STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235006	A. Building B. Wing	03/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Munson Healthcare Otsego Memorial Hospital Ltcu	825 N Center St Gaylord, MI 49735

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34568 This citation pertains to intake: MI00143410 Based on interview and record review, the facility failed to prevent staff to resident verbal and physical abuse for three Residents (R3, R14, R19) of three residents reviewed for abuse. This deficient practice resulted in R19 expressing fear of exposure to continued rough treatment during cares and fear of retaliation and the likelihood of feeling degraded by derogatory and profane comments by R3 and R14 based on the reasonable person concept. Findings include: Review of the facility's Investigation Summary/[Facility Name] dated [DATE] read, in part, .On [DATE]th (Certified Nurse Aide (CNA) K) reported to the (Director of Nursing (DON)) that resident (R19) had told her (CNA J) was rough with him, yanking on his arms and legs. 'I asked her to stop she does for a bit then does it again. She's mean to me and pulls and tugs on my arms. I'm scared of her. I especially don't like when she gets me out of bed in the mornings. I feel like she's going to pull my arms out of their sockets.' When asked if he was afraid of CNA J, (R19) said yes. CNA K said he was tearful and said he showed distress in his facial expression .R19 scored a ,d+[DATE] on the BIMS (Brief Interview for Mental Status) .[DATE]th, 2024 interview with CNA L stated that CNA J works too many hours and is always tired .she's so worn out and treats others poorly .when asked for examples CNA L gave in room with (R3) with cares CNA J stated 'Come on, (R3), roll your fat over.' And with (R14) crying all the time, CNA J stated Stop your God D*** crying! (R14) also grips hands of employees tightly and CNA J will yank her hand away and say, 'Don't F******* dig into me with your nails.' Review of CNA K and CNA L written statements confirmed the facility's Investigation Summary. An interview was conducted with R19 on [DATE] at 9:44 a.m., R19 declined to answer questions regarding his care with CNA J. R3 was noted to have expired prior to the survey start date of [DATE]. Review of R14's Minimum Data Set (MDS) assessment dated [DATE] revealed she scored a 99 on the BIMS score and was unable to be interviewed. (continued on next page)

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with CNA J on [DATE] at 12:37 p.m. When asked if she ever becomes frustrated with caring for residents, including those with cognitive impairments CNA J stated, I got frustrated with one resident who constantly rings her call light, or cries. In regard to the incident with R19, CNA J stated, I have taken care of (R19) for three years, he is a two person assist and cannot help you with his cares. When asked if CNA J has experienced burnout, she replied, I have worked 103 hours every two weeks, I'm always picking up and working shifts because I'm American. When asked if she has ever sworn in front of resident's CNA J stated, It may slip here and there. An interview was conducted with the Nursing Home Administrator (NHA) on [DATE] at approximately 1:00 p. m. The NHA confirmed that CNA J was terminated from employment due to the nature of the statements given to her from staff. The NHA confirmed the allegations were substantiated by the facility. Review of the facility's Resident Abuse Identification and Prevention revised on [DATE] read, in part, . [Facility Name] strictly prohibits mistreatment, neglect and abuse of residents and misappropriation of resident property, and does not tolerate verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion for any reason .

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34568 This citation pertains to intake: MI00143410 Based on interview and record review, the facility failed to report staff to resident verbal abuse for two Residents (R3, R14) of three residents reviewed for abuse. Findings include: Review of the facility's Investigation Summary/[Facility Name] dated [DATE] read, in part, .[DATE]th, 2024 interview with CNA L stated that CNA J works too many hours and is always tired .she's so worn out and treats others poorly .when asked for examples CNA L gave in room with (R3) with cares CNA J stated 'Come on, (R3), roll your fat over.' And with (R14) crying all the time, CNA J stated Stop your God D*** crying! (R14) also grips hands of employees tightly and CNA J will yank her hand away and say, 'Don't F******* dig into me with your nails.' Review of CNA K and CNA L written statements confirmed the facility's Investigation Summary. R3 was noted to have expired prior to the survey start date of [DATE]. Review of R14's Minimum Data Set (MDS) assessment dated [DATE] revealed she scored a 99 on the BIMS score and was unable to be interviewed. An interview was conducted with CNA J on [DATE] at 12:37 p.m. When asked if she ever becomes frustrated with caring for residents, including those with cognitive impairments CNA J stated, I got frustrated with one resident who constantly rings her call light, or cries. In regard to the incident with R19, CNA J stated, I have taken care of (R19) for three years, he is a two person assist and cannot help you with his cares. When asked if CNA J has experienced burnout, she replied, I have worked 103 hours every two weeks, I'm always picking up and working shifts because I'm American. When asked if she has ever sworn in front of resident's CNA J stated, It may slip here and there. An interview was conducted with the Nursing Home Administrator (NHA) on [DATE] at approximately 1:00 p. m. The NHA confirmed that CNA J was terminated from employment due to the nature of the statements given to her from staff. The NHA confirmed the allegations were substantiated by the facility and she did not report these additional incidents involving R3 and R14 to the State Agency as they did not come to her knowledge until after the investigation into R19. When asked why staff did not report these incidents sooner, the NHA stated she did not know. Review of the facility's Resident Abuse Identification and Prevention revised on [DATE] read, in part, . [Facility Name] requires any employee who becomes aware of any such incident, or suspects any such incident to report the matter immediately to the Nursing Home Administrator (NHA) .Reporting: All alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property are reported immediately but no later than 2 hours after the allegation is made. If the events do not involve abuse and do not result in serious bodily injury, report is expected to be made immediately but no later than 24 hours.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34568 Based on interview and record review, the facility failed to conduct thorough investigations for allegations of verbal abuse for two Residents (R3, R14) of three residents reviewed for abuse. This deficient practice resulted in the potential for additional unidentified abuse. Findings include: Review of the facility's Investigation Summary/[Facility Name] dated [DATE] read, in part, .[DATE]th, 2024 interview with CNA L stated that CNA J works too many hours and is always tired .she's so worn out and treats others poorly .when asked for examples CNA L gave in room with (R3) with cares CNA J stated 'Come on, (R3), roll your fat over.' And with (R14) crying all the time, CNA J stated Stop your God D*** crying! (R14) also grips hands of employees tightly and CNA J will yank her hand away and say, 'Don't F******* dig into me with your nails.' Review of CNA K and CNA L written statements confirmed the facility's Investigation Summary. R3 was noted to have expired prior to the survey start date of [DATE]. Review of R14's Minimum Data Set (MDS) assessment dated [DATE] revealed she scored a 99 on the BIMS score and was unable to be interviewed. An interview was conducted with CNA J on [DATE] at 12:37 p.m. When asked if she ever becomes frustrated with caring for residents, including those with cognitive impairments CNA J stated, I got frustrated with one resident who constantly rings her call light, or cries. When asked if CNA J has experienced burnout, she replied, I have worked 103 hours every two weeks, I'm always picking up and working shifts because I'm American. When asked if she has ever sworn in front of resident's CNA J stated, It may slip here and there. An interview was conducted with the Nursing Home Administrator (NHA) on [DATE] at approximately 1:00 p. m. The NHA confirmed that CNA J was terminated from employment due to the nature of the statements given to her from staff. The NHA confirmed the allegations were substantiated by the facility and she did not report these incidents to the State Agency as they did not come to her knowledge right away. When asked why staff did not report these incidents sooner, the NHA stated she did not know. The NHA acknowledged investigations had just started and were not yet complete. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's Resident Abuse Identification and Prevention revised on [DATE] read, in part, . Reporting: All alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property are reported immediately but no later than 2 hours after the allegation is made. If the events do not involve abuse and do not result in serious bodily injury, report is expected to be made immediately but no later than 24 hours .Upon notification of an alleged incident, the NHA or designee will take the following steps: Immediate preventative measures to ensure any further violation is prevented during the investigation .The NHA or appropriate designee will be responsible for reporting all alleged abuse/mistreatment/neglect to the appropriate State agency immediately but not more than 24 hours of the incident .Investigations will include but are not limited to confidential interview with staff, family members, residents as appropriate to their cognitive abilities, or anyone who may have been involved or witness to the incident. NHA or designee will notify resident's family or responsible person of alleged incident and investigation .Any substantiated abuse or mistreatment will be reported to the nurse licensing board or CENA (CNA) registry .

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34568 Based on observation, interview and record review, the facility failed to ensure one Resident (R22) with limited mobility was appropriately set up for meal service to maintain mobility out of three residents reviewed for Range of Motion (ROM). This deficient practice resulted in R22 appearing to experience not being able to feed himself easily and the potential for decreased mobility and ROM. Findings include: Review of R22's Admission Record revealed he was admitted to the facility on [DATE] with diagnosis including cerebral infarction, hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, aphasia, and dysphagia. His 3/1/24 Minimum Data Set (MDS) assessment revealed he scored a 3/15 on the Brief Interview for Mental Status (BIMS) score, indicating he was severely cognitively impaired. Further review of his MDS assessment revealed he had impairment of one side for both upper and lower extremity and required set-up for eating. On 3/25/24 at 11:42 a.m. R22 was observed to be eating his lunch in the television room attached to the main dining room. R22 was in his wheelchair with a bed side table sitting overtop of his lap, with his meal placed in front of him and his silverware noted to be on his right side. R22 was noted to have a severe contracture of his right hand and was unable to use it. An attempted interview was conducted with R22 but was unable to answer questions appropriately. R22 was observed to slurp soup from the bowl by using his left hand. When asked if he was able to grab the silverware located on his right side, R22 stated, No. Two unidentified staff members were noted to be in and out of the television room and did not stop to assist R22. R22 then began to eat his cherry pie out of the plastic container with his hands. On 3/26/24 at 11:57 p.m., R22 was noted to be in the same television room as the day before with a bedside table across his lap. R22 was only given a fork to complete his meal and placed the fork down to eat his apple pie with his fingers. R22 was asked if he could reach his spoon on his right side and he again stated, No. An interview was conducted with the Director of Nursing (DON) on 3/27/24 at approximately 3:30 p.m. The DON confirmed that R22's care plan did not identify that silverware should be placed on his left side so he could reach and feed himself. The DON stated that this would be corrected immediately.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 45123 Based on observation, interview, and record review the facility failed to provide timely Electronic Medical Record (EMR) access for their annual recertification survey. Findings include: On 3/25/24 at 9:55 AM, an entrance conference was conducted with the Nursing Home Administrator (NHA). The NHA was informed of the requirements on the Entrance Conference Worksheet, dated 10/2023, read in part, .INFORMATION NEEDED BY THE END OF THE FIRST DAY OF SURVEY .37. Provide each surveyor with access to all resident electronic health records - do not exclude any information that should be a part of the resident's medical record. Provide specific information on how surveyors can access the EHRs outside of the conference room. Please complete the attached form on page 4 which is titled Electronic Health Record Information . On 3/25/24 at 10:00 AM, the NHA was asked what kind of EMR system the facility had and replied that they utilize two different name brand EMRs. At that time the NHA was made aware and acknowledged understanding that each member of the survey team would need access to both systems to assist with the completion of the annual survey. On 3/26/24 at approximately 10:00 AM, an observation and record review was made of one the facilities EMR and lacked physician notes, physician orders, physical therapy notes, wound care notes, occupational therapy notes, and other required annual survey process records for review. On 3/26/24 at 10:30 AM, the survey team conducted a meeting and confirmed with the team coordinator that they had not received access to the second EMR which included the majority of the residents' medical records. On 3/26/24 at 10:31 AM, an interview was conducted with the NHA and a second request was made for full access to the facilities EMR. The NHA stated she would work on it, but that since there had been some changes with Information Technology (IT) she would see what she could do. On 3/26/24 at 12:30 PM, the NHA came to discuss her frustration with the survey team regarding access to one of the EMRs. At that time, she was unable to get the survey team access and stated that she needed to call an IT representative that she thought would be able to help. On 3/26/24 at 3:00 PM, an observation and record review were made and at that time it was discovered that one member had a username and password, but was unable to access the second EMR system and a second surveyor still had no access at all to the second EMR system. On 3/27/24 at 9:45 AM, an observation was made by Registered Nurse (RN) B of the EMR system and replied, You (surveyors) don't have the access that you need to pull up the medication list. On 3/27/24 at 10:20 AM, an interview was conducted with RN B and was asked if she had a miscellaneous tab in the EMR system and replied, Yes. RN B was made aware that the survey team did not have access to this tab. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 3/27/24 at 2:00 PM, the Medical Director came to be interviewed by a member of the survey team and stated, He realizes that the medical records are all over the place and they are located in multiple different systems. The Medical Director alluded to challenging efforts to accessing resident medical records. On 3/27/24 at 4:11 PM, an interview was conducted with the NHA, and she stated, It was difficult and frustrating to obtain access to the EMR for the survey team. It should not be that complicated. We are in the process of building one EMR system for our facility and it can not happen soon enough.