

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235606	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/13/2025
NAME OF PROVIDER OR SUPPLIER Fisher Senior Care and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 521 Ohmer Rd Mayville, MI 48744	

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)
<p>F 0553</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Allow resident to participate in the development and implementation of his or her person-centered plan of care.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49944</p> <p>This Citation pertains to Intake Number MI00147136.</p> <p>Based on interview and record review, the facility failed to hold a scheduled 72-hour care conference for one resident (R150) of one reviewed for care conferences, resulting in missing a care conference and lack of information for the family and resident.</p> <p>Findings include:</p> <p>Resident #150:</p> <p>R150 is [AGE] years old and admitted to the facility on [DATE] with diagnoses that include pneumonia, atrial fibrillation, chronic kidney disease and a malignant neoplasm of the bladder. R150 expired at the facility on [DATE]. R150 had a brief interview for mental status (BIMS score of 15, indicating they were cognitively intact.</p> <p>On [DATE] at 1:13PM, an interview was conducted with a confidential family member of R150. Family 'A' stated that a care conference was supposed to be held on Friday [DATE], Family 'A' wanted to join by phone and the facility said they would call her when it was time for the conference. Family 'A' stated that R150 eventually called them and said they never held the care conference on that day. Family 'A' said the care conference was completely omitted; we were ready for the conversation, but it just never happened. Family 'A' said they were told a time the conference would be held, and we were ready. Family 'A' stated she talked to R150 as well and R150 stated that the care conference never happened with her as well.</p> <p>(continued on next page)</p>

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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<p>F 0553</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On [DATE] at 11:32AM, an interview was conducted with Social Worker (SW) 'B'. SW 'B' was asked if they keep schedules for 72-hour care conferences. SW 'B' said that we schedule care conferences within 72hrs of admission. SW 'B' stated that another staff member schedules these care conferences, gives the family a card with the date and time and then lets us know. SW 'B' was asked when was R150 scheduled for a 72hr care conference. SW 'B' stated, I believe she was scheduled for [DATE], which was the day she passed away. SW 'B' then confirmed that R150 was scheduled on [DATE] at 7:30am for a care conference. SW 'B' verified with this surveyor that the meeting was set for [DATE]. SW 'B' was asked why the care conference wasn't held. SW 'B' stated, I don't know that answer, I truly don't know why it wasn't held. SW 'B' was asked what is discussed at the 72hr care conference. SW 'B' stated, we discuss the admission process, nursing is with us and they will review medications, dietary discusses diet, activities will discuss the activities in the facility and provide a calendar of events, and the director of therapy will discuss therapy's plan for the resident, we also discuss home evaluations for therapy and we discuss needs at home such as DME and home care.</p> <p>On [DATE] record review of the care conference calendar revealed that R150 had a care conference scheduled for [DATE] at 7:30am. Record review of the electronic medical record did not produce any record of the care conference being completed.</p> <p>Review of the policy titled, Resident/Family Participation- Assessment/Care Plans, revealed:</p> <ol style="list-style-type: none"> 1. The resident and his/her family, and/or the legal representative (sponsor), are invited to attend and participate in the resident's assessment and care planning conference. 4. The social services director or designee is responsible for contacting the resident's family and for maintaining records of such notices. Notices include: <ol style="list-style-type: none"> a. The date of the conference, b. The time of the conference, c. The location of the conference, d. The name of each family member contacted, e. The date and time the family was contacted, f. The method of contacting the family (e.g. mail, telephone, email, etc.) g. Input from family members when they are not able to attend, h. Input from the resident when he/she is not able to attend, i. Refusal of participation, if applicable, and j. The date and signature for the individual making the contact. 		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37771</p> <p>Based on observation, interview and record review, the facility failed to ensure a clean and homelike environment for four residents (#'s 28, 37, 100, 101), of seven reviewed for environmental concerns, resulting in personal items not labeled with Resident identification, food not labeled with an open date or refrigerated and the potential for spread of infection and food borne illness.</p> <p>Findings include:</p> <p>Resident #28:</p> <p>On 2/11/25 at 12:16 PM, an interview was conducted with Resident #28 who was sitting up in their wheelchair. The Resident answered questions and engaged in limited conversation. The Resident had a bathroom that was shared with the room next door. There was not a resident in that room at this time. There were a pair of TED hose (Anti-Embolism stockings used to reduce the risk of deep vein thrombosis (blood clot)). The Resident was asked if he wore the TED hose and reported sometimes them put them on, not sure why they are not on at this time. The TED hose did not have a room number or Resident identification on them.</p> <p>On 2/13/25 at 12:11 PM, an interview was conducted with the Director of Nursing (DON) regarding Resident #28's TED hose. During record review, there was no order for the TED hose, no discharge order from the hospital for the TED hose, and no care plan in place for the TED hose. An observation was made with the DON of the TEDs in the bathroom that was shared with another resident in the next room. The TEDs did not have any resident name or identification of who they belonged to.</p> <p>Resident #37:</p> <p>A review of Resident #37's medical record revealed an admission into the facility on [DATE] with diagnoses that included urinary tract infection, stroke, and dementia. A review of the Minimum Data Set (MDS) assessment revealed moderately impaired cognition and was independent with eating and needed supervision or touching assistance with toileting hygiene, bathing, upper and lower body dressing and mobility of roll left and right and lying to sitting.</p> <p>On 2/11/25 at 10:40 AM, an interview was conducted with Resident #37 and Resident Representative G. The Resident answered some questions but answers were unreliable and the Resident Representative answered most questions and engaged in conversation. An observation was made in Resident #37's room of Resident #37's denture cup positioned underneath the towel dispenser. The denture cup was positioned that when taking paper towels out of the dispenser after washing hands, had the potential to come in contact with drips of water.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 2/12/25 at 12:10 PM, an observation was conducted with Resident #37 sitting on the side of their bed and had just received their lunch meal that was brought in by staff. The Resident had a bottle of cranberry juice that was partially used. The bottle had manufactures use by date but did not have a date of when the juice had been opened. The Resident did not have the cranberry juice in a cup at the bedside. The Resident was questioned about the juice but when asked when the juice had been opened, she indicated she was unsure what day the bottle was opened or how long she had the juice on her table. The Resident reported she preferred to have the juice cold but that it was not taken to the refrigerator and was left at the bedside. The Resident did not know who had brought in the juice for her.</p> <p>On 2/12/25 at 12:20 PM, an interview was conducted with Culinary Specialist H regarding facility policy of food brought into the facility. The Culinary Specialist indicated that the items should be dated when brought in and when opened and have a discard date. When asked about a juice bottle that was left on the Resident's bedside table, that was partially used, the Culinary Specialist reported that it should be refrigerated after being opened. An observation was made in the Resident's room of the juice opened and partially consumed. The Culinary Specialist indicated it should not be left opened and not refrigerated.</p> <p>Residents #100 and 101:</p> <p>On 2/11/25 at 11:40 AM, an observation was made in Resident #100 and 101's room. The two residents shared a room and bathroom. Resident #100 was sleeping at the time and Resident #101 was not present in the room. Resident #100 had a urinal on the bedside table that had urine inside. The urinal did not have a room number or identification on it. The bathroom had another urinal on the handrail that did not have any identification of the urinal of which resident it belonged to.</p> <p>On 2/13/25 at 3:00 PM, an interview was conducted with the Infection Control Preventionist (ICP) F regarding the facility policy in labeling personal items. The ICP reported that personal items should be labeled with resident identification. An observation was made in Resident #100 and #101's room with a urinal in the bathroom that was not labeled. The ICP indicated that the urinal should be labeled as well as the one at Resident #100's bedside. An observation was made with the ICP of the denture cup of Resident #37 stored under the towel dispenser near the sink in the room. The ICP indicated the cup should not be stored there and removed the denture cup from under the towel dispenser and indicated they would do education for the staff and the resident. An observation of Resident #28's urinal was observed to be at the Resident bedside. The Resident was sharing a bathroom with the Resident in the next room. The ICP indicated the urinal should be marked with identification and reported education would be provided to the staff.</p>		