STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235459	A. Building B. Wing	03/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Altercare of Big Rapids Ctr for Rehab & Nursing CA	805 West Ave Big Rapids, MI 49307

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39056 Based on interview and record review, the facility failed to 1.) Accurately document administration of controlled substances and 2.) Ensure that narcotic medications were administered following the physicians' orders for 4 residents (Resident #5, Resident #7, Resident #9, and Resident #54), reviewed for controlled substances, resulting in medication errors. Findings include: Resident #5 (R5): Review of an Admission Record revealed R5 was a [AGE] year-old female, admitted to the facility on [DATE], with pertinent diagnoses which included: peripheral vascular disease. Review of R5's Physician Order revealed, gabapentin capsule; 100mg; once a day to be administered at 10:00 AM. Review of R5's Physician Order revealed, gabapentin capsule; 300mg; once a day to be administered at 10:00 PM. Review of R5's Controlled Substance Proof of Use Form for gabapentin 100mg revealed that on 3/4/24 at 9:12 AM and on 3/4/24 at 9:26 PM a dose of gabapentin was administered. Indicating the incorrect dose of gabapentin was administered on 3/4/24 at 9:26 PM. Review of R5's Controlled Substance Proof of Use Form for gabapentin 300mg revealed that on 3/4/24 (no time documented) a dose of gabapentin was administered. Indicating 400mg of gabapentin was administered instead of 300mg). Review of R5's Controlled Substance Proof of Use Form for gabapentin 100mg revealed that on 3/8/24 at 9:00 AM a dose was administered, on 3/9/24 at 8:14 PM a dose was administered, and on 3/9/24 at 9:12 AM a dose was administered. Review of R5's Controlled Substance Proof of Use Form for gabapentin 300mg revealed that on 3/8/24 there was no dose administered. Indicating R5 received a dose of gabapentin 100mg instead of 300mg at that time. Resident #7 (R7): (continued on next page)

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

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

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of an Admission Record revealed R7 was a [AGE] year-old male, admitted to the facility on [DATE], with pertinent diagnoses which included: seizures. Review of R7's Physician Order revealed, Briviact; 10mg/ml; 8ml via peg tube; twice a day. Review of R7's Medication Administration Record revealed both doses of Briviact were administered on 3/11/24 with a note Given by previous shift, per night shift RN (registered nurse). Review of R7's Controlled Substance Proof of Use Form for Briviact 8ml (80mg) revealed a dose was administered on 3/11/24 at 8:48 PM. Indicating there was no morning dose of Briviact administered. Resident #9 (R9): Review of an Admission Record revealed R9 was a [AGE] year-old female, admitted to the facility on [DATE], with pertinent diagnoses which included: chronic pain. Review of R9's Physician Order revealed, tramadol; 50mg tablet. Administer 25mg twice a day. Review of R9's Controlled Substance Proof of Use Form for Tramadol revealed that on 3/8/24 a dose was administered at 9:01 AM. There was no evening dose of tramadol documented as administered. Review of R9's Medication Administration Record revealed that both the morning and evening dose of tramadol were documented as administered on 3/8/24. Resident #54 (R54): Review of an Admission Record revealed R54 was a [AGE] year-old male, admitted to the facility on [DATE], with pertinent diagnoses which included: neuropathic pain (nerve pain). Review of R54's Physician Order revealed, Neurontin; 100mg capsule. Amount to administer: 200mg twice a day. Review of R54's Controlled Substance Proof of Use Form for gabapentin revealed that on 3/10/24 a dose was administered at 8:47 AM. There was no evening dose of tramadol documented as administered. On 3/11/24 a dose was administered at 11:56 AM. There was no evening dose of tramadol documented as administered. Review of R54's Medication Administration Record revealed that both the morning and evening doses of tramadol were documented as administered on 3/10/24 and 3/11/24. During an interview on 3/13/24 at 1:30 PM, Nursing Home Administrator confirmed that there were discrepancies with the above narcotic medications and reported the Director of Nursing would be completing licensed nurse education and disciplinary action. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility policy, Administering Medications (no date) revealed, .Administration .2. Medications are administered I accordance with written orders of the attending physician .Documentation: 1. The individual who administers the medication dose records the administration on the resident's MAR directly after the medication is given. At the end of each medication pass, the person administering the medications reviews the MAR to ensure necessary doses were administered and documented . Review of Fundamentals of Nursing ([NAME] and [NAME]) 10th edition revealed, The National Coordinating Council for Medication Error Reporting and Prevention (2018) defines a medication error as any preventable event that may cause inappropriate medication use or jeopardize patient safety. Medication errors include inaccurate prescribing, administering the wrong medication, giving the medication using the wrong route or time interval, administering extra doses, and/ or failing to administer a medication. Preventing medication errors is essential. [NAME], [NAME] A.; [NAME], [NAME] Griffin; Stockert, [NAME] A.; Hall, [NAME]. Fundamentals of Nursing - E-Book (p. 605). Elsevier Health Sciences. Kindle Edition.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31197 This citation has 2 separate Deficient Practice Statements A and B. Deficient Practice Statement A: Based on observation, interview, and record review the facility failed to routinely assess, monitor, and respond to new skin breakdown for 3 of 4 residents, (Resident #23) R23, (Resident #47) R47 and (Resident #63) R63. This deficient practice resulted in R47 impaired skin integrity to go unassessed, unmonitored and untreated. Findings include: The facility provided a policy for Pressure Injuries: Assessment, Prevention and Treatment (undated and unsigned) for review. The policy reflected, 2. Skin will be assessed routinely for the presence of developing pressure injuries and documented on the Nursing Skin Tool . The facility provided a policy for Alteration in Skin Integrity (partial thickness) undated and unsigned for review. The policy reflected, The facility will identify residents with alteration is skin integrity and implement appropriate measures to promote healing. Upon first assessment the clinician is expected to document the following in the medical record: underlying condition contributing to the scab, scab edges and wound bed, location, shape, and condition of surrounding tissues. Procedure: 1. Upon identification of a new alteration in skin integrity, a Licensed nurse will assess the area and enter documentation in the clinical record to reflect the appearance of the wound . R47: Review of the Face Sheet and Minimum Data Set (MDS) dated [DATE] revealed R47 admitted to the facility on [DATE]. Brief Interview for Mental Status (BIMS) reflected a score of 15 out of 15 which represents R47 was cognitively intact. During an initial tour on 3/11/24 at approximately 8:20 AM, R47 was observed in his room seated in a wheelchair with a dressing to the right lower leg that did not contain a date nor initials. When asked about the dressing to his leg, R47 stated that he did not know who put it on or how long it had been on. The weekly skin assessment from 2/1/24 to 3/11/24 were requested for review for R47. The facility provided copies of the Nursing Skin Tool dated 2/5/24 which was signed by the nurse and 2/15/24, 2/19/24, and 2/26/24 that were not signed by the nurse. The Nursing Skin Tool was incomplete and did not reflect the signature of any nurse for over 3 weeks. There was no indication on the Nursing Skin Tool what was under the dressing to the right leg. The progress notes from 2/1/24 - 3/11/24 were reviewed and did not reflect any skin breakdown or indication for a dressing to the right lower leg. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/11/24 the Medication Administration Record for March 2024 was reviewed, and it did not reflect any treatment orders for the right lower leg. During an observation on 3/11/24 at 3:35 PM, Registered Nurse (RN) R stated she did not know what the skin condition was under the right lower leg dressing and noted there were no orders to treat the area. R47 was asked about the skin issue but could not recall when it happened, who put the dressing on nor when it was applied. RN R confirmed there was no date or initials on R47's dressing and was observed as she removed it. The dressing had a large amount of drainage that covered most of the dressing. The Surveyor and RN R observed 4 small open areas of light pink skin (approximately 0.5 cm each) that had active weeping of clear fluid coming from each area. After assessing the right lower leg, RN R stated she would notify the physician and obtain a treatment order. R23: Review of the Face Sheet and Minimum Data Set (MDS) dated [DATE] revealed R23 admitted to the facility on [DATE]. Brief Interview for Mental Status (BIMS) reflected a score of 1 out of 15 which represents R23 had severe cognitive impairment. The MDS reflected the R23 required 2 staff assistance with all activities of daily living. The weekly skin assessment from 2/1/24 to 3/11/24 were requested for review for R23. The facility provided copies of the Nursing Skin Tool dated 2/5/24 and 2/12/24 for review. The Nursing Skin Tool was incomplete and did not reflect the signature of any nurse for over 5 weeks. R63: Review of the Face Sheet and Minimum Data Set (MDS) dated [DATE] revealed R63 admitted to the facility on [DATE]. Brief Interview for Mental Status (BIMS) reflected a score of 0 out of 15 which represents R63 had severe cognitive impairment. The MDS reflected the R63 required 2 staff assistance with all activities of daily living. The weekly skin assessment from 2/1/24 to 3/11/24 were requested for review for R63. The facility provided copies of the Nursing Skin Tool dated 2/19/24, 2/26/24, and 3/4/24 for review. The Nursing Skin Tool was incomplete and did not reflect the signature of any nurse for over 5 weeks. During an interview on 3/13/24 at approximately 11:00 AM, the Director of Nursing (DON) stated that she expected the nurses to assess and document skin assessments on the Nursing Skin Tool weekly. 37573 Deficient Practice Statement B This Citation pertains to Intake Number M100142728. Based on interview and record review, the facility failed to ensure that one resident (Resident #7) of 1 resident reviewed, received the medications necessary to prevent seizures. Findings include: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #7 (R7): Review of a Face Sheet revealed R7 originally admitted to the facility on [DATE] with pertinent diagnosis of epilepsy. In an interview on 3/11/24, Family Member (FM) P reported two weeks after R7 admitted to the facility he started to act differently and realized he was not getting his seizure medications which then led to him having a seizure and going to the hospital. Review of the Hospital discharge medications dated 1/20/24 for R7 included brivaracetam (Briviact, an anticonvulsant) 80 mg per G (gastro) tube 2 times daily and Oxcarbazepine (Trileptal, an anticonvulsant) 600 mg per G tube 2 times daily. Review of the Hospital Records dated 1/28/24 revealed R7 went to the hospital with diagnoses of acute seizure and chronic oromandibular dystonia (a neurological condition affecting the jaws, face, and mouth.) Living facility to call head and reported that she had not been getting his seizure medication for several days. The patient experienced repetitive eye blinking today, Review of the January Medication Administration Record (MAR) for R7 revealed he received Briviact 8 mL (milliliters) twice a day 1/21/24 to 1/23/24, and the morning dose on 1/24/24. Briviact is documented as unavailable from the 1/24/24 evening dose through 1/28/28. There is no record the resident received Trileptal in January. During an interview on 3/12/24 at 3:15 PM, Registered Nurse (RN) R reported that she was the nurse that completed R7's admission on 1/20/24. RN R reported that she had not completed an admission independently prior and had made errors. RN R reported that she had not entered all the medications into the EMR (electronic medical record) prior to the end of her shift and the oncoming nurse was to finish the medication reconciliation, which was not completed. Pharmacy: In an interview on 3/12/24 at 3:15 PM, Registered Nurse (RN) R reported that multiple attempts were made with the pharmacy to get R7's refill of Briviact, and the pharmacy would not release the medication without an updated prescription. In an interview on 3/13/24 at 1:00 PM, the Director of Nursing (DON) reported they had talked to the pharmacy extensively and there was some miscommunication on their end. This situation happened over the weekend. Review of an email correspondence thread between the facility and the pharmacy revealed that the pharmacy needed a new prescription for the Briviact before they could send it to the facility. Review of a Pharmacy Contract revealed Delivery: . agrees to deliver to [entity] six (6) days per week, Monday through Saturday, with an additional delivery if an emergency arises, except for circumstances and conditions beyond its control [entity] is available for assistance 24 hours per day, 365 days a year. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a pharmacy policy titled Orders/Delivery of Medications revealed: Medications will be ordered from [Pharmacy] in a manner that allows delivery to the facility on a timely basis. Timeliness will be assessed and will factor in the following: continuity of care, condition of the resident (severity/instability), category of medication, (antibiotic/analgesic) and the physician ordered start time. The facility will maintain accurate records of drug order and receipt.