STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235606	A. Building B. Wing	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fisher Senior Care and Rehab	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)
F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49944 This Citation pertains to Intake Number MI00147136. 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. Findings include: Resident #150: 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. 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. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 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. Review of the policy titled, Resident/Family Participation- Assessment/Care Plans, revealed: 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: 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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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 49944 Based on observation, interview and record review the facility failed to revise care plans for two residents (R19, R39) of a total sample of 17 residents, resulting in missing care plan updates and the potential for unmet needs. Findings include: Resident #19: R19 is [AGE] years old and admitted to the facility on [DATE] with diagnoses that include cerebral infarction, seizures, major depressive disorder and anxiety. R19 has a brief interview for mental status (BIMS) score of 5, indicating severe cognitive impairment. On [DATE] at 09:20AM, observation revealed that R19 is thin looking in appearance. On [DATE] at 03:19PM, record review of the electronic medical record (EMR) revealed R19's weight on [DATE] was 167.2lbs and on [DATE], R19's weight was 141.4lbs, this was a loss of 25.8lbs, 18% in 30 days. On [DATE] at 03:29PM, record review revealed that the care plan for nutrition didn't reflect weight loss until [DATE]. The last review of R19's nutrition care plan was [DATE]. Review of a dietary progress note indicates that the physician is aware of the weight loss, a physician note dated [DATE] addresses weight loss. On [DATE] at 12:13PM, an interview was conducted with Certified Dietary Manager (CDM) 'D'. CDM 'D' was asked who is responsible for updating the care plans for nutrition and weight loss. CDM 'D' stated that the dietitian and myself are responsible for that. CDM 'D was asked why the care plan wasn't updated until [DATE] when the first weight loss was identified back in [DATE]. CDM 'D' stated, I am not sure, but I will get back with you. CDM 'D' then said, ultimately it would be my responsibility to update the care plan along with the dietitian. Urinary Catheter or UTI: On [DATE] at 11:10AM, R19 was observed with an indwelling catheter in place. R19 states they have had their catheter for a long time, currently has a leg bag in place. On [DATE] at 01:57PM, record review of the physician's order for the indwelling catheter revealed it was an 18fr with 30cc balloon for neuromuscular dysfunction of the bladder, dated [DATE]. Record review revealed an order to change the catheter monthly on the 15th, order dated [DATE]. On [DATE] at 02:07PM, record review revealed a care plan in place for use of an indwelling catheter, the last update was [DATE] and states the catheter is a 16fr with 30cc balloon. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 02:23PM, an interview was conducted with the Director of Nursing (DON). The incorrect care plan was verified by the DON. The DON was asked who is responsible for updating care plans related to catheters. The DON stated that the infection control nurse is responsible for updating care plans for catheters. The DON was unsure why this care plan wasn't updated to reflect the correct catheter size. Resident #39: R39 is [AGE] years old and admitted to the facility on [DATE] with diagnoses that include acute respiratory failure, major depressive disorder, hypertension and chronic kidney disease. R39 has a BIMS score of 7 indicating severe cognitive impairment. On [DATE] at 09:37AM, record review revealed that R39 has a physician's order, dated [DATE] for do not resuscitate (DNR). Record review revealed signed documents for DNR, dated [DATE]. Record review revealed a care plan for advance directives that R39 was electing to be a full code and receive cardiopulmonary resuscitation (CPR), the care plan was updated on [DATE]. On [DATE] at 11:42AM, an interview was conducted with SW 'B'. SW 'B' was asked who is responsible for updating the care plan for code status. SW 'B' stated that whoever has the new order for code status, whether on admission or a change in status will update the care plan. SW 'B' stated I will update the care plan on admission if the documents are available and I know what the code status is. Verified with SW 'B that the advance directive care plan is not matching the physicians order or signed documents. Review of the policy titled, Care Plans- Comprehensive, revised [DATE], revealed: 8. Assessments of residents are ongoing and care plans are revised as information about the resident and the resident's condition changes.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37771 Based on observation, interview and record review, the facility failed to ensure that Resident #13 received vision services and that recommendations were addressed for one resident (Resident #13) of one resident reviewed for vision services, resulting in the lack of follow-up care for vision issues and the potential for vision abnormalities to be untreated or unidentified. Findings include: Resident #13: A review of Resident #13's medical record revealed an admission into the facility on [DATE] and re-admission on 5/4/23 with diagnoses that included Parkinson's Disease, dementia, heart disease, high blood pressure and diabetes. A review of the Minimum Data Set assessment revealed the Resident had intact cognition with a Brief Interview for Mental Status score of 13/15. On 2/12/25 at 8:50 AM, the Resident was dressed, seated in a wheelchair in their room. The Resident was interviewed, answered questions and engaged in limited conversation. The Resident was asked about any concerns he had and stated, My eyes are really bad. When asked what was wrong with his eyes, he reported difficulty with seeing good. The Resident indicated he did not need to see the eye doctor about glasses but that he needed to see the eye doctor and had not seen the eye doctor for extended period of time. A review of Resident #13's medical record of the document titled Eye Care Group, revealed date of exam: 11/30/2023; history of cataract, nuclear; Pseudophakia. Assessment: 1. Diabetes Type 2, without complications, 2. Cataract, nuclear; Both eyes, 3. Dry eye; Both eyes. Plan: 1. Continue bs (blood sugar) control, 2. Cataract surgery not recommended due to poor general health, 3. Medication Order; Artificial tears oph. Solution, apply 1 drop, Both eyes, three times daily for 90 days. Action Required By Nursing Home Staff: Glasses Required? No; Eyelid Care Required: Yes BID x 90 days; New Orders? Yes (see plan above). Recall: 5-6 Months. A review of Resident #13's medical record of the document titled Eye Care Group, revealed date of exam: 4/12/2024. Note: Patient was scheduled to be treated today, but was not treated. Reason: Patient was Unavailable. Signed by the Optometrist. (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident #13's medical record of the document titled Eye Care Group, revealed date of exam: 1/14/2025; history of cataract, nuclear; Diabetes Type 2, without complications; Dry eye; Pseudophakia. Assessment: 1. Diabetes Type 2, without complications, 2. Pseudophakia,3. Dry eye; Both eyes. Plan: 1. Monitor, 1. Continue bs (blood sugar) control, 2. Monitor, 3. Continue present eye medications, 3. Medication Order; Artificial tears oph. Solution, apply 1 drop, Both eyes, twice daily for 90 days. Action Required By Nursing Home Staff: Glasses Required? No; Eyelid Care Required: Yes BID x 90 days; New Orders? Yes (see plan above). Recall: 5-6 Months. A review of Resident #13's orders revealed no order in the month of January 2025 for the recommended eye drops in the plan for Artificial tears. A review of the progress notes revealed a lack of documentation on the recommendations of the Optometrist. A review of the progress notes revealed no documentation on why or where the Resident was on 4/12/24 when the Resident was not available to be seen by the Optometrist. On 2/12/25 on 12:58 PM, an interview was conducted with Nurse B who was the Social Worker Designee and the Scheduler/Medical Records E regrading Resident #13's appointments for eye care. The Scheduler was asked if Recall meant when the next appointment was to be made and she stated, Yes, that is there recommendation, of when to be seen again. A review of the Resident seen on 11/30/23 and next appointment was for 4/12/24, with the recommendation to be seen after the 11/30/23 appointment in the next 5 to 6 months, but the Resident was not available and had not been see by the eye care group until 1/14/25, was reviewed with Nurse B and Scheduler E. The Nurse was asked why or where the Resident was at when they were supposed to be seen by the eye care specialist. The Nurse and Scheduler indicated they did not know where the Resident was and indicated he could have been in activities or somewhere else in the building. A lack of documentation of where the Resident was and a lack of any interventions to try to assist in having the Resident available to be seen for eye care was reviewed. The Scheduler was asked if the eye doctor had come in prior to the January visit. The Scheduler returned and indicated the eye group had been back in October of 2024. When asked if the Resident was on the list to be seen, they indicated he had been on the list but were unsure why he had not been seen. The Scheduler reported prior to the end of the interview that the eye doctor had run out of time and was unable to see the resident. The Nurse and Scheduler were asked how soon the documents come back from the eye group. The Scheduler reported that the notes were back within 7 days, depending on the service and the doctor and the documents get uploaded into the electronic medical record. The recommendations for the eye drops had not been written for in the orders. When asked who gets the recommendations to get the orders into the medical record, the Nurse stated, I don't have an answer for that, will have to find out. (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/12/25 at 3:29 PM, an interview was conducted with the Director of Nursing (DON) regarding Resident #13's lack of eye care after an appointment was missed due to the Resident not available, with lack of documentation of why or where the Resident was, and the Resident not seen when eye care had returned October 2024 with recommendations to be seen every 5-6 months. The DON indicated that they don't know that the Resident was not seen until they get the communication form. When asked why the order for the eye drops, Artificial tears, apply 1 drop, both eyes, three times daily for 90 days, the DON reported that the eye doctor puts that for all his patients that he sees. It was reviewed with the DON of a lack of documentation regarding why the recommendation was not followed and if the Resident did not need them. A policy for Vision care was requested on 2/13/25 but was not provided by the facility prior to exit. A review of facility document titled Treatment Consent Form, revealed, .We offer a variety of services for our residents that will benefit their quality of life. Dental, Vision, and Podiatry consultation . services are available and will be provided as needed, if you choose .

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. 49944 Based on observation, interview and record review the facility failed to ensure medications were accurately administered for three residents (R4, R14, R25) of four residents reviewed for medication administration resulting in a medication error rate of 7.69%. Findings include: On 2/12/25 at 7:41am, Licensed Practical Nurse (LPN) 'C' prepared and administered medications for R25. The medications included: Acidophilus, Acetaminophen 500mg, pro-stat, Abilify 2mg, Buspar 5mg, Eliquis 5mg, Glipizide 10mg, Potassium Chloride 10mEq, Senna-S 8.6mg-50mg, Vitamin D 1000mcg, Metoprolol 100mg, Myrbetriq 25mg, Tamsulosin 0.4mg, Cymbalta 30mg, Lasix 40mg and Humalog 2units from an insulin pen. LPN 'C' prepared the insulin pens by dialing in the units to be administered to the resident. LPN 'C' did not prime the insulin pens prior to administering the prescribed units. On 2/12/25 at 8:02am, LPN 'C' prepared and administered medications for R4. The medications included: Novolog 7units from an insulin pen, Lantus 25units from an insulin pen, Amantadine 100mg, Chewable Aspirin 81mg, Gabapentin 100mg, Norvasc 5mg, Keppra 750mg, MagOx 400mg, Metformin 500mg, Myrbetriq 25mg, Senokot 8,6mg, Vesicare 10mg and Miralax 17gms in water. LPN 'C' prepared the insulin pens by dialing in the units to be administered to the resident. LPN 'C' did not prime the insulin pens prior to administering the prescribed units. On 2/12/25 at 8:15am, LPN 'C' prepared and administered medications for R14. The medications included: Gabapentin 400mg, Amlodipine 5mg, Fenofibrate 134mg, Fish Oil 1000mg, Hydrochlorothiazide 25mg, Metoprolol 25mg, Miralax 17gms in water, Multivitamin, Eliquis 5mg, Potassium 20 mEq, Flexeril 5mg, Vitamin D3 5000units, Tylenol Extra Strength 500mg and Lantus 40units in an insulin pen. LPN 'C prepared the insulin pen by dialing in the units to be administered to the resident. LPN 'C' did not prime the insulin pen prior to administering the prescribed units. On 02/12/25 at 11:08AM, an interview was conducted with the Director of Nursing (DON). The DON was asked how do you determine how much insulin to prime for insulin pens prior to dialing in the dosage for administration. The DON stated, we default to the manufacturers recommendation, our policy doesn't specify the amount of insulin to prime prior to administration. I usually prime the pen with 2 units prior to administration. On 02/12/25 at 11:12AM an interview was conducted with LPN 'C'. LPN 'C' was asked how much insulin should you prime in the insulin pen prior to administration. LPN 'C' stated they were not aware of having to prime the insulin pens. LPN 'C' stated they were just informed by other staff members that we are to prime 2 units in the pen before administering it. Record review of the policy titled, Injectable Medication Administration, revised January 2018, does not reference the amount of insulin to prime in the pen prior to administration.