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	368510	A. BUILDING _____ B. WING _____	4/17/2025

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IRON CO MEDICAL CARE FACILITY	1523 U S HIGHWAY 2 CRYSTAL FALLS, MI 49920

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F0000 SS=	INITIAL COMMENTS Iron County Medical Care Facility was surveyed for a Recertification survey on 4/17/2025. Intakes: MI00150932 Census: 107	F0000		
F0695 SS= D	Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: All times recorded in Eastern Daylight Time (EDT), unless otherwise noted. Based on observation, interview and record review, the facility failed to 1. Ensure oxygen was administered per physician order and; 2. Ensure maintenance of oxygen and nebulizer equipment in a sanitary manner, for one Resident (#65) of one resident reviewed for oxygen administration.	F0695	The facility will ensure that residents who need respiratory care are provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan and the resident goals and preferences. For Resident # 65, the DON and practitioner reviewed the residents recent oximetry readings and assessed the residents respiratory status and clarified the oxygen liter flow ordered. The DON replaced, labeled and dated the residents oxygen tubing. The DON placed barrier under equipment and ensured baggie available to store tubing when not in use per facility policy. The DNP reviewed the residents record and completed an assessment with onging treatment for diagnosis of COPD. No noted ill effects. 4/17/2025 " DON identified those residents who are currently receiving oxygen and audited tubing for accuracy on labeling and to ensure correct storage units to coil and place tubing in baggie when not in use. 1 of 3 was noted to have out of date oxygen tubing. Tubing changed and labeled correctly. " DON audited care plans for accuracy. 3 of 3	5/27/2025

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

Electronically Signed | 05/07/2025

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.

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	Findings include: Resident #65 (R65) Review of the Minimum Data Set (MDS) assessment, dated 2/2/2025, revealed R65 was admitted to the facility on 4/26/2024 and had diagnoses including Chronic Obstructive Pulmonary Disease (COPD), anxiety and dementia. Further review of the MDS revealed R65 scored 10 out of 15 on the Brief Interview for mental Status (BIMS), indicating the Resident had moderate cognitive impairment. On 4/15/2025 at 2:38 p.m., R65 was observed sleeping in bed and was receiving supplemental oxygen via nasal cannula from a portable oxygen concentrator with a flow rate of three liters per minute (3 L/min). A tag attached to the oxygen tubing was dated 3/13/2025. On 4/16/25 at 1:15 p.m., R65 was observed sleeping in bed and was receiving supplemental oxygen via nasal cannula from a portable oxygen concentrator with a flow rate of 3 L/min. The tag attached to the oxygen tubing remained dated 3/13/2025. Review of R65's Electronic Medical Record (EMR) revealed an active physician order, dated 9/4/2025 at 11:30 a.m. [Central Savings Time] for "O2 [oxygen] @ [at] 2 LITERS [per minute] AS NEEDED - Does not want humidified water."		up to date. " DON verified orders on all residents receiving oxygen to determine accuracy on rate of flow resident is receiving. " ADON obtained the current list of residents receiving nebulizer treatments. In each unit these residents reside, DON ensured nurses had proper cleaning supplies, area to allow equipment to dry, and proper storage containers for nebulizer equipment. To prevent oxygen tubing from becoming outdated, to ensure it is stored in a sanitary manner, and to ensure oxygen is administered per physician order the following has been completed and/or initiated: 4/18/2025- DON and ADON reviewed the following policies and deemed them to be appropriate with evidence-based practices: 1) Cleaning and Disinfecting Nebulizers Policy 2) Oxygen Use and Set-up Policy 3) Medication Administration Policy 5/1/2025- " All nurses currently working in the facility received 1:1 education on the following: 1) Cleaning and Storage of oxygen tubing & nebulizer equipment. 2) 5 Rights of Medication Administration with focus on Checking the Order to assure that oxygen is being administered at the ordered liter flow. 3) Hand Hygiene with focus on during medication administration. For those employees who are casual/student status, on vacation, or on LOA, training will be completed before/during their next scheduled shift. " DON and ADON created a Relias education module and post-test for all licensed nursing staff including a review of Cleaning and	

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	Review of R65's EMR, including progress notes, assessments, and the April 2025 Medication and Treatment Administration Records (MAR's and TAR's) revealed no indication for the increased rate of oxygen administration observed above in the physician's order section. The most recent oxygen order was dated 9/4/2024 and directed staff to provide a flow rate of 2 L/min as needed. Review of R65's most recent vital signs, dated 4/15/2025 at 8:53 a.m. (Central Daylight Time), revealed R65 was assessed as having an oxygen saturation level of "97%" on room air. R65's April 2025 MAR and TAR revealed no documentation indicating R65 was receiving supplemental oxygen. During an interview on 4/17/2025 at 9:05 a.m., the Director of Nursing (DON) reported oxygen was to be administered per physician order and if a greater need is identified, nursing staff should conduct and document an assessment indicating the change in condition requiring administration of a higher rate of oxygen than what was ordered. The DON reported staff should also notify the physician and document the notification, along with any new orders, in the EMR. On 4/17/2025 at 9:20 a.m., R65 was observed lying in bed, awake, receiving supplemental oxygen via nasal cannula from a portable oxygen concentrator set to deliver 3 L/min. The tubing was again observed to be dated		Disinfecting Nebulizer Policy, and Oxygen Use and Set-up Policy. Focus on storing oxygen tubing, cleaning of equipment after each use, changing of oxygen tubing, and how/what to use to clean equipment. " DON and ADON created a Relias education module and post-test for all CNAs with emphasis on storing tubing when not in use. " 1:1 Education to AMA and NAA on delivery of oxygen tubing and humidifier bottles. Emphasis on: o Placing new tubing themselves and NOT delegating it out to another staff member. o Reapproach resident if unable to apply when they first attempt. o Review of Oxygen Use and Set-Up Policy To ensure the education and changes implemented are followed, monitoring has been implemented to ensure sustainability of compliance: DON/ADON or designee will complete audits of: 1) Oxygen administered per physician order and labeling of oxygen tubing is up-to-date to be completed weekly X 2 month, and random audits X 1 month. 2) Storing of equipment in a sanitary manner 2X per week for one month, weekly for one month, and random for one month. The facility will schedule follow-up evaluations to ensure that these practices are maintained over the long term and that any trends are addressed promptly. DON will present a compliance report based on the audit findings to be reviewed during monthly QAPI meetings by the team for 3 months; with recommendations by QAPI for further monitoring if consistent compliance has not been achieved. DON/ADON will be responsible for attaining and sustaining overall compliance with this	

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	3/13/2025. Further observation revealed a nebulizer atop R65's nightstand with tubing attached leading from the machine with the medication chamber and mouthpiece lying directly on the nightstand without a protective barrier between the equipment and the top of the nightstand. It was noted during the observation an illegible date was written in black marker on the side of the medication chamber. At the time of the observation R65 reported she was feeling shorter of breath lately and was unaware of what concentration of oxygen she was receiving from the concentrator. R65 reported her most recent nebulizer treatment was administered the previous day, on 4/16/2025. During an interview on 4/17/2025 at 9:25 a.m., Licensed Practical Nurse (LPN) "G" stated, if a resident required an increase in supplemental oxygen above what was ordered, nursing should document the change in condition in a progress note and notify the physician to report changes and obtain a new order for the higher rate. LPN "G" reviewed R65's EMR and stated the active order was for supplemental oxygen at 2 L/min as needed. LPN "G" reported he could not find an assessment documented in the EMR warranting the increase of R65's supplemental oxygen from 2 L/min to 3 L/min. During an observation of R65 immediately following the interview, LPN "G" confirmed R65 was being administered oxygen at 3 L/min and stated, "I have no idea		plan of correction.	

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	why." LPN "G" was asked about the date on the oxygen tubing. LPN "G" confirmed the tubing dated 3/13/25 was out of date and reported facility protocol was to change the tubing weekly. LPN "G" was alerted to the nebulizer tubing with medicine chamber and mouthpiece portions resting directly on the top of the nightstand. LPN "G" detached the tubing and reported the equipment should have been cleaned and stored in a plastic bag. During an interview on 4/17/2025 at 11:15 a.m., facility Infection Preventionist (IP) "I" reported the facility protocol was for oxygen tubing to be replaced and appropriately dated every two weeks. IP "I" was queried about the maintenance of nebulizer equipment and reported nursing staff were responsible to ensure appropriate care and storage of the administration sets. IP "I" reported the tubing, medication chamber and mouthpiece should be disassembled after each use, cleansed and dried, then stored in a plastic bag. IP "I" provided the facility policy at the time of the interview. Review of the facility policy titled, "Cleaning & Disinfecting Nebulizers," effective date 2025, revealed the following: "After each aerosol treatment, remove the cup. Mask or mouthpiece and wash with warm water and mild dish detergent. Thoroughly rinse the parts to remove all soap and residue. Allow the parts to air dry on a			

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	clean surface using a paper/cloth barrier between them." Review of the facility policy, titled, "Oxygen Use and Set-Up," provided by the DON with an effective date of 3/18/2020, revealed the following: "The physician standing order for oxygen is only for emergency purposes for 24 hours. If oxygen is started, notify the physician and obtain an order for oxygen to include liter flow/min, frequency of oxygen an oxygen saturation checks and conserving devices if used. O2 tubing on concentrator and companions on wheelchairs will be changed every 2 weeks and prn [as needed] ... The nurse is responsible for beginning oxygen therapy per MD [physician] orders: turning on O2 companions, setting flow rate, checking to ensure there is proper flow from the nasal cannula and checking oxygen saturations each shift for any resident receiving oxygen therapy."			
F0756 SS= E	Drug Regimen Review, Report Irregular, Act On §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i)	F0756	For Resident #67, the consultant pharmacist completed a drug regime review and submitted to the DON and attending physician. The DON assured that the practitioner addressed any recommendations in the DRR. For Resident #36, the consultant pharmacist completed a drug regime review and submitted to the DON and attending physician. The DON assured that the practitioner addressed any recommendations	5/27/2025

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	Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: All times are noted in Eastern Daylight Time unless otherwise noted Based on interview and record review, the facility failed to ensure that Medication Regimen Reviews (MRR) were reviewed, addressed by the Physician, and maintained in the clinical record for four Residents (#67, #36, #65, and #90) of five residents reviewed for MRR, resulting in the potential for the		in the DRR. For Resident #65, the consultant pharmacist completed a drug regime review and submitted to the DON and attending physician. The DON assured that the practitioner addressed any recommendations in the DRR. For Resident #90, the consultant pharmacist completed a drug regime review and submitted to the DON and attending physician. The DON assured that the practitioner addressed any recommendations in the DRR. The DON/designee audited the EMR for all residents and identified those residents who did not have a DRR in April 2025. The DON notified the pharmacist that these reviews needed to be completed. DON and ADON had a phone conference with pharmacy consultant about our process and how to correct. To ensure the pharmacy recommendations are being answered according to policy, the process needs to come back to an in-house process instead of reports being sent electronically to an outside source, Theoria. DON and ADON met with DNP about changing the processing of pharmacy consultation reports by bringing the process back internally instead of sending them to Theoria to process. DNP in agreement. 4/21/2025- Confirmed Pharmacist would be at the facility in person on 4/24/2025 to meet and discuss survey findings and finalize the plan to bring the process back to an in-house process. 4/24/2025- DON and ADON met with consulting pharmacist to review Medication Regimen Review policy and discussed new process as	

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	administration of unnecessary medications and adverse medication side effects. Findings include: Resident #67 (R67) Review of the Minimum Data Set (MDS) assessment dated 3/20/25 revealed R67 was admitted to the facility on 12/11/23 with active diagnoses that included: dementia, anxiety disorder, depression, psychotic disorder, and diabetes mellitus. R67 scored a 7 of 15 on the Brief Interview for Mental Status (BIMS) assessment reflective of severe cognitive impairment. Review of R67's Electronic Medical Record (EMR) revealed no pharmacy reports were available for 10/21/24, 11/27/24, 12/26/24, 2/17/25, and 3/21/25. During an interview on 4/16/25 at 11:42 a.m., the Director of Nursing (DON) stated, "I do not know where the pharmacy reports are ... I should keep them, but I don't." The DON examined the EMR and acknowledged that she was unable to find the pharmacy reports. During an interview on 4/17/25 at 9:37 a.m., the DON acknowledged that there was no way to review what the pharmacist recommended, if the Medical Director (MD) or Nurse Practitioner (NP) agreed/disagreed with the recommendations, or if the MD or NP gave a reason for their decision.		follows: 1) After receiving monthly pharmacy recommendations, ADON will print and separate them for delivery as follows a. Nursing-will be handed to the Administrative Medical Assistant to initiate processing. b. Physician-will be handed to DNP and/or medical director for review and response. c. GDRs-a meeting will be scheduled for the Behavior Team to review and give their recommendations to DNP/medical director for review and response. 2) Once all recommendations have been reviewed and have a response, all reports will be given to charge nurse for processing. 3) A copy of the summary of MRRs will be given to charge nurses to indicate orders they process. 4) Recommendations will then go to HIM to be scanned into the residents medical record. 5) DON/ADON will review the completion of recommendations weekly. 4/25/2025- Received current Pharmacy Consultation Reports from pharmacist with new and outstanding recommendations. 4/28/2025- DON and ADON reviewed all GDRs with IDT. ADON distributed all pharmacy recommendations to either Administrative Medical Assistant for processing or DNP for review. 1:1 Direction given to DNP about internal process by ADON. To prevent pharmacy recommendations responses being delayed and ensure they are a part of the residents medical record, the following has been completed and/or initiated: DON, ADON, and pharmacy consultant reviewed and updated Medication Regimen	

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	During and interview on 4/17/25 at 10:45 a.m., the Nursing Home Administrator (NHA) acknowledged there was no one at the facility ensuring the pharmacy consults were being addressed and stated, "I know the system is broken and we are deficient." Resident #36 (R36) Review of the MDS assessment, dated 3/23/2025, revealed R36 was admitted to facility on 6/8/2017 and had diagnoses including dementia, diabetes, post-traumatic stress disorder (PTSD) and stroke. Review of R36's EMR revealed no pharmacy reports were available for 11/25/2024 and 12/20/2024. On 4/16/024 at 12:50 p.m., the DON reported all available pharmacy recommendations had been provided. Review of the pharmacy recommendations provided by the DON revealed no reports for R36 for the dates requested. Resident #65 (R65) Review of the MDS assessment, dated 2/2/2025, revealed R65 was admitted to the facility on 4/26/2024 and had diagnoses including Chronic Obstructive Pulmonary Disease (COPD), anxiety, hypertension, diabetes and dementia.		Review Policy and changed the timeframes the attending physician/DNP must respond to: 1) 45 days (from 60 days) then the DON will bring them back to attending physician/DNP 2) 50 days (from 65 days) then the DON will notify the Medical Director and /or the Administrator. ADON completed 1:1 educated with all charge nurses on change of internal process. 5/5/2025-DON verified the processing of Aprils pharmacy recommendations has been completed and all have been sent to HIM to scan in to the residents medical record. To ensure the changes implemented are followed, DON/ADON or designee will review: 1) The monthly Pharmacy Consultation Summary Reports weekly for progress 2) If by Day 30, a pharmacy recommendation has still not been addressed, DON will bring it back to attending physician/DNP to review per ICMCFs Medication Review Policy. DON/ADON or designee will audit completed recommendations for: 1) Completion of pharmacy recommendation by attending physician/DNP with signature and recommendation/rationale. 2) Completed recommendations have been added to residents medical record. 10 audits X 1 month, 6 audits X 1 month, 4 audits X 1 month. DON will present a compliance report based on the audit findings at monthly QAPI meetings for review by the team for 3 months, with recommendations by QAPI for further monitoring if consistent compliance has not been achieved. Ongoing monitoring thereafter will be continued by DON/ADON to ensure compliance in accordance with the policy. DON will be responsible for attaining and sustaining overall compliance with this plan of	

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	Review of R36's EMR revealed no pharmacy reports were available for 1/27/2025. On 4/17/2025 at 9:02 a.m., the DON reported all pharmacy recommendations had been provided. The DON was alerted to the missing recommendations for R36 and R65. Another request was made for the missing recommendations for R36 and R65. The reports were not received by the end of the survey on 4/17/2025 at 2:00 p.m. Resident #90 (R90) Review of R90's Admission Record revealed admission to the facility on 2/9/24, with current active diagnoses that included: fracture of the left femur, mild cognitive impairment, urinary tract infection and vitamin D deficiency. Review of R90's EMR revealed no pharmacy reports were available for 10/14/2024 and 12/26/2024. On 4/17/25 at 10:45 a.m., the DON confirmed all available pharmacy recommendations had been provided, and acknowledged no Medication Regimen Review reports were available for the above dates for R90. Review of the "Medication Regimen Review" policy, effective date: 9/11/24, revealed the following, in part: "Medication Regimen Review (MRR) or Drug Regimen Review, is a thorough evaluation of the medication		correction.	

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	regimen of a resident, with the goal of promoting positive outcomes and minimizing adverse consequences and potential risks associated with medication ... D. The pharmacist shall document, either manually or electronically, that each medication regimen review has been completed. a. The pharmacist shall document either that no irregularity was identified or the nature of any identified irregularities... F. Written communications from the pharmacist shall become a permanent part of the resident's medical record..."			
F0757 SS= D	Drug Regimen is Free from Unnecessary Drugs §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-§483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by:	F0757	The facility will develop a plan to ensure residents receive medications that are appropriate, necessary, and free from duplication. Review of the medical record indicates that Resident #90 has received the ordered dose of Vitamin D3 since July 1, 2024. The DON/designee reviewed the Drug Regime reviews for the month of April 2025. There was no duplicative therapy identified that the physician had not addressed. Physician Orders Policy given to the Nursing Administration Team and charge nurses in house for review, to verify and evaluate our current process. RCA completed by DON and ADON to identify how error occurred. Upon process review, we	5/27/2025

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	368510	A. BUILDING _____ B. WING _____	4/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IRON CO MEDICAL CARE FACILITY	1523 U S HIGHWAY 2 CRYSTAL FALLS, MI 49920

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	Based on interview and record review, the facility failed to prevent duplicate drug therapy of Vitamin D for one Resident (#90) of five residents reviewed for unnecessary medications. This deficient practiced resulted in an excessive dose of D3 and the potential for Vitamin D toxicity. All times noted are Eastern Daylight Savings Times (EDST) unless otherwise noted. Findings include: Resident #90 (R90) Review of R90's Admission Record revealed admission to the facility on 2/9/24, with current active diagnoses that included: fracture of the left femur, mild cognitive impairment, urinary tract infection and vitamin D deficiency. Review of available Medication Regimen Review (MRR) reports for R90 revealed the following, in part: 1. Consultation Report Date 5/30/24, "Comment: [R90] receives ergocalciferol (vitamin D2) 50,000 units weekly on Thursdays. vitamin D3 is more efficiently absorbed and utilized by the body and may be better at increasing and maintaining vitamin D in the body. Recommendation: Please consider changing from ergocalciferol (vitamin D2) to vitamin D3 50,000 units weekly on Thursdays ... Physician Response: I		identified our transcription of orders would improve with redundancy built into the system. The Nursing Administrative Team revised the process to include a double note signature. 1:1 Education on the importance of double noting orders occurred for all charge nurses, neighborhood licensed staff, and nursing administrative team currently in the facility. All other nursing staff not in the building will be educated before or during their next shift. DON and ADON created a Physician Order Policy review with post-test for all licensed staff on Relias with focus on: double noting by licensed staff ensuring no duplicate orders and to identify the same medication under a different name. For those employees who are casual/student status, on vacation, or on LOA, Relias education will be completed before/during their next scheduled shift. To ensure the education and changes implemented are followed, monitoring has been implemented to ensure sustainability of compliance. ADON updated Provider Visitation Log Sheets for DNP and Medical Director to include space to verify the order has been double noted by a licensed staff member. DON/ADON or designee will audit 2 Provider Visitation Log Sheets (that contain up to 22 orders) and 6 Omnicare pharmacy recommendation sheets weekly for one month to ensure order was processed per facility policy to ensure double noting was completed by second licensed staff. Then 1 provider visitation log sheets and 4 Omnicare pharmacy recommendation sheets weekly for one month, then 1 provider visitation log sheet and 2 Omnicare pharmacy recommendations weekly for one month. DON will present a compliance report based	

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	accept the recommendation(s) above, please implement as written." Signed by R90's Physician on 6/3/24. 2. Consultation Report Date 6/28/24. "Comment: [R90's] prescriber accepted a pharmacy recommendation to change vitamin D2 to vitamin D3 on 6/3/24. This medication change occurred however the vitamin D2 did not get discontinued. Recommendation: Please discontinue vitamin D2 per pharmacy recommendation." Review of R90's June 2024 Medication Administration Record (MAR) revealed ergocalciferol (vitamin D2) 1.25 MG (milligrams) (50,000 units) continued to be administered on 6/6, 6/13, 6/20, and 6/27/24 per a physician order with a Start Date of 4/4/24, and a discontinue date of 7/3/24. An additional physician order for Cholecalciferol (vitamin D3) (50,000 units), with a Start Date of 6/5/24, was administered to R90 on 6/5, 6/12, 6/19, and 6/26/24 resulting in duplicative administration of vitamin D weekly (100,000 units total) to R90 during the month of June 2024. During an interview on 4/17/25 at 10:56 a.m., the Director of Nursing (DON) and Assistant Director of Nursing (ADON) "N" were asked about R90's May and June pharmacy "Consultation Reports". The DON and ADON "N" reviewed R90's physician orders, pharmacy recommendations and MAR documentation. Both confirmed R90 received		on the audit findings to be reviewed during monthly QAPI meetings by the team for 3 months; with recommendations by QAPI for further monitoring if consistent compliance has not been achieved. DON will be responsible for attaining and sustaining overall compliance with this plan of correction.	

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	duplicative administration of vitamin D throughout June 2024. The DON acknowledged she was unaware this duplication had occurred. The DON stated, "The audit side of this (medication regimen review) is what I was not seeing because of the (different) electronic process. There is a process for double-checking (physician orders) but I believe this was just missed." Review of the "Medication Regimen Review" policy, effective date 9/11/24, revealed the following, in part: "Medication Regimen Review (MRR) or Drug Regimen Review, is a thorough evaluation of the medication regimen of a resident, with the goal of promoting positive outcomes and minimizing adverse consequences and potential risks associated with medication. The MRR includes: I. Review of the medical record in order to prevent, identify, report, and resolve medication-related problems, medication errors, or other irregularities..."			
F0759 SS= E	Free of Medication Error Rts 5 Prcnt or More §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to maintain a medication error rate less than 5% in four	F0759	The facility will develop a plan to maintain a medication error rate of 5% or less. For Resident #95, a review of labs was completed by DON and ADON to assess for potassium toxicity and resident was monitored through daily nursing notes for any signs or symptoms. Follow-up labs obtained and reviewed by DNP. For Resident #8, a review of labs was completed by DON and ADON to assess for potassium toxicity and resident was monitored through daily nursing notes for any signs or	5/27/2025

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	Residents (#95, #8, #70, & #23) of 12 residents reviewed for medication administration. This deficient practice resulted in a medication administration error rate of 13.33%, based on 4 medication errors in 30 opportunities for error. Findings include: Resident #95 (R95) R95 was admitted to the facility on 6/25/24 with diagnoses of dementia, Down Syndrome, hypokalemia (low potassium level), and others. R95 had a physician's order dated 4/15/25 to administer three 10 mEq (milliequivalent) Potassium Chloride ER (extended release) capsules. The order contained the instruction: "Do not crush." On 4/16/25 at 12:50 PM, Registered Nurse (RN) "K" was observed preparing and administering medications on the 800-unit, Lilac Lane. When preparing medications for R95, RN "K" opened the capsules of potassium and crushed the content of the capsules before placing the crushed content in pudding. RN "K" was asked why the potassium medication for R95 was crushed. RN "K" said she was a charge nurse and did not usually administer medications, so she had another nurse prepare a list of residents who required medication to be crushed. RN "K" produced a sheet of paper listing residents' names. Next		symptoms. Follow-up labs obtained and reviewed by DNP. For Resident #70, a review of labs was completed by DON and ADON to assess for potassium toxicity and resident was monitored through daily nursing notes for any signs or symptoms. Follow-up labs obtained and reviewed by DNP. For Resident #23, a review of bowel movements was completed by DON to assure that resident did not have any unusual increased or decreased frequency of bowel movements and continued to monitor activity through daily nursing notes and CNA task documentation. ADON identified all residents who receive potassium and all who receive crushed, opened, or modified medications had the potential to be affected. Immediate 1:1 education given to nurses in facility on Do Not Crush medications. DON and ADON reviewed Medication Administration Policy and updated the Oral Crushed Medication section to reflect a physician order is needed to crush any medication and to administer multiple crushed medication together. DON and ADON completed an RCA. DON and ADON created a Relias module and posttest reinforcing the following: If pill is dropped onto cart or floor, place in Drug Buster and retrieve a new pill to administer. Shake well to mix suspensions. Crushed medications require a Physician order to crush. Potassium orders require a DO NOT CRUSH order but may Opened and sprinkled. If resident refuses medications, document in EHR and notify Charge Nurse.	

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	to R95's name was written "crush." R95's physician's orders and care plan were reviewed on 4/16/25. R95 did not have a physician's order to crush medications. The care plan did not indicate medications were to be crushed. Resident #8 (R8) R8 was admitted to the facility on 6/28/19 with diagnoses including but not limited to hypokalemia. R8 had a physician's order dated 1/21/25 to administer two 10 mEq capsules of potassium chloride ER three times a day related to hypokalemia. The order instructions included: "Do not crush." During medication administration on 4/16/25 at 12:50 PM, RN "K" opened the potassium ER capsules and crushed the content before placing the content in applesauce to administer to R8. After administering the medication in applesauce, RN "K" assisted R8 to take a sip of water from a cup. R8's physician's orders and care plan were reviewed on 4/16/25. R8 did not have a physician's order to crush medications. The care plan did not indicate medications were to be crushed. Resident #70 (R70) R70 was admitted to the facility on 12/21/22 with diagnoses including Alzheimer's Disease		If medication has been prepared and it is then refused, destroy in Drug Buster. Perform hand hygiene prior to administering medication. Perform hand hygiene after medication administration. If resident is displaying difficulty with any medication (IE: taste, form, size) notify physician. For those employees who are casual/student status, on vacation, or on LOA, training will be completed before/during their next scheduled shift. DON gave full list of residents who receive crushed medications to DNP for review and write an order for long-acting medications indicating: 1) Do Not Crush OR 2) Do Not Crush, but may open and sprinkle and combine OR 3) May crush and Do NOT combine OR for all medications: 4) May crush and combine Once orders are processed, MDS will update Care Plan to reflect this. DON created a new form: Refusal of Medication/Medication Form Change Request for charge nurse (notified by neighborhood nurse) to fill out for residents who may require a change in medication form for any reason. Completed forms will be given to DNP for any action required. DON verified that audits are performed by pharmacy consultant monthly for any residents who should have an order stating, Do Not Crush. Omniviews DO NOT CRUSH medication list was added to all units medication information binders, placed at the north side nurses station, and given to Administrative Medical Assistants.	

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	and hypokalemia. R70 had a physician's order dated 1/21/25 to administer two potassium chloride 10 mEq capsules three times per day for hypokalemia. During medication administration to R70 in their room on 4/16/25 at 1:31 PM, LPN "L" placed one capsule of potassium chloride in R70's mouth. The potassium chloride capsules were blue in color. R70 began chewing the capsule. R70 chewed the potassium capsule continuously until their mouth and lips turned blue from the blue capsules. LPN "L" attempted to give R70 the second capsule while R70 was still chewing the first capsule. R70 shook her head "no." LPN "L" exited the room and returned to the medication cart outside the room. LPN "L" labeled the medication cup with R70's name and placed it in the top drawer of the medication cart atop the cup containing R93's baclofen. LPN "L" was told R70 was still chewing the first potassium capsule. LPN "L" re-entered R70's room and stayed until R70 was finally able to swallow the capsule. LPN "L" did not offer water to R70 after the capsule was swallowed. Nurse progress notes and medication notes were reviewed on 4/17/25 at 9:04 AM. LPN "L" did not document the difficulty R70 had with swallowing the potassium capsules, nor was there any documentation indicating R70's physician was notified the resident did not receive the prescribed dose of		To ensure the policy review and changes implemented are followed, DON/ADON or designee will randomly audit a medication pass with focus on: medications are not being altered or combined without an order, no prepared medication stored in medication cart, performing hand hygiene, medication disposed of appropriately if contaminated or refused, shaking of liquid medications, and notification to charge nurse for medication refusal. Audits will occur on two nurses weekly on each shift for one month, then one nurse on each shift weekly for 2 months, then one nurse monthly on-going to ensure compliance with facility guidelines. Pharmacy consultant to audit residents orders monthly and ensure Do Not Crush orders are present for those medications that should not be crushed. Will send recommendations if order is missing. MDS coordinator or designee will conduct quarterly audits to verify that any resident on crushed, opened, modified, or combined medications has a corresponding intervention in their care plan. DON will present a compliance report based on the audit findings at monthly QAPI meetings for review by the team for 3 months, with recommendations by QAPI for further monitoring if consistent compliance has not been achieved. Ongoing monitoring thereafter will be continued by DON to ensure compliance in accordance with the policy. DON will be responsible for attaining and sustaining overall compliance with this plan of correction.	

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	medication or requesting to change the medication to liquid form. Resident #23 (R23) R23 was admitted to the facility on 1/12/15 with diagnoses that included constipation. R23 had a physician's order dated 1/21/25 for Senna (laxative) Oral Syrup one teaspoon (tsp) twice daily for constipation. During medication administration on 4/17/25 at 7:50 AM, LPN "M" removed the bottle of senna from the medication cart before removing the cap from the bottle and pouring one tsp of medication from the bottle into a medication cup. LPN "M" did not shake the bottle of medication prior to pouring it into the medication cup to ensure the medication was dispersed throughout the liquid for uniform distribution of the active ingredient. LPN "M" crushed R23's other medications and placed all medications, including the unshaken liquid senna into a cup of coffee. LPN "M" provided R23 the cup of coffee containing the medications. R23's physician's orders and care plan were reviewed on 4/16/25. R23 did not have a physician's order to crush medications or to administer medications in coffee. The care plan did not indicate medications were to be crushed or placed in coffee. The Director of Nursing (DON) was interviewed on 4/17/25 at 11:31 AM. The			

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	DON said the beads in potassium capsules should not be crushed. The DON said physicians' orders are required to crush, open or modify medication forms of delivery. When asked the expectation for disposition of medication if a nurse prepares a medication and a resident either refuses or is not available to administer medications, the DON said the medications were expected to be destroyed in a drug buster solution. The DON confirmed medication cups containing medications should not be labeled and stored in medication carts. The DON said nurses should be washing their hands during medication administration between residents. The DON said medications that fall on the medication cart during preparation should be disposed of in drug buster solution. The DON confirmed liquid medication should be shaken prior to pouring the medication. The DON conveyed the expectation of physician notification if a resident does not take medications as prescribed. According to the United States Food and Drug Administration (FDA), the prescribing information for potassium chloride extended-release capsules include the following, in part: "... Administration and Monitoring . . . Take with meals and with a full glass of water or other liquid ... should be swallowed immediately without chewing and followed with a glass of water or juice to ensure complete swallowing of the microcapsules..." (www.accessdata.fda.gov/drugsatfda_docs/label/2018/018238s046lbl.pdf).			

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	The facility policy titled "Medication Administration" dated as effective 10/7/21 documented, in part: "...Medications will be administered per MD orders . . . Perform hand hygiene prior to administering medication . . . "Shake well" to mix suspensions. . . 17. Crush medications as ordered. Do not crush medications with "do not crush" instructions. 18. Observe resident consumption of medication. 19. Perform hand hygiene after medication administration . . . If resident refuses medications, document in EHR (Electronic Health Record) and notify Charge Nurse. If medication has been prepared and it is then refused, destroy in Drug Buster . . . 24. Report and document any adverse side effects or refusals . . . Crushed medications require a Physician order to crush, and this must also be added to that specific medication on the EMAR [Electronic Medication Administration Record] . . ."			
F0880 SS= E	Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain 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. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling	F0880	The facility will develop a plan to ensure hand hygiene will be performed during a fresh water pass and post catheter care. For resident #11, DON and ADON monitored daily nursing notes on the 24 hour report for any signs or symptoms of potential infection. None noted. For resident # 32, DON and ADON monitored daily nursing notes on the 24-hour report for any signs or symptoms of potential infection. None noted. For resident #33, DON and ADON monitored daily nursing notes on the 24-hour report for	5/27/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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	infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as		any signs or symptoms of potential infection. None noted. For resident # 38, DON and ADON monitored daily nursing notes on the 24-hour report for any signs or symptoms of potential infection. None noted. For resident #50, DON and ADON monitored daily nursing notes on the 24-hour report for any signs or symptoms of potential infection. None noted. For resident #52, DON and ADON monitored daily nursing notes on the 24-hour report for any signs or symptoms of potential infection. None noted. For resident #55, DON and ADON monitored daily nursing notes on the 24-hour report for any signs or symptoms of potential infection. None noted. Housekeeping disinfected the high-touch surfaces in room. The DON/ADON and designees identify residents on Enhanced Barrier Precautions who were potentially affected. For any identified, the DON/ADON will monitor daily nursing notes on the 24-hour report for any signs or symptoms of potential infection. Immediate 1:1 education was provided to Resident Assistants in the facility on proper hand hygiene protocol between residents when passing water jugs. All others were educated before or during their next working shift. DON and ADON completed policy reviews on the following: 1) Hand Hygiene Policy reviewed and updated to indicate when it□s appropriate to perform hand hygiene: a. Perform Hand Hygiene before and after: i. Performing invasive procedures ii. Handling medications iii. Handling contaminated items	

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IRON CO MEDICAL CARE FACILITY	**1523 U S HIGHWAY 2 CRYSTAL FALLS, MI 49920**

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	evidenced by: Based on observation, interview and record review, the facility failed to ensure hand hygiene was performed during fresh water pass and catheter care, for 7 Residents (R11, R32, R33, R38, R50, R52 and R55), out of 22 sample residents reviewed for hand hygiene. This deficient practice resulted in the potential for cross-contamination of infectious organisms between residents in the facility. All times noted are Eastern Daylight Savings Time (EDST) unless otherwise noted. Findings include: During an observation of fresh water pass on 4/15/25 at 2:08 p.m. , Certified Nurse Aide (CNA) "A" was observed delivering fresh water mugs and removing the previously used water mugs from resident rooms. CNA "A" delivered fresh water and removed previously used water mugs from R11's, R32's, R33's, R52's, R50's, and R38's rooms, without the performance of hand hygiene between rooms. During an interview on 4/15/25 at approximately 2:30 p.m., when asked if they had performed hand hygiene between rooms while passing fresh water and removing used water mugs from resident rooms, CNA "A" stated, "No, I did not do any hand hygiene between the rooms. I should probably grab hand sanitizer for my pocket. We have one (hand sanitizer bottle) at the nurses' station." CNA "A" acknowledged understanding of the importance of hand hygiene between touching each residents clean and dirty water mugs. R55		iv. Contact with blood and body fluid, secretions, excretions, mucous membranes, etc v. Assisting with/providing personal care vi. Eating vii. Using the restroom viii. Sneezing, coughing, blowing or wiping nose. b. When in doubt, wash your hands. 2) Catheter Care Policy-updated to indicate it□s appropriate to remove gloves and perform hand hygiene after performing catheter care but before touching clean items. Then don new, clean gloves. 3) Drinking Water Distribution Policy-updated to indicate hand hygiene is to be performed before entering a resident□s room and after placing the empty jug on the cart. DON and ADON created an education module with posttest on Relias for: 1) all Resident Assistants on performing hand hygiene between resident rooms 2) all CNAs on when to perform hand hygiene after performing catheter care, but before touching clean items such as closet handle, clothing, or clean brief. Per facility policy, you are required to remove gloves, perform hand hygiene, and don new, clean gloves. For those employees who are casual/student status, on vacation, or on LOA, training will be completed before/during their next scheduled shift. To ensure compliance with hand hygiene after education, DON/ADON or designee will perform hand hygiene audits during a water pass 6x/week for 2 weeks, 4x/week x 2 weeks, then 2x weekly for two months. Audits for hand hygiene for residents on Enhanced Barrier Precautions will be completed by DON/ADON or designee with focus on reducing the risk for cross	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	368510	A. BUILDING _____ B. WING _____	4/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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	During R55's catheter care observation on 4/16/25 at 2:04 p.m., CNA "O" and CNA "C" both donned Enhanced Barrier Precautions (EBP) which included gloves. CNA "O" performed the care, while CNA "O" was assist with positioning of R55. CNA "O" used a clean, wet cloth to cleanse R55's catheter tubing and genitals. CNA "O" realized a clean incontinence brief was required and left R55's bedside with the dirty gloves used to cleanse R55's genitals still on their hands. CNA "O" opened the Resident's closet doors by grabbing the handles with their contaminated gloves, retrieved a clean incontinence brief, and closed the closet door. R55's brief was changed with CNA "O" still wearing the contaminated gloves. CNA "O" and CNA "C" both assisted R55 with his clothing and application of protective boots to both feet. CNA "O" remained in contaminated gloves touching clothing, the protective boots and environmental surfaces. During an interview on 4/16/25 at 2:17 p.m., CNA "O" was asked to explain the purpose of Enhanced Barrier Precautions. CNA "O" stated, "It is to protect him from UTIs (urinary tract infections)." CNA "O" agreed they did touch the cabinet handles, protective booties and resident clothing with their dirty gloves and acknowledged they should have performed hand hygiene and donned clean gloves after cleaning R55's genitals and catheter tubing. During an interview on 4/16/25 at 2:20 p.m., Registered Nurse (RN) "B" was asked when hand hygiene and donning of clean gloves should be performed during catheter care. RN "B" said gloves should be removed when dirty and hand hygiene performed before touching other environmental surfaces. RN "B" acknowledged the risk for cross-contamination between residents and staff when environmental surfaces were		contamination. 2 audits weekly for 1 month, 1 audit weekly for 2 months. DON will present a compliance report based on the audit findings to be reviewed during monthly QAPI meetings by the team for 3 months; with recommendations by QAPI for further monitoring if consistent compliance has not been achieved. DON will be responsible for attaining and sustaining overall compliance with this plan of correction.	

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	contaminated by the CNA "O's" dirty gloves. Review of the "Hand Hygiene" policy, effective date 2025, revealed the following, in part: " ... All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. This applies to all staff working in all locations within the facility ... The use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves, and immediately after removing gloves ..." During an interview on 4/17/25 at 11:00 p.m., the above observations were discussed with the Director of Nursing (DON). The DON expressed understanding of the deficiency concern related to the failure to perform hand hygiene and the potential for cross-contamination of infectious organisms within the facility.			