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	04/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fisher Senior Care and Rehabilitation	521 Ohmer Road Mayville, MI 48744

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure that advance directives were updated in a timely manner and explained in clear language for one resident (Resident #42) of one resident reviewed for code status.Findings Include:Resident #42:On [DATE] at 9:15 AM, a review was conducted of Resident #42's medical record and it revealed she was admitted to the facility on [DATE] with diagnoses that included Anxiety, Intellectual Disabilities and Dementia. Resident #42 her own responsible party. Further review of record yielded the following:Physician Orders:DNR-Do Not Resuscitate - placed on [DATE]Code Status Form:On [DATE] Signed by Resident #42, two physicians and two witnesses that .in the event my heart and breathing stop, no person shall attempt to resuscitate me.Care Plan: .Advance Directives have been discussed & the following has been decided DNR. I am my own decision maker .Care Conferences:[DATE]: .Care plan and code status reviewed, and she wishes to remain a CPR (Cardiopulmonary Resuscitation) .XXX[DATE]: .Care plan and code status reviewed, and she wishes to remain a CPR.XXX[DATE]: .Care plan and code status reviewed, and she wishes to remain a CPR. It can be noted Resident #42 updated her code status in 2025 to CPR and it was never updated in the order set or care plans. During three care conferences, spanning nine months, she indicated her wishes for CPR designation that were not followed. On [DATE] at 9:40 AM, an interview was conducted with Social Worker D regarding Resident #42's code status. She stated she did not recall if she alerted anyone that her code status changed after Care Conference and she cannot update orders. Social Worker D was asked with the resident's diagnosis of intellectual disability does she fully understand the difference between CPR and DNR. She expressed there was a recent cognitive decline, and they were petitioning for a guardian on her behalf and its plausible it was not explained clear enough for Resident #42.Social Worker D (in the presence of this writer) asked Resident #42 if she understood what CPR meant and she asked the social worker to explain it to her. She proceeded to explain if she stopped breathing if she wants staff to pump her chest and she stated yes. It was apparent Resident #42 did not fully comprehend what was being asked. Social Worker D stated she would follow up with her. On [DATE] at 12:35 PM, Social Worker D stated she spoked to Resident #42 and explained CPR (pushing on chest) versus DNR (want to go peacefully) in their totality and what would occur in each scenario. She stated, oh no, she would not want them to push on her chest and would like to go peacefully. They are going to leave her as a DNR. Social Worker D stated during care conferences she does not believe Resident #42 understood the discussion and she (Social Worker) did not do a good job with explaining code status in clear language at her level of comprehension, Review was conducted of the facility policy entitled, Advance Directives, revised [DATE]. The policy stated, .The Interdisciplinary Team will review annually with the resident his or her advance directives to ensure that such directives are still the wishes of the resident.changes or revocations of a directive must be submitted in writing to the Administrator.

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 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** Based on observation, interview and record review the facility failed to ensure that oxygen was administered as ordered for 1 resident (Resident #43) of 1 resident reviewed for respiratory care. Findings Include: Respiratory Care Resident #43:A record review of the Face sheet and Minimum Data Set/MDS assessment indicated Resident #43 was admitted to the facility on [DATE] with diagnoses: Respiratory failure, Primary Pulmonary hypertension, Emphysema, COPD, dependence on supplemental oxygen, and heart failure. The MDS assessment dated [DATE] revealed the resident had full cognitive ability with a Brief Interview for Mental Status/BIMS score of 15/15 and the resident needed some assistance with care. On 4/13/2026 at 1:28 PM, Resident #43 was observed sitting in her room in a wheelchair. She had on a nasal cannula connected to an oxygen concentrator that was set at 6 Liters/L of oxygen per minute. There was no humidification bottle to provide moisture that would aid in preventing her nose from becoming dried out. Resident #43 was asked about her oxygen settings, and she said it had recently changed. The resident was asked about her oxygen use, and she said she needed it and had been using it for a while. A review of the physician orders for Resident #43 identified the following: O2 at 5 L via NC (nasal cannula) continuously, start date 11/24/2025. A review of a Physician's Note for Resident #43 dated 4/6/2026 at 7:46 PM provided, . Dependence on supplemental oxygen. Pulmonary: O2 at 5L via NC continuously. A review of the Care Plans for Resident #43 provided the following: Potential/actual alteration in oxygen exchange r/t copd, osa, oxygen dependence, hypercapnic (high carbon dioxide levels) (respiratory) failure, emphysema, date created and started 11/24/2025 and revised 3/25/2026 with Interventions including: O2 as ordered: 5L via Nasal Cannula as ordered, date created and initiated 11/24/2025 and revised 2/16/2026. On 4/14/2026 at 12:05 PM, Resident #43 was observed resting in bed. Her oxygen concentrator settings were viewed with Registered Nurse J. When asked what the oxygen was set to, she said it was set at 6L/minute; it was observed to be set at 6L a minute. Nurse J was asked about humidification use with the oxygen because it was set at a higher dose and she said, she said they usually they waited to add it unless the resident complained of being dry. On 4/14/2026 at 12:10 PM, the physician oxygen order for Resident #43 was reviewed in the electronic medical record/emr with Nurse J; she said the order read 5L/minute via nasal cannula. A review of the facility policy titled, Oxygen Administration & Safety, origination date July 1, 2008 and effective date 6/7/17 provided, Purpose: Safe administration of oxygen therapy to the resident. Oxygen administration will be provided per physicians' order observing appropriate safety measures. Procedure: 1. Check physician's order for liter flow and method of administration.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to provide a clinical rationale for administration of duplicate antidepressant therapy for two residents (Resident #4 & Resident #37) and ensure accurate indication for use of an antipsychotic medication for one resident (Resident #43) of seven residents reviewed for unnecessary medications.Findings Include:Resident #4: On 4/14/2026 at approximately 12:00 PM, a review was conducted of Resident #4's medical records and it revealed she readmitted to the facility on [DATE] with diagnoses that included, Metabolic Encephalopathy, Atrial Fibrillation, Major Depressive Disorder and Mood Disorder. Furter review of the record yielded the following:Physician Orders:Mirtazapine Oral Tablet 45 MG (milligrams) for Major Depressive Disorder- started on 9/13/2025Zoloft Oral Tablet 2.5 MG for Major Depressive Disorder. Ordered on 3/24/2026Review was conducted of Resident #4's nursing, physician and psychiatric progress notes were and there was no documentation located regarding Resident #4 usage of dual antidepressant therapy.On 4/14/2026 12:40 PM, Social Worker D was asked if there was any supporting documentation in chart related to Resident #4 need for dual antidepressant therapy. She reported she would look at her chart and follow up.On 4/15/2026 at 11:00 AM, Social Worker D stated she was unable to locate a risk versus benefits related to Resident #4's dual therapy but shared their physician was completing the needed documentation within 20 minutes. Resident #37:On 4/13/2026 at 3:30 PM, a review was conducted of Resident #37's medical record and it indicated she was admitted to the facility on [DATE] with diagnoses that included, Alzheimer's, Anxiety, Chronic Kidney Disease, Major Depressive Disorder and Insomnia. Further review yielded the following:Physician Orders:Trazadone HCl (hydrochloride) Oral Tablet 100 MG for Major Depressive Disorder - started on 9/12/2025Venlafaxine HCl ER Oral Tablet Extended Release 24 Hour 150 MG for Major Depressive Disorder - started on 3/24/2026Resident 37's nursing, physician and psychiatric progress notes were reviewed and there was no documentation located regarding Resident #4 usage of dual antidepressant therapy.On 3/14/2025 at 2:55 PM, Social Worker D reported Resident #27 was admitted to the facility on multiple psychotropic medications and they have been working to gradually reduce them. They are currently working on reducing the venlafaxine as their psychiatrist believes it is increasing the residents' anxiety. It was explained that while all this may be true, documentation regarding the reasoning for the current usage of dual antidepressant therapy is still required. Social Worker D reported from her review of the charting there was no supporting documentation for dual therapy located in Resident #37's chart. Resident #43:On 4/14/2026 at 2:00 PM, a review was conducted of Resident #43's medical records and it revealed the resident admitted the facility on 11/24/2025 with diagnoses that included Acute Respiratory Failure, Major Depressive Disorder and Pulmonary Hypertension. Further review of her records yielded the following:Physician Orders:Olanzapine Oral Tablet- for Major Depressive Disorder.According to the FDA (Food and Drug Administration) Olanzapine (Zyprexa) is an atypical antipsychotic indicated: As oral formulation for the: Treatment of schizophrenia. (1.1) Adults: Efficacy was established in three clinical trials in patients with schizophrenia.Acute treatment of manic or mixed episodes associated with bipolar I disorder and maintenance treatment of bipolar I disorder.Care Plan: .I have an alteration in my mood state r/t (related to) depression). I am ordered antidepressant and antipsychotic medication.On 4/14/2026 at 2:55 PM, Social Worker D reported Resident #43 admitted to the facility on Zyprexa and other psychotropics, as she was being followed by her local Community Mental Health (CMH). She was not agreeable to any medication changes until recently but there was no supporting documentation to this statement. The Social Worker was asked if she requested any of Resident #43's mental health documentation for her treatment team and she stated she did not. The social worker was asked if Major Depressive Disorder was an appropriate indication for use for Olanzapine and she stated it was not.Review was conducted of the facility policy entitled, Use of Psychotherapeutic Medications, (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	revised 2/01/2025. The policy stated, . A resident will not receive psychotherapeutic medications unless such a medication is needed to treat a specific condition as diagnosed and documented in the clinical record with clearly defined target behaviors and non-pharmacological interventions are not effective. Duplicative drug therapy will be discouraged and closely monitored.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to administer insulin per professional standards for one resident (Resident #43) of one resident reviewed for insulin administration, resulting in inaccurate site administration with the likelihood of malabsorption of insulin. Findings include. Resident #43: On 4/14/2026, at 8:26 AM, During medication administration task, Nurse K gathered morning medications for Resident #43 including their Insulin Glargine (Lantus) pen. Nurse K prepared the pen, entered the resident's room prepared the resident's right arm approximately 1 and 1/2 inches below the center of the deltoid muscle and injected the 10 units of insulin. On 4/14/2026, at 9:30 AM, Nurse K approached surveyor and asked if they did something wrong and Nurse K was asked if they felt where they injected the insulin pen/needle if there was enough subcutaneous tissue and Nurse K offered, the needle is so small. On 4/14/2026, at 1:45 PM, a record review of Resident #43's electronic medical record (EMR) revealed an admission on [DATE] with diagnoses that included Diabetes Mellitus, Heart failure Chronic Obstructive Pulmonary Disease. Resident #43 required assistance with Activities of Daily Living (ADL) and had intact cognition. A review of the Physician orders revealed Insulin Glargine Subcutaneous Solution 100 UNIT/ML (milliliters) (Insulin Glargine) Inject 10 unit subcutaneously (tissue located, occurring, or administered in the fatty layer directly beneath the skin) . On 4/14/2026, at 4:11 PM, Nurse Consultant B was alerted of the insulin pen administration observation for Resident #43 and was asked to provide the administration guidelines for insulin pens. Nurse Consultant B planned to educate Nurse K . On 4/15/2026, at 11:00 AM, a record review of the Lantus insulin glargine injection How to use your Lantus Solostar pen revealed areas to avoid . Only use the outer back area of the upper arm where there is fatty tissue .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure that Personal Protective Equipment (PPE) was worn during high contact care for one resident (Resident #4) of one resident reviewed for enteral feeding [a method of delivering liquid nutrients directly into the stomach via a percutaneous gastrostomy tube (PEG)], resulting in the likelihood of transmission of Multi-Drug Resistant Organisms (MDRO). Findings include:Resident #4: On 4/13/2026, at 3:30 PM, a record review of Resident #4's electronic medical record (EMR) revealed an admission on [DATE] with diagnoses that included feeding tube, Stroke and hypotension. Resident #4 required assistance with all Activities of Daily Living (ADL's) and had intact cognition. A record review of the Kardex revealed INFECTION Enhanced barrier precautions for MDRO prevention, includes gown and gloves for high-contact resident care activities . On 4/15/2026, at 8:54 AM, Prior to entry into Resident #4's room there was a 3-drawer caddy that housed PPE/gowns adjacent to the doorway and an enhanced barrier precautions sign on their doorway. Upon entry, Nurse I was observed standing on the left side of the bed with their knees touching the bed sheet. Nurse I was administering enteral feed solution via the Peg tube. Nurse I did not have on a protective gown. On 4/15/2026, at 8:56 AM, the Assistant Director of Nursing (ADON) A was asked if Nurse I should be wearing a protective gown while administering enteral feeding and ADON A stated, yes. On 4/15/2026, at 8:57 AM, an observation of Nurse I at the bedside of Resident #43 performing enteral feeding with no gown on along with ADON A was conducted. On 4/15/2026, at 8:58, ADON A exited Resident #43's room and offered the nurse would be educated. On 4/15/2026, at 11:00 AM, a record review of the facility provided Enhanced Barrier Precaution Policy Revision Date: April 1, 2024 revealed Expand the use of PPE and refer to the use of gown and gloves during high-contact resident care activities that provided opportunities for transfer of MDROs to staff hands and clothing. High-Contact Resident Care Activities include: . Device care or use: . feeding tube .