STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235601	A. Building B. Wing	08/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Iron River Care Center	330 Lincoln Avenue Iron River, MI 49935

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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 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly All times are in Eastern Daylight Time (EDT) unless otherwise noted.Based on interview and record review, the facility failed to ensure quarterly meetings of the Quality Assessment and Assurance (QAA) Committee were attended by the required members. Findings include:On 8/14/25 at 3:12 PM, the Social Services Coordinator (SSC) confirmed she was the designated coordinator of the facility's Quality Assurance Performance Improvement (QAPI) program. The SSC said committee meetings for QAA were held quarterly.The QAA meeting signature sheets were reviewed with the SSC. The signature sheets revealed QAA meetings were held on 10/16/24, 1/16/25, 4/30/25, and 7/30/25.The signature sheet for 4/30/25 and 7/30/25 did not contain the signature of the Administrator (NHA). The SSC was asked if the NHA attended the meetings on those dates, but she could not recall if the NHA was present at those meetings.The SSC reviewed the signature sheets and confirmed the absence of signatures for the NHA on 4/30/25 and 7/30/25. The SSC confirmed the signature sheets did not contain signatures of a governing board or someone in a leadership role with the authority to change facility systems.The undated policy Quality Assurance and Performance Improvement read, in part: . The QAA Committee shall be interdisciplinary and shall: a. Consist at a minimum of: i. The Director of Nursing Services; ii. The Medical Director or his/her designee; iii. At least three other members of the facility's staff, at least one of which must be the Administrator, owner, a board member or other individual in a leadership role.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. All times are in Eastern Daylight Time (EDT) unless otherwise noted.Based on observation, interview, and record review, the facility failed to implement an infection prevention and control program in accordance with facility policies to prevent the potential transmission of communicable diseases and infections resulting in the potential for the transmission of pathogens and the spread of infectious organisms to all 55 residents in the facility. Findings include:During medication administration on 8/13/25 at 12:56 PM, Registered Nurse (RN) E removed medications from blister packs (medication packages that organize and secure individual doses of medication within a sealed plastic and foil compartment) by pushing the medications from the blister pack directly into her ungloved hand before placing the medications into a medication cup or pill-crushing sleeve. RN E separated the plastic drinking cups by placing her ungloved fingers along the rim of the cups where residents drink.On 8/14/25 at 2:10 PM, RN E was observed at the cart containing back-up supplies of controlled substances. RN E dispensed a controlled substance from a blister pack directly into her unwashed, ungloved hand. When asked about placing medications into her hand, RN E said, I don't know why I do that. RN E confirmed a medication cup should be utilized instead of dispensing medications into her hand. Housekeeper (HKP) F was observed removing the soiled waste from the refuse receptacles on two medication carts on 8/13/25 at 12:50 PM. HKP F placed the full bags of dirty waste on the floor while placing new waste liners in the refuse receptacles.On 8/14/25 at 10:04 AM, RN G was observed completing dressing changes on the left distal medial foot and right gluteal cleft of Resident #9 (R9). RN G donned gloves before starting the dressing change procedure on R9's left foot. RN G removed the soiled dressing from the wound, cleansed the wound, and applied a treatment and dressing without performing hand hygiene or glove changes during the dressing change procedure and after touching the soiled dressing. After completing the dressing to R9's left foot, RN G performed hand hygiene and changed gloves before removing the dressing from R9's right gluteal. RN G disposed of the soiled dressing and completed cleansing, treatment, and dressing of the wound. RN G did not perform hand hygiene or change gloves during the procedure after touching the soiled dressing. The Director of Nursing (DON) was interviewed on 8/14/25 at 4:05 PM. When queried regarding dispensing of medications, the DON said a medication cup should be utilized to dispense medications from blister packs. When asked about the process for changing refuse from waste receptacles, the DON said the refuse bags were expected to be directly disposed of in refuse bins, containers in the soiled utility room, or taken to the main disposal container outside the building. The DON agreed refuse should never be placed directly onto the floor.The policy Medication Administration dated as reviewed/revised 7/24/25 read, in part: . Medications are administered.in accordance with professional standards of practice, in a manner to prevent contamination or infection.Remove medication from source, taking care not to touch medication with bare hand .The policy Clean Dressing Change dated as reviewed/revised 3/17/25 read, in part: . It is the policy of this facility to provide wound care in a manner to decrease potential for infection and/or cross-contamination.remove the existing dressing. Remove gloves.Wash hands and put on clean gloves.The policy Infection Prevention and Control Program dated as reviewed/revised 7/5/25 read, in part: . This facility has established and maintains an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections as per accepted national standards and guidelines .

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** All times are in Eastern Daylight Time (EDT) unless otherwise noted.Based on interview and record review, the facility failed to send a copies of residents' written Notice of Transfer to representative of the Office of the State Long-Term Care Ombudsman for five Residents (#3, #56, #9, #59, & #44) of five residents reviewed for hospitalization. Findings include:Resident #9 (R9) was hospitalized on [DATE]. No documentation was in the EMR or on the written Notice of Transfer form indicating the Ombudsman was provided with a copy of the Notice of Transfer. Resident #3 (R3) was transferred to the hospital Emergency Department (ED) on 6/4/25. There was no documentation in the Electronic Medical Record (EMR) or on the written Notice of Transfer form indicating the Ombudsman was provided with a copy of the Notice of Transfer. Resident #56 (R56) was transferred to the ED on 6/1/25. No documentation was in the EMR or on the written Notice of Transfer form indicating the Ombudsman was provided with a copy of the Notice of Transfer. Resident #44 (R44) was transferred to the hospital ED on 7/26/25. There was no documentation in the EMR or on the written Notice of Transfer form indicating the Ombudsman was provided with a copy of the Notice of Transfer. Resident #59 (R59) was transferred to the hospital ED on 7/31/25. There was no documentation in the EMR or on the written Notice of Transfer form indicating the Ombudsman was provided with a copy of the Notice of Transfer. During an interview on 8/13/25 at 4:40 p.m., Social Services Director A reported that a Notice of Transfer from the facility is sent via email to the Long-Term Care (LTC) Ombudsman and she did not send the list of discharges to the ombudsman for June 2025 or July 2025. During a phone interview on 8/14/25 at 11:36 a.m., the LTC Ombudsman C reported that she had not received a list of discharges from the facility since March of 2025. Review of policy titled Transfer and Discharge date reviewed/revised 7/7/25, read in part .The transfer or discharge notice will be provided to. the.LTC Ombudsman.and the facility will maintain evidence that the notice was sent to the Ombudsman.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** All times are in Eastern Daylight Time (EDT) unless otherwise noted.Based on interviews, and record review, the facility failed to implement its policy and procedure to develop and revise individual resident specific comprehensive care plans revisions for three residents (Residents #32, #5 and #1) of 14 residents reviewed for care planning, resulting in the potential for unmet resident care needs and a failure to maintain their highest practicable physical, mental and psychosocial well-being. Findings include: Resident #1 (R1) Review of R1's Electronic Medical Record (EMR) revealed an initial admission to the facility on 1/10/25 with diagnoses including Alzheimer's disease, anxiety disorder, and dementia. Review of R1's Minimum Data Set (MDS) assessment, dated 7/15/25, revealed a Brief Interview for Mental Status (BIMS) score of 11, indicative of moderately impaired cognition. Further review of MDS Section GG (Functional Abilities and Goals) revealed R1 required substantial/maximal assistance for wheeling 150 feet once seated in her wheelchair. The care plan for R1 included a focus which read, I am an elopement risk/wanderer dated 4/29/25. This care plan included interventions of: - - Identify pattern of wandering: Is wandering purposeful, aimless, or escapist? Is resident looking for something? Does it indicate the need for more exercise? Intervene as appropriate. - WANDER ALERT: right ankle During an interview on 8/14/2025 at 10:20 AM, Registered Nurse (RN) I stated R1 had some changes in condition and a new MDS had been completed on 7/15/2025. On 8/14/25 at approximately 10:30 AM, R1 was observed in her room, and she was not wearing a wander alert guard (a device which prevents elopement). During an interview 8/14/2025 11:35, RN G stated, No she (R1) does not wander and had a significant change. RN G said R1 does not move her wheelchair at all and no longer wanders. RN G confirmed a wander alert guard was not in place for R1. During an interview on 8/14/25 at approximately 1:00 PM, RN I stated R1 did not wander and confirmed R1 did not propel her wheelchair. RN I agreed the care plan for R1 needed to be updated. Review of Fundamentals of Nursing ([NAME] and [NAME]) 8th edition revealed, If the patient's status has changed and the nursing diagnosis and related nursing interventions are no longer appropriate, modify the nursing care plan. An out of date or incorrect care plan compromises the quality of nursing care. Review and modification enable you to provide timely nursing interventions to best meet the patient's needs .It is necessary to revises related factors and the patient's goals, outcomes, and priories. Date any revisions. Revise specific interventions that correspond to the new nursing diagnoses and goals. Revisions need to reflect the patient's present status. [NAME], P. A., [NAME], A. G.,Stockert, P. A., & Hall, A. (2014). Fundamentals of Nursing (8th ed.). St. Louis: Mosby. p. 257-258 the requisite knowledge to complete an accurate assessment .Review of the MDS 3.0 RAI Manual v1.16, Chapter 3 Section N: Medications, revealed .The intent of the items in this section is to (continued on next page)

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	235601	A. Building B. Wing	08/14/2025

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Revisions need to reflect the patient's present status. [NAME], P. A., [NAME], A. G., Stockert, P. A., & Hall, A. (2014). Fundamentals of Nursing (8th ed.). St. Louis: Mosby. p. 257-258 . Resident #32: Review of Face Sheet revealed R32 was originally admitted to the facility on [DATE] with pertinent diagnoses which included: Dementia Review of a Minimum Data Set (MDS) assessment for R32, with a reference date of 8/4/25 revealed a Brief Interview for Mental Status (BIMS) score of 3 out of a total possible score of 15, which indicated R32 was severely cognitively impaired. Further review of this MDS assessment read in part: Section E – Behavior-1. Behavior of this type occurred 1 to 3 days. R32 was coded at (1)- B. Verbal behavioral symptoms directed toward others (e.g., threatening others, screaming at others, cursing at others) . Review of R32s MDS dated [DATE] read in part: Section E – Behavior-1. Behavior of this type occurred 1 to 3 days. R32 was coded at (1)- B. Verbal behavioral symptoms directed toward others (e.g., threatening others, screaming at others, cursing at others) . Review of R32's Progress Behavior Note read in part: 7/13/2025 13:27 Behavior Note Text: Resident was agitated with staff during morning care. Resident was hitting staff and yelling at them. Resident spit morning med out on the floor. Resident is showing signs of increased pain and stiffness. Resident refused ROM with staff today. Review of R32's Progress Note read in part: 6/19/2025 00:04 .Progress Note Text: Resident has been disagreeable with other residents in the dining room. He has also been putting remote from Dining room TV in his pocket since yesterday. Review of R32's Progress Behavior Note read in part: 6/14/2025 18:25 Behavior Note Text: It was reported to writer that resident was verbally aggressive in dining room at lunch time. Yelling in the direction of another resident. It is noted resident. Review of R32's Progress Note read in part: 6/12/2025 10:36 Alert Note Text: When aide went in to do a check, resident was trying to strike at aide and was using fowl language. Resisting cares. On-site provider updated on resisting cares and combative behaviors on 6/11/25. Review of R32's Progress Note read in part: 6/11/2025 Progress Notes CHIEF COMPLAINT Asked to see resident due to increasingly aggressive behaviors over the last few days. Behavior was actually worse than it was 2weeks ago when I saw him for inappropriate behavior toward female staff members. Review of R32's Progress Note read in part: 5/27/2025 16:38 Behavior Note Text: Staff nurse reported to writer that resident has been gravitating towards specific female residents around dinner time/afternoon shift. Writer notified social services.Interviewed CNA who reported resident following female reaching for them. CNA and floor nurse reported no inappropriate touching by residents. Resident is easily redirected, but only for short periods of time. Review of current R32's current Care Plans read in part: Alteration in thought process r/t (related too) (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	cognitive awareness impairment. Date Initiated: 02/15/2023. Interventions on this care plan did not reflect any changes, updates or revisions since 2023. Review of current R32's current Care Plans read in part: I have impaired cognitive function/dx of dementia or impaired thought processes r/t impaired decision-making, short-term memory loss. I have a history of increased confusion in the evening. I have a history of wandering into unoccupied rooms and urinating on the floor. Date Initiated: 02/15/2023. Further review of R32's care plans and interventions for this focused area were not updated or revised since 2/15/23. Resident #5: Review of Face Sheet revealed R5 was originally admitted to the facility on [DATE] with pertinent diagnoses which chronic kidney disease, stage 3. Review of a Minimum Data Set (MDS) assessment for R5, with a reference date of 7/28/25 revealed a Brief Interview for Mental Status (BIMS) score of 4 out of a total possible score of 15, which indicated R5 was severely cognitively impaired Review of R5's Progress notes read in part: 6/29/2025 05:05 Infection Note Text: Resident continues on oral antibiotic Augmentin for abscess on buttock . Review of R5's Progress notes read in part: 7/28/2025 05:14 Infection Note Text: Resident continues on oral antibiotic Levaquin for the treatment of UTI. Review of current R5's current Care Plans revealed there were no care plans that reflected R5s status of a long history of UTI's, nor was there a care plan in place indicating antibiotic use. Further review of R5's care plans revealed many of the focus areas, and interventions had not been updated/revised since 2022. Review of R5's Progress notes revealed: 7/28/2025 05:14 Infection Note Text: Resident continues on oral antibiotic Levaquin for the treatment of UTI. In an interview on 8/14/25 at 9:25 AM, Registered Nurse (RN) O it was a group effort to update/revise the care plans. RN O reported R32s' and R5s care plans should include aggressive behaviors, UTIs and antibiotic use, as well as appropriate updated interventions. In an interview on 8/14/2025 at 2:37 PM., Social Services Director (SSD) A reported she does not develop, or update/revise resident care plans. SSD A reported she thinks the nurses. Assistant Director of Nursing (ADON) or Director of Nursing (DON) are responsible for care plans. SSD A reported changes in resident behaviors should be added to care plans and revised as needed. SSD A reported, R32 should have had a behavioral care plan Focus of sexual/aggressive behaviors towards female residents in place, and or updates to his current care plan to reflect new behaviors. In an interview on 8/14/2025 at 1:22 PM., Director of Nursing (DON) reported Resident #5 has had a long history of UTIs with antibiotic use, and R5 has a history of aggressive/agitative behaviors. DON reported both R32 and R5's current care plans should have been updated and/or revised to reflect their current focus areas of concern. DON reported it is a team effort on resident care plans, and clearly some residents care plans have not been revised as they should be per policy and procedure. (continued on next page)

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	235601	A. Building B. Wing	08/14/2025

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Iron River Care Center	330 Lincoln Avenue Iron River, MI 49935

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a facility Policy with a revision date of 6/11/2025 titled Comprehensive Care Plans . read in part: It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment. Policy Explanation and Compliance Guidelines: 1. The care planning process will include an assessment of the resident's strengths and needs and will incorporate the president's personal and cultural preferences in developing goals of care. Services provided or arranged by the facility, as outlined by the comprehensive care plan, shall be culturally[1]competent and trauma-informed. 2. The comprehensive care plan will be developed within 7 days after the completion of the comprehensive MDS assessment. All Care Assessment Areas (CAAs) triggered by the MDS will be considered in developing the plan of care. Other factors identified by the interdisciplinary team, or in accordance with the residents' preferences, will also be addressed in the plan of care. The facility's rationale for deciding whether to proceed with care planning will be evidenced in the clinical record. 3. The comprehensive care plan will describe, at a minimum, the following: a. The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. b. Any services that would otherwise be furnished, but are not provided due to the resident's exercise of his or her right to refuse treatment. c. Any specialized services or specialized rehabilitation services the nursing facility will provide as a result of PASARR recommendations. d. The resident's goals for admission, desired outcomes, and preferences for future discharge. e. Discharge plans, as appropriate. f. Resident specific interventions that reflect the resident's needs and preferences and align with the resident's cultural identity, as indicated. If the resident is non-English speaking, the facility will identify how communication will occur with the resident. The care plan will identify the language spoken and tools used to communicate. 4. The comprehensive care plan will be prepared by an interdisciplinary team, that includes, but is not limited to: a. The attending physician or non-physician practitioner designee involved in the resident's care, if the physician is unable to participate in the development of the care plan. b. A registered nurse with responsibility for the resident. c. A nurse aide with responsibility for the resident. d. A member of the food and nutrition services staff. e. The resident and the resident's representative, to the extent practicable. Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. Examples include, but are not limited to:i. The RAI Coordinator. ii. Activities Director/Staff. iii. Social Services Director/Social Worker. iv. Licensed therapists. v. Family members, surrogate, or others desired by the resident.vi. Administration. vii. Discharge Coordinator. viii. Mental health professional. ix. Chaplain. 5. The comprehensive care plan will be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly MDS assessment. Care plans will be updated throughout the year as needed with any changes in residents' plan of care. 6. The comprehensive care plan will include measurable objectives and timeframes to meet the resident's needs as identified in the resident's comprehensive assessment. The objectives will be utilized to monitor the residents' progress. Alternative interventions will be documented, as needed.7. The physician, other practitioner, or professional will inform the resident and/or resident representative of the risks and benefits of proposed care, of treatment, and treatment (continued on next page)

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	235601	A. Building B. Wing	08/14/2025

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	alternatives/options. The facility will attempt alternate methods for refusal of treatment and services and document such attempts in the clinical record, including discussions with the resident and/or resident representative.8. Qualified staff responsible for carrying out interventions specified in the care plan will be notified of their roles and responsibilities for carrying out the interventions, initially and when changes are made.

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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 one resident (R2) of one Resident reviewed for PASARR (Preadmission screening/Annual Resident Review) obtained a PASARR level 2 (DCH-3878) evaluation to determine the appropriate setting for the individual and if specialized services were needed. This deficient practice resulted in the potential for unmet mental health needs. Findings include: All times are in Eastern Daylight Time (EDT) unless otherwise noted.Review of R2's electronic medical record (EMR) revealed an initial admission to the facility on 4/17/2023 with diagnoses including unspecified dementia with agitation and with psychotic disturbance and post-traumatic stress disorder. A review of R2's Minimum Data Set (MDS) significant change assessment, dated 6/5/25, revealed a Brief Interview for Mental Status (BIMS) should not be completed as the resident is rarely/never understood. Further review of MDS Section E under Behavioral Symptoms revealed R2 was coded as having both physical behavioral symptoms directed towards others (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually) occurring 1 to 3 days and Verbal behavioral symptoms directed towards others (e.g., threatening others, screaming at others, cursing at others) occurring 1 to 3 days. Further, these behaviors were noted to Significantly interfere with the resident's care. A review of the active physician's orders included an antipsychotic drug (Seroquel) prescribed 3/17/2025, as well as a current order for an antidepressant drug (Remeron) prescribed 6/12/2024. The care plan for R2 included:- a focus which read in part, I am resistive to care r/t (related to) . Anxiety, Dementia. I can become verbally and physically aggressive during cares.- a focus which read in part, I have impaired cognitive function/dementia or impaired thought processes r/t Dementia, impaired decision making, long term memory loss, pain, poor nutrition, short term memory loss.- a focus which read in part, I have potential to demonstrate verbal and physical behaviors (hitting, kicking, pushing, slapping, pinching etc.) r/t Dementia Poor impulse control,- a focus which read in part, I have a history of trauma that affects/has the potential to impact me negatively. PASARR Level I (DCH - 3877) instructions, Distribution: If any answers to items 1 - 6 in SECTION II is Yes, send ONE copy to the local Community Mental Health Services Program (CMHSP), with a copy of form (PASARR 2) DCH-3878 if an exemption is requested. The nursing facility must retain the original in the patient record and provide a copy to the patient or legal representative. Although the PASARR Level I (DCH - 3877) dated 3/3/25 did contain answers of yes, the medical record did not contain a PASARR level 2 (DCH-3878) screening. During an interview on 8/12/2025 at approximately 4:30 PM, the PASARR level 2 (DCH-3878) for R2 was discussed with Social Services staff A. She confirmed she did not submit PASARR level 2 (DCH-3878) forms. On 8/14/2025 at 9:50 AM, the Assistant Director of Nursing (ADON) B searched but did not find a PASARR level 2 (DCH-3878) for this year (2025). ADON B could not find a PASARR level 2 (DCH-3878) for R2 for any previous year. It was determined the PASARR level 1 (DCH-3877) had been submitted 3/3/25, but the PASARR level 2 (DCH-3878) had not been received and no PASARR level 2 (DCH-3878) had ever been obtained. The facility policy titled Resident Assessment - Coordination with PASARR Program and dated as Reviewed/Revised 7/7/2025 read in part, This facility coordinates assessments with the preadmission screening and resident review (PASARR) program under Medicaid to ensure that individuals with a mental disorder (MD), intellectual disability (ID) or a related condition receives care and services in the most integrated setting appropriate to their needs. The facility must screen the individual using the State's Level I screening process and refer any resident who has or may have MD, ID, or related condition, to the appropriate state-designated authority for Level II PASARR evaluation and determination. The Level II resident review must be completed within 40 calendar days of admission.

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	235601	A. Building B. Wing	08/14/2025

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** All times are in Eastern Daylight Time (EDT) unless otherwise noted.Based on interview and record review, the facility failed to develop a comprehensive, person-centered care plan for 2 Residents (#5 & #32) of 14 residents reviewed for comprehensive care planning, resulting in recurring urinary tract infections (UTI's) for R5, and the potential for further unrecognized sexual and aggressive behaviors towards female residents as well as decline in uncommunicated care needs between disciplines and unmet care needs. This deficient practice resulted in the potential for unidentified and unmet individualized care needs.Findings include: Review of the Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, v1.16, Chapter 4: Care Area Assessment (CAA) Process and Care Planning, revealed .the comprehensive care plan is an interdisciplinary communication tool. It must include measurable objectives and time frames and must describe the services that are to be furnished to attain or maintain the resident 's highest practicable physical, mental, and psychosocial well-being. The care plan must be reviewed and revised periodically, and the services provided or arranged must be consistent with each resident's written plan of care . Resident #5:Review of Face Sheet revealed R5 was originally admitted to the facility on [DATE] with pertinent diagnoses which included: chronic kidney disease, stage 3.Review of a Minimum Data Set (MDS) assessment for R5, with a reference date of 7/28/25 revealed a Brief Interview for Mental Status (BIMS) score of 4 out of a total possible score of 15, which indicated R5 was severely cognitively impaired. Further review of the document revealed that R5 was coded under section GG as GG0130. Self-Care: (2)-Substantial/maximal assistance - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort: (2) for C. Toileting hygiene: The ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement. If managing an ostomy, include wiping the opening but not managing equipment.Review of R5 MDS assessment dated [DATE], revealed: Section H - Bladder and Bowel- H0300. Urinary Continence- 2. Frequently incontinent (7 or more episodes of urinary incontinence, but at least one episode of continent voiding) .Review of R5 MDS assessment dated [DATE], revealed: Section H - Bladder and Bowel- H0300. Urinary Continence- 3. Always incontinent (no episodes of continent voiding) .Review of R5's Progress notes read in part: 6/29/2025 05:05 Infection Note Text: Resident continues on oral antibiotic Augmentin for abscess on buttock .Review of R5's Progress notes read in part: 7/27/2025 09:31 N Adv - Dehydration Risk Evaluation Findings: Dehydration risk findings': Renal Disease or Liver Disease.Dehydration risk findings: Incontinence (bowel or bladder.Dehydration Risk Score: 8.0 When the Score Value is 4 or above the Resident is at Risk for Dehydration.Review of R5's Progress notes read in part: 7/28/2025 05:14 Infection Note Text: Resident continues on oral antibiotic Levaquin for the treatment of UTI.Review of R5's Current Care Guide (staff documentation of residents Activity of Daily Living (ADLS) 8/1/25-8/15/25 columns noted for documentation were as follows: Intervention-Time- Schedule for August 2025 (days separated in columns) -Position: All. read in part: Section: GG - Toilet Transfer and GG - Toileting Hygiene QShift (Q-every) revealed from 8/1/25-8/14/25 the document revealed R5 was Transferred to toilet, and Toileting hygiene was completed as follows for a 24 hour period: 8/1/25-8/13/25: 3 times per day, on 8/14/ 25 R5 was toileted 2 times in a 24 hour period.Review of current R5's current Care Plans revealed there were no Resident Focused Care Plans in place that reflected R5's status of a current and a history of UTI's, nor was there a care plan in place indicating antibiotic use.In an interview on 8/14/25 at 12:10 PM., Certified Nurse Aide (CNA) D Reported R5 often gets Urinary Tract Infections UTIs. CNA D reports she is not always informed when R5 has a UTI. CNA D reported R5 takes antibiotics off and off, and it should be carefully planned so that the CNA/nursing staff is aware of signs and symptoms of R5 when she is getting a UTI or has one. CNA D reported the resident care plans drive the CNA care guides, so all staff caring for the (continued on next page)

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	235601	A. Building B. Wing	08/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Iron River Care Center	330 Lincoln Avenue Iron River, MI 49935

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	residents know the residents individual care needed. CNA D reported residents are to be toileted/check/changed every 2 hours on every shift.Resident #32:Review of Face Sheet revealed R32 was originally admitted to the facility on [DATE] with pertinent diagnoses which included: Dementia.Review of a Minimum Data Set (MDS) assessment for R32, with a reference date of 8/4/25 revealed a Brief Interview for Mental Status (BIMS) score of 3 out of a total possible score of 15, which indicated R32 was severely cognitively impaired. In an interview on 8/14/25 at 9:25 AM, Registered Nurse (RN) O reported care plan changes were the interdisciplinary team responsibility. RN O reported the reported it was a group effort to update/revise the care plans and whoever in the room had a computer would make those changes to the care plans. MDS Nurse O created the comprehensive care plan initially, but it is the responsibility of each department to update the care plan or during the IDT (Interdisciplinary Team) team meeting. RN O' reported residents are supposed to be checked/changed and toileted every 2 hours during each shift. In an interview on 8/14/2025 at 1:22 PM., Director of Nursing (DON) reported Resident #5 has had a long history of UTIs. DON reported R5 should have both focused areas of UTI and antibiotic use on her care plans. DON reported that any nurse can develop a care plan, update and revise care plans, but typically the MDS nurse should be updating and developing care plans with the assessments, the Assistant DON and/or herself will also put care plans in place. DON reported R32 should have had a care plan developed for behaviors towards other female residents as soon as the behavior occurred to ensure all staff were aware of the potential for abuse. Review of a facility Policy with a revision date of 6/11/2025 titled Comprehensive Care Plans . revealed: It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment. Policy Explanation and Compliance Guidelines: 1. The care planning process will include an assessment of the resident's strengths and needs and will incorporate the president's personal and cultural preferences in developing goals of care. Services provided or arranged by the facility, as outlined by the comprehensive care plan, shall be culturally1] competent and trauma informed.2. The comprehensive care plan will be developed within 7 days after the completion of the comprehensive MDS assessment. All Care Assessment Areas (CAAs) triggered by the MDS will be considered in developing the plan of care. Other factors identified by the interdisciplinary team, or in accordance with the residents' preferences, will also be addressed in the plan of care. The facility's rationale for deciding whether to proceed with care planning will be evidenced in the clinical record.3. The comprehensive care plan will describe, at a minimum, the following: a. The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. b. Any services that would otherwise be furnished, but are not provided due to the resident's exercise of his or her right to refuse treatment. c. Any specialized services or specialized rehabilitation services the nursing facility will provide as a result of PASARR recommendations. d. The resident's goals for admission, desired outcomes, and preferences for future discharge. e. Discharge plans, as appropriate. f. Resident specific interventions that reflect the resident's needs and preferences and align with the resident's cultural identity, as indicated. If the resident is non-English speaking, the facility will identify how communication will occur with the resident. The care plan will identify the language spoken and tools used to communicate.g. Individualized interventions for trauma survivors that recognizes the interrelation between trauma and symptoms of trauma, as indicated. Trigger-specific interventions will be used to identify ways to decrease the resident's exposure to triggers which re-traumatize the resident, as well as identify ways to mitigate or decrease the effect of the trigger on the resident.4. The comprehensive care plan will be prepared by an interdisciplinary team, that includes, but is not limited to: a. The attending physician or non-physician practitioner designee involved in the resident's care, if the physician is unable to participate in the development of the care plan. b. A registered nurse with responsibility for the (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident. c. A nurse aide with responsibility for the resident. d. A member of the food and nutrition services staff. e. The resident and the resident's representative, to the extent practicable. Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. Examples include, but are not limited to:i. The RAI Coordinator. ii. Activities Director/Staff. iii. Social Services Director/Social Worker. iv. Licensed therapists. v. Family members, surrogate, or others desired by the resident.vi. Administration. vii. Discharge Coordinator. viii. Mental health professional. ix. Chaplain.5. The comprehensive care plan will be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly MDS assessment. Care plans will be updated throughout the year as needed with any changes in residents' plan of care.6. The comprehensive care plan will include measurable objectives and timeframes to meet the resident's needs as identified in the resident's comprehensive assessment. The objectives will be utilized to monitor the residents' progress. Alternative interventions will be documented, as needed.7. The physician, other practitioner, or professional will inform the resident and/or resident representative of the risks and benefits of proposed care, of treatment, and treatment alternatives/options. The facility will attempt alternate methods for refusal of treatment and services and document such attempts in the clinical record, including discussions with the resident and/or resident representative.8. Qualified staff responsible for carrying out interventions specified in the care plan will be notified of their roles and responsibilities for carrying out the interventions, initially and when changes are made.

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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** All times are in Eastern Daylight Time (EDT) unless otherwise noted. Based on interview and record review, the facility failed to follow physician orders for wound care for one Resident #44 (R44) of one resident reviewed for physician orders for the care of wounds. This deficient practice resulted in the potential for infection and a delay in healing.Findings include:Resident #44 (R44)Review of R44's Minimum Data Set (MDS) assessment dated [DATE], revealed admission to the facility on 7/22/25, with active diagnoses that included: diabetes mellitus, wound infection, and peripheral vascular disease (reduced circulation of blood to a body part) or peripheral arterial disease (circulatory condition in which narrowed blood vessels reduce blood flow to the limbs).Further review of the MDS Section M Skin Conditions revealed R44 had three venous and arterial ulcers.Review of discharge document from hospital dated 7/16/25, read in part .Wound follow up note from physician.There are chronic wounds on the left leg and foot.Left Lower Extremity (LLE) wounds.remove dressing, cleanse with saline. Please make sure to scrub wounds with gauze to remove any loose slough (necrotic tissue). Apply single layer xeroform(C) to all open wounds. Cover with ABDs (abdominal pad) and wrap with kerlix(C). Change dressing daily and as needed.During an interview on 8/13/25 9:30 a.m., R44 reported he has a couple open sores on his left foot or leg Review of the Treatment Administration Record (TAR) dated July 2025 revealed there were no treatments completed for the LLE wounds.Review of the TAR dated August revealed there were no treatments completed for the LLE woundsReview of the Electronic Medical Record (EMR) revealed there were no physician who ordered treatments for the LLE wounds.During an interview on 8/14/25 at 4:20 p.m., the Director of Nursing and Assistant Director of Nursing acknowledged there were no physician ordered treatments for the LLE wounds.Review of policy titled Clean Dressing Change last reviewed/revised 3/17/25, read in part .It is the policy of this facility to provide wound care in a manner to decrease potential for infection and/or cross-contamination. Physician orders will specify type of dressing and frequency of changes.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure resident safety by implementing care planned interventions for two residents at high risk for falls (Resident R9 and R59) out of four residents reviewed for falls. This deficient practice resulted in subsequent falls with injury including a broken neck. Findings include: All times are in Eastern Daylight Time (EDT) unless otherwise noted.Resident #9 (R9) During an interview on 8/12/2025 at 1:32 PM, R9 stated, I fell from my recliner at night a few months back. I hit my head, and it knocked me out and I broke my neck. R9 was sitting in her recliner during the interview and her neck collar was at her side lying on her bed. She stated she had taken it off as it hurt her jaw. Review of R9's electronic medical record (EMR) revealed an initial admission to the facility on 4/9/25 with diagnoses including congestive heart failure, chronic respiratory failure, anxiety disorder, dependence on supplemental oxygen and difficulty walking. Review of R9's Minimum Data Set (MDS) assessment, dated 7/8/25, revealed a Brief Interview for Mental Status (BIMS) score of 10, indicative of moderately impaired cognition. Accident and Incident reports were requested for R9 and reports dated 6-28-25 and 7/2/25 revealed two falls. The 6/28/25 Accident and Incident report read in part, Nursing description: CNA (Certified Nurse Aide) reported resident on the floor in bathroom. Writer observed resident sitting on floor next to toilet facing sink, leaning right side against wall. Resident states, 'I slipped'. Report did not indicate interventions were added to the plan of care. Four days later the 7/2/25 Accident and Incident read in part, Nursing description: Called to resident room by CNA who had been sitting at main desk and heard a loud noise from resident room that sounded like a fall. Upon entering resident room noted to be lying on floor on back, head was facing the opposite bed and feet towards window. She did state she hit her head but unsure on what piece of furniture in room. Noted to have large bruise appearing on front, top forehead. Action Taken. resident transported to local hospital via ambulance. Incident Description: There were no witnesses, and incident was as noted above. As per provider orders, resident was transferred to (name of) ED (Emergency Department) and was diagnosed with a cervical fracture (a break in one or more of the seven vertebrae in the neck). During an interview on 8/14/2025 at 3:22 PM, the Director of Nursing (DON) was asked about these falls. The DON stated R9 had a BIMs of 14 at the time of the fall on 7/2/25 and returned from the hospital with a BIMS of 10 but was able to recall the event and cause. The DON stated the resident was care planned as a fall risk. The DON was asked if the care plan was updated after the fall on 6/28/25 to include interventions to prevent further falls. The DON was unable to find preventative interventions that had been added to the care plan even though the care plan for falls included the intervention of: Review information on past falls and attempt to determine cause of falls. Record possible root causes. Alter remove any potential causes if possible. Educate me/family/caregivers/IDT as to causes. Date Initiated: 04/10/2025 (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #59 (R59) Review of R59's MDS assessment dated [DATE], revealed admission to the facility on 3/13/25, with active diagnoses that included peripheral vascular disease (reduced circulation of blood to a body part) or peripheral arterial disease(circulatory condition in which narrowed blood vessels reduce blood flow to the limbs), diabetes mellitus, and malnutrition. Review of the incident report titled Fall with Injury dated 7/30/25, read in part .Nursing description.Certified Nurses Aide (CNA) notified nurse resident was on his back on the floor next to his bed.resident stated he slipped out of bed when trying to reposition himself.injuries report post incident.fracture.left hip. Review of radiology note from the hospital dated 7/31/25, read in part .left hip acute sub-capital hip fracture with impaction. Review of Electronic Medical Record (EMR) revealed R59 was readmitted to the facility on [DATE]. Review of R59's care plan revealed there were no interventions added to the care plan following the fall with fracture to prevent falls. During an interview on 8/13/25 at 3:55 p.m., the Director of Nursing (DON) acknowledged there were no interventions in R59's care plan following R59's fall with fracture to prevent falls. Review of policy titled Fall and Fall Risk Managing last revised March 2025, read in part .In conjunction with the attending physician, staff will identify and implement relevant interventions to try to minimize serious consequences of falling.

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	235601	A. Building B. Wing	08/14/2025

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** All times are in Eastern Daylight Time (EDT) unless otherwise noted. Based on observation, interview, and record review, the facility failed to provide oxygen services including obtaining physician orders for oxygen, physician orders for the oxygen flow rate (amount of oxygen delivered to the patient), and routine changing of oxygen tubing for one Resident #44 (R44) of three residents reviewed for oxygen services.Findings include:Resident #44 (R44)Review of R44's Minimum Data Set (MDS) assessment dated [DATE], revealed admission to the facility on 7/22/25, with active diagnoses that included: diabetes mellitus, wound infection, peripheral vascular disease (reduced circulation of blood to a body part) or peripheral arterial disease (circulatory condition in which narrowed blood vessels reduce blood flow to the limbs), respiratory failure, and chronic obstructive pulmonary disease (ongoing lung condition caused by damage to the lungs).During an observation on 8/13/25 at 9:31 a.m., R44 received oxygen via nasal cannula with undated oxygen tubing.During an observation on 8/14/25 at 9:57 a.m., R44 received oxygen via nasal cannula with undated oxygen tubing.During an interview on 8/14/25 at 10:00 a.m., R44 reported he was unsure when he started receiving oxygen, but he required oxygen when he was hospitalized in July prior to admission to the facility.Review of the Electronic Medical Record (EMR) revealed in the Treatment Administration Record (TAR) the oxygen tubing had not been changed in July or August.Review of the EMR revealed no physician orders for R44 to receive oxygen, no orders for the flow rate of oxygen, and no orders changing of oxygen tubing.During an interview on 8/14/25 at 3:06 p.m., the Director of Nursing (DON) reported she was unaware of when R44 started on oxygen and acknowledged there were no physician orders for oxygen, the flow rate of oxygen, and changing oxygen tubing. The DON reported that the residents who receive oxygen have the oxygen tubing changed weekly and the tubing is marked.Review of policy titled Oxygen Administration date implemented 7/14/22, read in part .Oxygen is administered under orders of a physician.based on.equipment setting for flow rates.change oxygen tubing and mask or cannula weekly and as needed.

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	235601	A. Building B. Wing	08/14/2025

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** All times are in Eastern Daylight Time (EDT) unless otherwise noted. Based on observation and interview, the facility failed to effectively maintain the physical plant including resident bathrooms. This resulted in water damage to the walls in resident rooms (shared bathrooms) 203/205 and 207/209, missing bathroom baseboard tiles, bathtub used for storage and the increased likelihood for further water damage, cross-contamination and bacterial harborage, with a possible decrease in the satisfaction of living, for residents who use these areas. Findings Include In an observation on 8/12/2025 at 2:50 PM., it was noted in the shared bathroom of rooms 203/205 the wall behind the toilet paint was bubbled out. This surveyor felt the wall and noted it to be wet towards the baseboards, and damp upwards behind the toilet. The drywall underneath was noted to have water damage on the entire backside wall of the toilet. This softened area of the wall extended upward approximately 3 1/2 feet, and when pushed lightly the right-side corner attached to the right wall (of the toilet) pushed inward, separating the corner of the wall to the right of the toilet, and the wall behind the toilet. 08/12/2025 2:30 PM Observation during facility tour with maintenance director showed baseboard tiles missing behind the toilet in the shared bathroom for rooms 308-310. The wall behind the toilet was also noted with water damage. 08/13/2025 at 9:12 AM during a tour of the facility with maintenance director J, the 200 wing Bath was noted being used for storage. The bathtub was noted full of equipment, and the tub was surrounded with unused equipment. When asked, maintenance director J stated that this bath has not been in use since 2019, and the line has not been flushed. He stated that all lines in the building get flushed on a regular basis, except for this bathtub line, and the outside taps. 08/13/2025 9:23 AM During a facility tour, while in the bathroom shared between rooms [ROOM NUMBERS], the wall behind the toilet was noted with water damage. Water damaged walls were also noted in the shared bathrooms between 207/209. Maintenance director J stated he was unaware of the water damage in these rooms.