STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235641	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chesaning Nursing and Rehabilitation Center	201 S Front St Chesaning, MI 48616

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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37666 This Citation Pertains to Intake Number MI00151360. Based on observation, interview and record review, the facility 1) Failed to ensure accurate orders for a feeding tube and 2) Failed to ensure maintenance of the feeding tube, including water flushes, for 2 residents (Resident #1 and Resident #2) of 2 residents reviewed for feeding tubes. Findings Include: Resident #1: A record review of the Face sheet and Minimum Data Set/MDS assessment indicated Resident #1 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses: History of a stroke, left sided weakness, tongue and throat cancer, feeding tube, chronic pain syndrome, depression, weakness, hypertension and atrial fibrillation. The MDS assessment, dated 02/08/2025, revealed the resident had full cognitive abilities with a Brief Interview for Mental Status/BIMS score of 15/15 and the resident needed some assistance with all care. On 3/26/2025 at 11:29 AM, during an interview with Nurse B, she said Resident #1 had a feeding tube that he had recently started using. The nurse said the tube had recently been replaced (the resident was transferred to the hospital on 3/11/2025 and returned 3/13/2025), because the previous feeding tube became dislodged. She said the resident had encountered severe pain when he received an attempted bolus of tube feeding, but the new tube was working well for him. Nurse B said Resident #1 was receiving Radiation and Chemotherapy treatments for oral and throat cancer and went to a Cancer Center 5 days a week for treatment. She said the feeding tube was initially placed in preparation for a time he might need it. He had been eating orally prior to discomfort in his mouth from the radiation treatments. A record review of the physician orders for Resident #1 identified the following: Regular Diet, chopped texture, thin consistency (liquids), start date 1/4/2025. Clean PEG (feeding tube) site with saline and apply 4x4 gauze daily and PRN (as needed), start date 1/30/2025. (continued on next page)

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

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Flush PEG with 20cc of normal saline, start date 1/29/2025. Six times a day for painful swallow/unable to meet needs orally relate to tongue cancer, Bolus 250 ml Jevity 1.5 with an additional 200 ml water with PEG, start date 3/10/2025 and end date 3/19/2025. Enteral feed at bedtime, give dual system Jevity 1.5 @100 ml/hr with H2O 80 ml/hr total feed 1200 ml, start date 3/13/2025 and end date 3/19/2025. Enteral feed at bedtime. Give dual system Jevity 1.5 @ 100 ml/hr with H2O 80 ml/hr total feed 1200 ml, start date 3/19/2025. A review of the Medication Administration Record/MAR and Treatment Administration Record/TAR for Resident #1, revealed there was no documentation of Jevity being provided until 3/21/2025 until 3/21/2025. On 3/10/2025, an order was written for a bolus of Jevity 1.5, there was no documentation on the March 2025 MARTAR for Resident #1 that a nurse had attempted to provide the bolus of Jevity 1.5 to him. The 3/10/2025 order overlapped an additional order written 3/13/2025 for Jevity 1.5 to be given at 100 ml/hour. They were both discontinued on 3/19/2025. On 3/19/2025 an additional order was written for Jevity 1.5, which was the same as the 3/13/2025 order. A review of the MAR/TAR indicated there was no documentation by the nurses that Resident #1 had received or refused the Jevity 1.5 until 3/21/2025. The MAR/TAR for March 2025 did not mention the resident received water flushes to his feeding tube until 3/21/2025. A review of the February 2025 MARTAR for Resident #1 did not identify water flushes for the feeding tube. There was no indication the feeding tube had been flushed to keep it patent and in working condition. On 3/11/2025 the resident had severe abdominal pain when Nurse D attempted to bolus the Jevity 1.5 through Resident #1's feeding tube. He was transferred to the hospital and the feeding tube was replaced. He returned to the facility on [DATE]. On both the February and March 2025 MAR/TAR an order was identified as follows: Flush PEG with 20cc of Normal Saline three times a day for PEG tube care, order date 1/29/2025. The resident's Peg tube was placed 1/28/2025. The nurses were occasionally documenting that they were flushing the Peg tube with the 20cc of Normal Saline. On 3/26/2025 at 10:25 AM, Nurse E was asked about the 20cc Normal Saline flush of the Peg tube for Resident #1 and said the 20cc was a small amount and it would not flush the tube. She said she had not seen the order and did not do anything with the Peg tube. On 3/26/2025 at 2:24 PM, Registered Dietitian L was interviewed and said she had input the order on 3/10/2025 for Resident #1 to have a bolus of Jevity 1.5 with a water flush. She said it was discontinued when the resident had pain and had the tube replaced. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/27/2025 at 9:15 AM, Resident #1 was interviewed with Nurse B also present. He was sitting in wheelchair in his room and had recently been assisted by staff with his morning care. The resident said he was now using his feeding tube since it has been replaced and receives tube feeding and water flushes. He said the tube was working well and he wasn't having any issues with the new tube. The resident showed his abdomen; there was a gauze dressing over the peg tube insertion site. He said there was no redness or drainage. He said the first time they tried to use the other tube, he had so much pain they had to stop and send him to the hospital to have it replaced. During an interview with Nurse D on 3/27/2025 at 12:05 PM, she said on 3/11/2025 Resident #1 had severe abdominal pain when she attempted to bolus (a single large dose) the Jevity 1.5 through Resident #1's feeding tube. He was transferred to the hospital and the feeding tube was replaced. He returned to the facility on [DATE]. On 3/27/2025 at 2:45 PM, Nurse C was interviewed about the order for water flushes for Resident #1. She looked at the 3/10/2025 order for Jevity 1.5 and a water flush in the electronic medical record and she said the box was not checked to send it to the MAR or TAR when the order was placed; so, it did not show on the MAR/TAR for the nurses to document whether they had provided the care. A review of the Care Plans for Resident #1 identified the following: (Resident #1) has nutritional problem .1/25 PEG placed for use as needed . 3/10/25 (Resident) wanted to start using PEG for feeding/water flush due to oral pain preventing his ability to meet needs orally, date revised 3/10/2025 with Interventions including: Tube feeding and water flushes as ordered, date initiated 3/10/2025. There was no additional Care Plan addressing care and monitoring of Resident #1's feeding tube. Resident #2: A record review of the Face sheet and MDS assessment indicated Resident #2 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses: Parkinson's, diabetes, COPD, history of a stroke, difficulty swallowing, a feeding tube, fibromyalgia, heart disease, anxiety, depression chronic pain and an autonomic condition. The MDS assessment dated [DATE] revealed the resident had full cognitive ability with a BIMS score of 14/15 and he needed assistance with all care. On 3/26/2025 at 10:25 AM, Resident #2 was observed lying in bed. Nurse C was present and showed the resident's abdomen had 2 peg tube sites: an old now unused site and a new site with the Peg tube. The old site had some redness surrounding it and dried dark drainage. The gauze dressing on the site was very damp and had no date or initials when it was changed. Nurse C said she had not yet changed it that day and she wasn't sure who had placed the dressing. She said the resident's tube feeding was currently off, but would start again at 1:00 PM. She said she would start it and also provide the water flush. A review of the physician orders for Resident #2 revealed the resident had tube feeding and a pureed texture diet with pleasure foods dated 1/26/2025 and: (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Water to run via PEG@ 100/hr concurrently (1500 ml total per day,: two times a day for hydration water to run concurrent with enteral feeding at 100 ml/hr; 1 PM to 8 PM and 10 PM to 6 AM, dated 3/22/2025. Glucerna 1.5 Cal oral liquid (Nutritional Supplements) Give 100 ml via PEG-Tube in the afternoon for dysphagia continuous via pump, run from 1 PM to 8 PM, order date 12/17/2024 and discontinued 3/21/2025. Glucerna 1.5 Cal Oral Liquid (Nutritional Supplements) Give 120 ml via PEG-Tube at bedtime for dysphagia Glucerna to run at 100/hr from 10 PM to 6 AM (800 ml total), order date 3/21/2025. Glucerna 1.5 Cal Oral Liquid (Nutritional Supplements) Give 120 ml via PEG-Tube in the afternoon for dysphagia continuous via pump, run from 1 PM to 8 PM, order date 3/21/2025. The physician orders did not mention water flushes of the feeding tube. A review of the MAR/TAR for March for Resident #2 revealed the nurses were documenting they were administering the tube feeding, but there were not entries for flushing the feeding tube to keep it patent (clear/open/unclogged). A review of the Care Plans for Resident #2 identified the following: (Resident #2) has potential nutritional problem related to dysphagia, history failure to thrive, Parkinsons, (diabetes), GERD, (no teeth) and refuses to wear his dentures. Potential for weight loss. Feeding tube . Hospice, date initiated 10/25/2025 and revised 1/8/2025. The interventions do not mention a water flush to maintain the PEG tube. There was no Care Plan for maintenance of the feeding tube for Resident #2. On 3/27/2025 at 2:50 PM, Nurse A was asked about the Normal Saline flush of the Peg tube for Resident #1 and she said she was not familiar with flushing the Peg tube with Normal saline. She said she spoke with the physician and the order was discontinued. Reviewed with Nurse A there was a lack of documentation that the feeding tube was being flushed with water, as Nurse C had identified the orders were not pulling over to the MAR/TAR for the Resident's (#1 and #2). She said they would fix it. A review of the facility policy titled, Care and Treatment of Feeding Tubes, date implemented 3/26/2025 provided, It is a policy of this facility to utilize feeding tubes in accordance with current clinical standards of practice, with interventions to prevent complications to the extent possible . Feeding tubes will be utilized according to physician orders which typically include: the kind of feeding and its caloric value, volume, duration, mechanism of administration, and frequency of flush . The resident's plan of care will address the use of feeding tube, including strategies to prevent complications . Direction for staff on how to provide the following care will be provided: . Frequency of and volume used for flushing, including flushing for medication administration, and what to do when a prescriber's order does not specify .

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37666 This Citation Pertains to Intake Number MI00151360. Based on observation, interview and record review, the facility failed to follow accepted standards of practice for obtaining a physician's order, assessment and monitoring of a Central Venous Catheter/CVS Mediport IV for one resident (Resident #1) of 1 resident reviewed for IV catheters. Findings Include: Resident #1: A record review of the Face sheet and Minimum Data Set/MDS assessment indicated Resident #1 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses: History of a stroke, left sided weakness, tongue and throat cancer, feeding tube, chronic pain syndrome, depression, weakness, hypertension and atrial fibrillation. Resident #1 was receiving chemotherapy and radiation therapy for the cancer. The MDS assessment dated [DATE] revealed the resident had full cognitive abilities with a Brief Interview for Mental Status/BIMS score of 15/15 and the resident needed some assistance with all care. On 3/27/2025 at 9:20 AM, Resident #1 was interviewed with Nurse B present. He was sitting in a wheelchair in his room and had recently been assisted by staff with his morning care. The resident said he was receiving chemotherapy and radiation at the Cancer Center. He pointed to his chest and said his IV was there. Nurse B confirmed the resident had a Central line IV catheter for chemotherapy. A review of the physician orders for Resident #1 provided the following: Refer patient to vascular surgery for mediport placement, dated 12/31/2024. There was no further mention of an IV, Central line Mediport (a surgical implanted port for IV medications) in the physician orders. A review of the Medication Administration Records/MAR and Treatment Administration Records/TAR for Resident #1 for February and March 2025 indicated there was no mention of the IV Mediport, where it was located or if it as monitored by the nurses. A review of the progress notes identified the following: A provider note dated 1/14/2025, . Having mediport placed this week . A provider note dated 1/7/2025, . Mediport placed on 1/3/25-site appears stable . There were no additional notes or assessments of the Mediport site or dressing to the site. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/27/2025 at 2:05 PM, Nurse C was interviewed about Resident #1's Central Line IV that was being used for chemotherapy. She said only the staff at the Cancer Center used the Mediport and changed the dressing. Nurse C was asked if Resident #1's nurses at the facility were monitoring to ensure the dressings were intact, there was no bleeding through the dressing or redness, pain or warmth around it. She said they were not. Reviewed the physician orders and MAR/TAR for Resident #1 with Nurse C and she said there was no mention of the Mediport. A review of the Care Plans for Resident #1 identified the following: The resident has actual impairment to skin integrity of the surgical incisions: Mediport and (PEG tube insertion on 1/24/2025), date initiated 11/22/2024 and revised 1/25/2025, with 2 interventions: Avoid scratching and keep hands and body parts from excessive moisture. Keep fingernails short, date initiated 11/22/2024; Keep skin lean and dry. Use lotion on dry skin, both interventions initiated on 11/22/2024. Prior to the resident having the Mediport implanted. The Care Plan was not specific to the Mediport. There were no additional Care Plans that mentioned the Mediport Central Line. On 3/27/2025 at 2:55 PM, Nurse A was interviewed about the lack of physician orders, monitoring and documentation of the Mediport for Resident #1. She said she would look into it. The facility provided a policy for flushing, locking and removing a Central line, but not for management of a Central line, including monitoring for adverse effects.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37666 This Citation Pertains to Intake Number MI00151360. Based on observation, interview and record review, the facility failed to ensure that 1) Physician's orders for dialysis services; 2) Post- Dialysis assessment and monitoring were completed and 3) Dialysis communication forms were complete and included pre-dialysis and post-dialysis assessment, including location and assessment of the dialysis access site for one resident (Resident #4) of 1 resident reviewed for Dialysis care. Findings Include: Dialysis Resident #4: A record review of the Face sheet and Minimum Data Set/MDS assessment indicated Resident 34 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses: Chronic kidney disease, receives dialysis, Diabetes, obesity, anemia, gout, hypothyroidism. Hypertension and bipolar disorder. The MDS assessment dated [DATE] revealed the resident full cognitive abilities. On 3/27/2025 at 11:42 AM Nurse C was interviewed about Resident #4 receiving dialysis services, she said the resident did not have a physician order for dialysis services. She said there was also no orders for the dialysis access site or monitoring. The nurse said the resident had a dialysis access device in the left arm and it was supposed to be assessed and monitored. On 3/27/2025 at 12:50 PM, Resident #4 was interviewed. She said she had just returned from dialysis; she said she had dialysis on Tuesday, Thursday and Saturdays. She said she had a fistula in her right arm for dialysis. The resident said today at the dialysis center they had a hard time with the fistula as it was bleeding, and they had to place extra dressings on top of it. A record review of the physician orders for Resident #4 revealed there was no mention that Resident #4 had a dialysis access site or fistula. A review of the Medication Administration Records/MAR and Treatment Administration Records/TAR for March 2025 indicated there was no mention of a dialysis catheter access device/fistula or monitoring for adverse events. A review of the dialysis communication forms used for communication of assessment information before (by the facility), during (by the dialysis center) and after dialysis (by the facility) services identified that the forms were not always completed by the facility. On occasion the Pre-dialysis assessment information was incomplete or blank, but the Post-dialysis assessment information that the facility was to complete after the resident returned from the dialysis center was often blank. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post dialysis form assessment information includes: Date/time; shunt location/status; Bruit/thrill present: Yes, No, N/A; Bleeding: Yes, No; General condition of resident: Vital Signs; Nurse Signature. From 2/25/2025 to 3/22/2025, 9 of 10 Dialysis communication forms were incomplete and 8/10 had no post dialysis assessment information completed by a nurse- the section was blank. A review of the Care Plans for Resident #4 revealed there was no Care Plan for dialysis services or that mentioned her dialysis access device, location, assessment, or monitoring. A review of the progress notes revealed there was one progress note with assessment information related to Resident #4 receiving dialysis services: 3/6/2025 at 7:22 PM, Resident returned from dialysis at 12:30 PM, shunt has pressure dressing in place no bleeding observed at this time. Positive bruit and thrill. Resident denies any pain or discomfort at time of arrival. Vital signs were monitored. A review of the facility policy titled, Hemodialysis, dated August 2024 provided, This facility will provide the necessary care and treatment consistent with professional standards of practice, physician orders, the comprehensive person-centered care plan, and the resident's goals and and preferences, to meet the special medical, nursing, mental, and psychosocial needs of residents receiving hemodialysis. The facility will assure that each resident receives care and services for the provision of hemodialysis consistent with professional standards of practice. This will include: The ongoing assessment of the resident's condition and monitoring for complications before and after dialysis treatments received at a certified dialysis facility . Ongoing assessment and oversight of the resident before, during and after dialysis treatments .Ongoing communication and collaboration with the dialysis facility regarding dialysis care and services .