive sleep apnea, type 2 diabetes and heart failure. The 5-day Medicare Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of [DATE], reflected R51 scored 14 out of 15 (cognitively intact) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool). According to the MDS history, R51 died in the facility on [DATE]. A Progress Note for [DATE] at 10:38 PM reflected R51 was admitted to the facility at 3:30 PM with stable vital signs. R51 was receiving four liters of oxygen per minute and did not have respiratory distress, coughing, wheezing or shortness of breath. A Progress Note for [DATE] at 9:09 AM reflected, the nurse was alerted to a full arrest on the rehab unit. The note reflected R51 was in a supine position (lying on back, face up), with oxygen via nasal cannula in place. According to the note, lividity (bluish-purple discoloration of skin after death) was present. The note reflected R51's mouth, finger tips, stomach and extremities (arms/legs) were purple. Upon arrival of the ambulance and Fire Department, asystole (type of cardiac arrest when the heart stops beating entirely) was present on the cardiac monitor, according to the note. A Progress Note for [DATE] at 10:05 AM further reflected when the nurse responded to notification of R51's full arrest, R51 was cold to the touch, was not breathing and did not have a pulse. Rigor mortis was present in R51's jaw, according to the note. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	A Progress Note for [DATE] at 11:17 AM reflected that at 7:00 AM, a Registered Nurse (RN) was informed by a Certified Nurse Aide (CNA) that R51 requested their CPAP (Continuous Positive Airway Pressure/machine that delivers continuous air through the mouth and/or nose to help keep airway open during sleep) machine be removed. According to the note, the CNA assisted with removal and placed oxygen on R51. The RN asked the CNA to check R51's oxygen saturation, which was 90%. The RN responded to R51's room at 8:05 AM and noted R51 in a supine position. R51's fingers and nails were purple. The note reflected R51 had dependent lividity to the face and upper and lower extremities. R51 had rigor mortis in the jaw, was cold to touch, was not breathing and did not have a heartbeat. R51 was pronounced deceased at 8:07 AM. A Progress Note for [DATE] at 12:35 PM reflected a late entry note for time correction. The note reflected the RN responded to R51's room at 8:15 AM, and R51 was pronounced deceased at 8:17 AM. During a phone interview on [DATE] at 9:13 AM, Licensed Practical Nurse (LPN) G reported working 6:00 AM to 2:00 PM on [DATE] and receiving report on R51. LPN G reported their first time seeing R51 was around 8:00 AM, when they were noted unresponsive. LPN G described they had exited the room of another resident and were walking by R51's room, which was dark. LPN G turned on R51's light and observed them to be blue and purple in color. LPN G yelled for the crash cart and checked for R51's pulse. R51 did not have a pulse, was cold to touch and had lividity to her entire lower body, according to LPN G. LPN G reported R51 had oxygen in place, but she was uncertain of the oxygen liter flow. LPN G also noted that there was a CPAP in R51's room. The crash cart was brought to the room, and two additional nurses responded. When asked if she knew the last time anyone saw R51 prior to being noted unresponsive, LPN G stated she heard that another nurse and CNA had gone in and were responding to a breathing issue for R51, but she was unsure of the details of that issue. During a phone interview on [DATE] at 9:42 AM, CNA D reported responding to R51's call light, around 7:00 AM, for a request to assist with turning R51's CPAP machine off and providing the nasal cannula, which was out of R51's reach. CNA D stated R51 was requesting oxygen because the CPAP was not helping them breathe. CNA D reported turning the oxygen concentrator on, but she was unsure what the oxygen liter flow was set to at the time of the interview. CNA D stated there was air coming out of the nasal cannula when providing it to R51. CNA D reported notifying a midnight nurse that R51 seemed coherent and used their call light, stating they were struggling to breathe. Approximately ten minutes after having oxygen in place, R51's oxygen saturation was 90% to 91%, and R51 did not indicate any struggles or complaints, according to CNA D. She reported R51's room was dark, so she was unable to see R51's color but did not notice R51 being short of breath when talking. A Physician's Order, dated [DATE], reflected R51 was to receive four liters of oxygen per minute, via nasal cannula, every shift. Review of R51's medical record did not reflect orders for the use of CPAP or BiPAP. The admission nursing respiratory assessment did not indicate the use of CPAP or BiPAP, however a list of personal belongings in R51's medical record reflected R51 had a CPAP machine. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	In an interview on [DATE] at 11:05 AM, RN E reported working 10:00 PM to 6:30 AM ([DATE] to [DATE]) but was not R51's assigned nurse for the shift. CNA D came to her, stating R51 had a CPAP on but was stating they felt they could not breathe. R51's CPAP was removed, and oxygen was applied. RN E asked for R51's oxygen saturation to be checked, which was reported by the CNA to be 91%, around 7:00 AM to 7:10 AM. RN E reported staying late to document, and around 8:10 AM, LPN G called for the crash cart. RN E went to assist, and 911 was immediately contacted. Upon arrival to the room, RN E noted that R51 was in bed with oxygen via nasal cannula in place and was unsure of the liter flow without looking (in the medical record). RN E stated R51 had dependent lividity, purple fingernails and purple skin. Upon checking R51's airway, rigor mortis was noted to their jaw. RN E reported R51's death was called. When Emergency Medical Services (EMS) arrived, R51 was flat lined (asystole) on the cardiac monitor. Review of the medical record did not reflect that R51 had been assessed by a licensed nurse after report of difficulty breathing on the morning of [DATE]. Review of R51's [DATE] Medication Administration Record (MAR) reflected an order, dated [DATE], for two puffs of Albuterol Sulfate HFA Inhalation Aerosol Solution 108 (90 Base) micrograms per actuation (mcg/act) to be inhaled orally, every six hours, as needed, for wheezing or shortness of breath. The medication was not documented as being administered. R51's [DATE] MAR reflected an order, dated [DATE], for Ipratropium-Albuterol Inhalation Solution 0XXX,d+[DATE].5 milligrams per three milliliters (mg/3 mL) to be inhaled orally, every six hours, as needed, for wheezing or shortness of breath. The medication was not documented as being administered. In an interview on [DATE] at 1:48 PM, Regional Clinical Director (RCD) I reported reviewing staff statements, speaking with some of the nurses, reviewing R51's medical record and ensuring the RN on duty followed the facility's policy on Cardiopulmonary Resuscitation (CPR). RCD I was not aware of anything clinically acute occurring prior to R51 being noted unresponsive. RCD I acknowledged that there should have been a follow-up assessment by a nurse after R51 reported difficulty breathing. On [DATE] at 2:26 PM, RCD I reported R51 admitted with a BiPAP, from the hospital, which would have already had R51's settings programmed.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38383 This citation pertains to intake MI00150737. Based on observation, interview and record review, the facility failed to ensure call lights were responded to in a timely manner for five (R24, R26, R37, R42 and R43), from a census of 54 residents. Findings include: Resident #37 (R37): Review of the medical record reflected R37 admitted to the facility 12/20/23 and readmitted [DATE], with diagnoses that included type 2 diabetes. The Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 3/10/25, reflected R37 scored 12 out of 15 (moderate cognitive impairment) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool). On 06/02/25 at 3:41 PM, R37 was observed seated in a recliner, in their room. Approximately three times per week, on third shift, they waited about 30 minutes for staff to answer their call light to use the urinal. On first and second shift, they waited 15 to 30 minutes to get out of bed. R37 reported the facility was understaffed and did they best they could. Reports for call light response times for R37's room, dated 5/5/25 to 6/4/25 at 10:48 AM, reflected their call light was on for greater than 20 minutes a total of 47 times. The same report reflected a call light response time up to 39 minutes and 16 seconds on 5/18/25. Resident #24 (R24): Review of the medical record reflected R24 admitted to the facility on [DATE] and readmitted [DATE], with diagnoses that included type 2 diabetes, muscle weakness and need for assistance with personal care. The Quarterly MDS, with an ARD of 5/9/25, reflected R24 scored 12 out of 15 (moderate cognitive impairment) on the BIMS. On 06/02/25 at 3:53 PM, R24 was observed seated in a wheelchair, in their room. R24 reported generally, call light response times were 15 to 30 minutes, on day shift, to get assistance to the bathroom. Once in a while, R24 had episodes of incontinence as a result, per their report. Reports for call light response times for R24, dated 5/5/25 to 6/4/25 at 10:30 AM, reflected R24's call light was on for greater than 20 minutes a total of 14 times. The same report reflected a call light response time up to 35 minutes and 20 seconds on 6/1/25. Resident #42 (R42): Review of the medical record reflected R42 admitted to the facility on [DATE] and readmitted [DATE], with diagnoses that included heart failure. The Quarterly MDS, with an ARD of 5/20/25, reflected R42 scored nine out of 15 (moderate cognitive impairment) on the BIMS. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 06/02/25 at 12:45 PM, R42 was observed seated in a wheelchair, in their room. According to R42, they experienced extended call light wait times from 40 minutes to two hours for staff assistance. Reports for call light response times for R42, dated 5/5/25 to 6/4/25 at 9:44 AM, reflected R42's call light was on for greater than 20 minutes a total of 15 times. The same report reflected a call light response time up to 35 minutes and 20 seconds on 5/7/25. Resident #43 (R43): Review of the medical record reflected R43 admitted to the facility on [DATE], with diagnoses that included peripheral vascular disease and adult failure to thrive. The Quarterly MDS, with an ARD of 3/15/25, reflected R43 scored 13 out of 15 (cognitively intact) on the BIMS. On 06/02/25 at 12:45 PM, R43 was observed in their room, seated in their wheelchair. According to R43, they experienced extended call light wait times from 40 minutes to two hours for staff assistance. Reports for call light response times for R43, dated 5/5/25 to 6/4/25 at 9:44 AM, reflected R43's call light was on for greater than 20 minutes a total of six times. The same report reflected a call light response time up to 37 minutes and 41 seconds on 6/1/25. Resident #26 (R26): Review of the medical record reflected R26 admitted to the facility on [DATE] and readmitted [DATE], with diagnoses that included end stage renal disease and dependence on renal dialysis. The Admission MDS, with an ARD of 4/2/25, reflected R26 scored 10 out of 15 (moderate cognitive impairment) on the BIMS. On 06/02/25 at 11:54 AM, R26 was observed in their room, seated in a recliner. R26 expressed that at times, their call light was answered in five to ten minutes, and at other times, it took an hour for staff to respond. R26 stated sometimes staff would have to leave their room to get something and would not return. R26 reported issues seemed more problematic at shift change times. Reports for call light response times, dated 5/5/25 to 6/4/25 at 10:34 AM, reflected R26's call light was on for greater than 20 minutes a total of 17 times. The same report reflected a call light response time up to 33 minutes and 6 seconds on 5/29/25. In an interview on 06/04/25 at 1:42 PM, Nursing Home Administrator (NHA) A reported being aware of concerns/complaints pertaining to extended call light response times, and the facility was actively attempting to improve response times. NHA A reported the goal was to answer a call light within 10 minutes, and staff were educated not to turn the call light off until the resident's need had been met.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 45038 Based on observation, interview, and record review the facility failed to ensure proper medication storage of medications for two residents (#2, #3) out of 54 current residents residing at the facility and failed to label mediation in accordance with accepted professional standards, dating of open multi-dose medication, observed in one medication room out of three medication rooms reviewed. Findings included: Resident #3 (R3): Review of the medical record demonstrated R3 was admitted to the facility 04/04/2025 with diagnoses that included cellulitis (bacterial infection) of left lower limb, psoriasis (condition in which skin cells build up and form scales and itchy, dry patches) , type 2 diabetes, atrial fibrillation, atherosclerotic heart disease (build-up of fats in artery walls), hypertension, sleep apnea, asthma, hypothyroidism (low thyroid hormone), glaucoma (group of eye conditions that damage the optic nerve), fibromyalgia (wide spread musculoskeletal pain) , irritable bowel syndrome, sepsis (condition resulting in extreme response to infection), pneumonia, depression, and chronic obstructive pulmonary disease (COPD). Review of the Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 04/10/2025, revealed R3 had a Brief Interview for Mental Status (BIMS) of 15 (intact cognition) out of 15. During observation and interview on 06/02/2025 at 11:38 a.m. R3 was observed sitting up in her recliner at the bedside. Trelegy 100mcg(micrograms)/62.5mcg/25mcg inhaler and Azelastine 0.1% nasal solution was observed to be sitting on her over bed table. R3 explained that she is allowed to take those medications without the nurse present. Review of R3's medical record had not revealed a physician order for self-administration of medication. R'3s medical record had not revealed a self-administration of medication assessment. R'3s plan of care had not revealed a self-administration of medication plan of care. In an interview on 06/04/2024 at 08:57 a.m. Director of Nursing (DON) B explained that it was facility policy and practice that residents could keep medication in their room and perform self-administration. DON B explained that residents must be assessed for self-administration prior to medication being left in the room and prior to self-administrated. DON B explained if the resident is assessed as safe a physician order would be obtained, resident plan of care would be updated, and lock box would be provide to the resents for storage of the medication in the resident's room. DON B reviewed R3's medical record and could not demonstrate that R3 had a self-administration assessment completed, a self-administration plan of care, or a physician order for self-administration of medication. DON B could not explain why R3 had been observed with medication at R3's bedside. During review of medication storage room on 06/04/2025 at 01:18p.m., it was observed in Rehabilitation Medication Room refrigerator an opened multi-dose 1 ml (milter) vial of Tuberculin 5 tu (tuberculin unit)/0.1ml that was not dated when the tuberculin had been opened. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235574	A. Building B. Wing	06/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cascade Senior Care Center, LLC	2121 Robinson Rd Jackson, MI 49203

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 - Few	During an interview on 06/04/2025 at 01:20 p.m. Licensed Practical Nurse (LPN) T explained that the multi-dose vial of tuberculin should have been dated when opened. LPN T explained that multi-dose vial of tuberculin will be disposed of appropriately and would not be used for residents. In an interview on 06/04/2025 at 02:04 p.m. Regional Clinical Director of Clinical Services I explained that it was professional practice to date all multi-use medical at the time that the medication container was opened. 34705 Resident #2 (R2): Review of the Face Sheet and Minimum Data Set (MDS) dated [DATE], reflected R2 was a [AGE] year old female admitted to the facility on [DATE], with diagnoses that included chronic obstructive pulmonary disease and depression. The MDS reflected R2 had a BIM (assessment tool) score of 14 which indicated her ability to make daily decisions was cognitively intact. During an observation and interview on 06/02/25 a 11:58 AM R2 was laying in bed with two medications sitting on the bedside table, dulera inhaler 100mcg/5mcg and fluticasone nasal spray 50mcg. R2 reported the nurse had brought them in earlier and did not administer to R2 and left the room. R2 reported does not take medication on own. During an interview on 6/04/25 at 8:58 AM, Director of Nursing (DON) B reported had been in position at facility for about three months. DON B reported residents should not have medications at the bedside unless they have been assessed to self administer medications. DON B reported R2 had not been assessed to self administer medication, no physician order to self administer and was not care planned for self administration of medications. DON B reported resident medication should be locked in medication carts.