STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235243	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Gtc	2950 Lafranier Rd Traverse City, MI 49686

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. 49310 Based on observation, interview, and record review, the facility failed to assess and determine if self-administration of medications was clinically appropriate for two Residents (#18 and #49) of two residents reviewed for self-administration of medications. Findings include: Resident #18 (R18) R18 was prescribed a bronchodilator (a medication that relaxes the muscles in the airways and increases air flow to the lungs) twice daily and every six hours as needed for shortness of breath. The medication was ordered to be delivered through a nebulizer (a machine that creates mist from liquid medication). On 1/29/25 at 8:55 AM, R18 was observed in his room holding a nebulizer mask to his face. The nebulizer was turned on and mist was emitting from the nebulizer mask. R18 was alone in the room without a nurse or staff member present. The medical record of R18 was reviewed on 1/29/25 at 9:02 AM. An interdisciplinary team (IDT) assessment for self-administration of medication was not located in the medical record. The care plan did not document or mention R18 self-administering medications. R18's admission assessment Nursing Admission Evaluation - Part 2 - V7 section XI dated 12/22/24 read, in part: 1. Does the resident wish to self-administer medications? The response to the question was documented No with no additional comments provided on the assessment. Resident #49 (R49) R49 was prescribed a bronchodilator and anticholinergic medication (a combination of medications to relax muscles in the airways and increase air flow to the lungs) every four hours for acute and chronic respiratory failure. The medication was ordered to be delivered through a nebulizer to R49's tracheostomy (a hole in the windpipe to help with breathing). On 1/28/25 at 11:07 AM, R49 was observed in his room with a nebulizer mask to his tracheostomy. The nebulizer was turned on and mist was emitting from the nebulizer mask. R49 was alone in the room without a nurse or staff member present. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235243	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/30/2025
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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The medical record of R49 was reviewed on 1/28/25 at approximately 3:00 PM. The form Self-Administration of Medications Evaluation of Resident's Ability - V2 dated 4/3/24 was the most recent document for assessment of self-administration of medication. Section F.3 of the form was the portion of the assessment for the IDT to document the determination regarding R49's ability to self-administer medications. Section F.3 was completely blank and did not contain documentation of the IDT's determination whether R49 was deemed by the IDT to be safe or unsafe to self-administer medications. The instructions on the Self-Administration of Medications Evaluation of Resident's Ability - V2 form read, in part: This form should be completed upon initial move-in for any resident who self-administers his/her medications (both oral and non-oral). The evaluation should be repeated quarterly as long as the resient [sic] continues to self-administer medications . There were no assessments for self-administration of medication for R49 after 4/3/24. The Director of Nursing (DON) was interviewed on 1/30/25 at 11:32 a.m. The DON said self-administration of medication assessments were required before residents were allowed to self-administer medications. When asked when R49 was last assessed for self-administration of medications, the DON replied 4/3/24. When asked the frequency of assessments for self-administration of medications, the DON replied, The assessments would only be done if there's a physical decline. The DON was asked if an assessment was completed to determine if R18 was clinically appropriate to self-administer medications, and she responded, It was not. The policy Medication - Resident Self-Administration of dated as reviewed/revised on 1/30/24 read, in part: . A resident may only self-administer medications after the facility's interdisciplinary team has determined which medications may be self-administered safely . Each resident is offered the opportunity to self-administer medications during the routine assessment by the facility's interdisciplinary team . The results of the interdisciplinary team assessment are recorded in the resident's medical record . The care plan must reflect resident self-administration and storage arrangements for such medication .

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41978 Based on observation, interview and record review, the facility failed to ensure appropriate assessments and timely notification of a change in condition were completed per professional standards for one Resident (#10) of two resident's reviewed for respiratory infection, resulting in R10 being transferred to the emergency department with the potential for complications/worsening of influenza, including pneumonia and sepsis, as a result of delay in treatment. Findings include: Review of the Minimum Data Set (MDS) assessment, dated 11/2/2024, revealed R10 was admitted to the facility on [DATE] and had diagnoses including esophageal cancer, coronary artery disease (CAD), heart failure, diabetes, and dementia. Review of Sections J and O of the MDS assessment revealed R10 had no shortness of breath and did not use supplemental oxygen or any respiratory treatments. R10 was dependent on staff for all transfers, ambulation, bathing and dressing and required setup assistance only (helper sets up or cleans up, resident completes the activity) with eating. R10 scored 6 out of 15 (6/15) on the Brief Interview for Mental Status, indicating severe cognitive impairment. On 1/28/2025 at 11:28 a.m. a sign for Transmission Based Precautions (TBP) was observed attached to the door leading to R10's room. Certified Nursing Assistant (CNA) A and CNA B were observed donning personal protective equipment (PPE) in preparation to enter R10's room. During an interview at the time of the observation, CNA A reported PPE was necessary to wear during care of R10 for recently diagnosed influenza. R10 was observed sleeping in bed and was not using supplemental oxygen. There was no portable oxygen concentrator or tank observed in R10's room. Review of R10's electronic medication record (EMR), conducted on 1/28/2025 at 1:34 p.m., revealed no documentation of R10's recent diagnosis of influenza, including the Resident's condition prompting the need for testing. The EMR contained no documentation of signs, symptoms, assessments, or indications for the use of Droplet Precautions for infection surveillance. Further review of R10's EMR, revealed an assessment titled Pertinent Charting Initial - Infections/Signs Symptoms, dated 1/28/2025 at 3:50 p.m., which was entered by the Director of Nursing (DON) on 1/28/2025 at 2:11 p.m. Review of the documentation revealed the following: Date infection/signs and symptoms occurred: 1/28/2025. Site of Infection: influenza . Interventions: monitor for s/sx [signs and symptoms] of worsening condition and notify provider, monitor VS [vital signs] as ordered and prn [as needed] . The infection documentation did not indicate what signs or symptoms of influenza illness R10 was experiencing. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/29/2025 at 8:28 a.m., R10 was observed seated in bed eating breakfast. R10 was alert and asked for his television to be turned on. R10 was observed eating unassisted and was not using supplemental oxygen. At the time of the observation, the facility's Infection Preventionist, Registered Nurse (RN) D, was observed in the hallway restocking the PPE cart outside of R10's room. During an interview at the time of the observation, RN D reported R10 appeared to be feeling well in spite of his recent diagnosis of influenza A. RN D stated only residents with signs and symptoms of infection were being tested for influenza per the facility's protocol. During an interview on 1/29/2024 at 1:08 p.m., the DON was asked what the process was for documenting a change in a resident's condition, including signs and symptoms of influenza infection. The DON stated signs and symptoms of illness should be documented along with continued monitoring and respiratory assessments. The DON reported she was unaware staff were not documenting R10's respiratory and infection status, including his signs and symptoms of illness. A request for all facility policies related to changes in condition was requested from the DON at the time of the interview. During an interview on 1/29/2025 at 1:42 p.m., Licensed Practical Nurse (LPN) L reported R10 had developed a severe cough and was started on an antiviral medication. Continued review of R10's EMR, conducted on 1/30/2025 at 7:27 a.m., revealed the following: Late Entry. Effective Date: 1/27/2025, 10:20 [a.m.]. Created Date: 1/29/2025, 14:26 [2:26 p.m.]. Staff came to see me on 1/27/2025 resident had cough and decreased appetite and wasn't himself. tested and was positive for Influenza A. The EMR had no assessment documented in response to the report of R10 developing a cough and decreased appetite on 1/27/2024. There was no documentation of respiratory assessments or infection charting in response to R10 developing a severe cough as reported by LPN L on 1/29/2025. On 1/30/2025 at 8:01 a.m., R10 was observed lying in bed and was receiving supplemental oxygen via a nasal cannula with the oxygen concentrator set to deliver 3L/min (three liters per minute). R10 nodded yes, when asked if he was feeling worse than yesterday. R10 appeared weak and did not lift his head from the pillow during the interview. During an interview on 1/30/2025 at 8:22 a.m., RN C stated he received report from the previous shift indicating R10's blood pressure and oxygen saturation level dropped overnight and R10 was now requiring the administration of supplemental oxygen to keep his oxygen saturation within an acceptable range. RN C stated he had not been in to assess R10 yet this shift. RN C was unsure if a complete respiratory assessment of R10 was done on the previous shift in response to the respiratory status change requiring administration of supplemental oxygen. RN C stated he was unsure if a provider was notified regarding R10's change in condition, then added Nurse Practitioner (NP) E wound be in the building to do rounds today and would be alerted to R10's condition. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/30/25 at 11:28 AM, an interview was conducted with the Infection Prevention (IP) nurse and the Director of Nursing (DON). The IP nurse stated if a resident was identified as being ill by another member of the nursing team, the IP nurse would investigate the symptoms reported by the resident, to track them accurately. If the illness was identified as Influenza or Covid 19, the IP nurse stated pertinent charting would be initiated by the nurse caring for the resident, or the IP nurse. The IP nurse and DON stated pertinent charting requires nursing staff to do vitals every four hours, in conjunction with a thorough assessment of heart and lungs. The IP nurse stated if pertinent charting has been initiated, it will turn red in the nurses' chart when not completed in that 4-hour time limit. Further review of R10's EMR and Vital Sign documentation, conducted on 1/30/2025 at 12:15 a.m., revealed R10s oxygen saturation on 1/30/2025 at 2:09 a.m. was documented as 90% on oxygen via nasal cannula. R10's prior reading on 1/28/2025 at 8:04 p.m. was documented as 90% on room air. It was noted there was no documentation of any other vital signs for R10 from 1/28/2025 at 8:04 p.m. or prior to the administration of supplemental oxygen on 1/30/2025. The EMR did not contain documentation of a complete respiratory assessment, including lung sounds and the Resident's response to the oxygen administration. There was no documentation in the EMR of provider notification of R10's change in condition which required administration of supplemental oxygen. On 1/30/2025 at 12:37 p.m., RN C was asked the status of R10's condition. RN C stated R10 keeps taking off his oxygen causing his oxygen saturation to decrease. RN C reported educating R10 on the need to keep the nasal cannula in place to ensure delivery of the oxygen. When asked if R10 had any abnormal lung sounds, RN C stated not that I noticed. RN C reported NP E was in the building and would be notified of R10's condition. RN C was observed walking down the hall toward NP E's office at that time. On 1/30/2025 at 1:12 p.m., NP E was asked if he was made aware of R10's change in condition requiring the administration of supplemental oxygen. NP E stated he was aware R10 tested positive for influenza A, but did not know R10's condition had changed, requiring oxygen, until just now being informed by RN C. NP E stated RN C was informed R10 would be included in rounds and indicated R10 may need to be evaluated in the emergency department for pneumonia. Review of R10's EMR, conducted on 1/30/2025 at 1:48 p.m., revealed the following: 1/30/2025, 13:34 [1:34 p.m.] Provider in to assess resident and recommends transfer out to [local emergency department] for evaluation. Spoke with resident daughter and she agrees with this decision. Call placed to 911 for non-emergent transfer to [emergency department] for evaluation. Review of the facility policy titled, Notification of Changes, last reviewed 1/1/2022, revealed the following, in part: The facility must inform the resident, consult with the resident physician and/or notify the resident's family member or legal guardian when there is a change . Circumstances requiring notification include: Significant change in the resident's physical, mental or psychosocial conditions such as deterioration of health . Circumstances that require a need to alter treatments. This may include: New treatment . (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The policy Oxygen Administration dated as reviewed/revised 10/26/23 read, in part: .Oxygen is administered under orders of a physician . Staff shall document the initial and ongoing assessment of the resident's condition warranting oxygen and the response to oxygen therapy .Staff shall notify the physician of any changes in the resident's condition, including changes in vital signs, oxygen concentrations, or evidence of complications associated with the use of oxygen .

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49310 Based on observation, interview, and record review, the facility failed to: 1. Accurately document a wound, 2. Determine wound etiology, 3. Ensure physician assessment and documentation of a wound, 4. Implement Enhanced Barrier Precautions (EBP), and 5. Complete wound treatments as ordered for one Resident (#32) of two residents reviewed for pressure injuries. Findings include: Resident #32 (R32) was admitted to the facility on [DATE]. A Minimum Data Set (MDS) assessment dated [DATE] documented R32 had no wounds or pressure injuries on admission to the facility. R32 had a Brief Interview for Mental Status (BIMS) score of 13 indicating he was cognitively intact. The MDS assessed functional range of motion limitations in R32's upper extremity. R32 was assessed as requiring staff assistance with bed mobility and was dependent on staff for transfers. On 1/28/25 at 12:07 PM, R32 was observed in bed with a heel elevation device under his knees. His lower extremities were externally rotated with the lateral ankles lying against the mattress of the bed. R32 said he had a wound on his ankle. When asked why the heel elevation device was under his knees, R32 said, I don't know - that's where they always put it. On 1/29/25 at 10:23 AM and 1/29/25 at 11:20 AM, R32 was observed lying on his back in bed with the heel elevation device placed under his knees. R32's ankles were directly against the mattress of the bed. A wound evaluation in R32's medical record dated 1/17/25 documented a new stage 2 pressure injury (Partial-thickness loss of skin with exposed dermis, presenting as a shallow open ulcer. Granulation tissue, slough and eschar are not present in a stage 2 pressure injury) to R32's right lateral malleolus (ankle). The pressure injury measured 1.83 centimeters (cm) x 1.14 cm x 0.1 cm (length, width, and depth respectively). The ulcer had a documented area of 1.4 square centimeters (cm^2). The document revealed the presence of slough in the wound bed with a light amount of serous exudate (clear drainage). A photograph of the wound showed the wound bed to be obscured with slough. A wound evaluation dated 1/22/25 reiterated the wound was a pressure injury, stage 2 with slough present. A photograph of the wound showed the wound bed was obscured. The measurements were 1.58 cm x 0.9 cm x 0.2 cm with an area measuring 1.04 cm^2. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A wound evaluation dated 1/29/25 documented measurements of 1.84 cm x 1.19 cm x 0.2 cm with an area measuring 1.61 cm^2. A photograph of the wound showed the wound bed remained obscured. The wound evaluation documented the wound as a pressure injury, stage 2 with slough in the wound bed and light serous exudate. Documentation on the form read the wound was improving despite the measurements revealing the wound was 17% longer and 33% percent wider with a 54% increase in area. A physician's order dated 1/17/25 for treatment for R32's right lateral malleolus was to cleanse the wound, apply an antimicrobial debriding agent (medication to remove debris or dead tissue from a wound), covered with gauze and a dry dressing change. The treatment was ordered to be completed daily. The Treatment Administration Record (TAR) of R32 did not contain a nurse's initials on 1/20/25 indicating the treatment was not documented completed as ordered by the physician. There were no progress notes or documentation found in the medical record indicating the treatment had been completed on 1/20/25. Physician documentation was reviewed and did not include notation or assessment of the wound on R32's right ankle. R32 did not have a physician's order or care plan for EBP. The door to R32's room did not contain signage indicating EBP were in place for R32. On 1/29/25 at 11:51 AM, Certified Nurse Aide (CNA) I and CNA J were observed assisting R32 with incontinence care while performing a mechanical lift transfer from the bed to a recliner. Neither CNA I nor CNA J were wearing personal protective equipment (PPE) aside from gloves. On 1/30/25 at 10:38 AM, Registered Nurse (RN) G was observed completing a dressing change to the wound. The right lateral malleolus had an ulcerated wound with no exudate. The wound bed was completely obscured by pale yellow slough so the base of the wound could not be visualized for depth measurement. There was erythema (redness) and swelling surrounding the wound. RN G did not wear any PPE throughout the dressing change procedure aside from gloves. RN G said nurses do not measure pressure injuries because the facility had a wound nurse who completed assessments and measurements weekly. RN G was asked the stage of the wound. RN G responded, Well, since I can't see the base of it, it's hard to tell. The wound nurse does all the staging. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/30/25 at 12:02 p.m., The Director of Nursing (DON) and RN K were interviewed. RN K confirmed she was the facility wound nurse and said she was certified in wounds. Wound evaluation forms were referenced and reviewed. RN K confirmed she completed the assessments and documentation of R32's wound evaluations. RN K was asked if stage 2 pressure injuries contained slough. She replied they did not. RN K was asked the stage of R32's wound. RN K said, If it's a stageable wound it would be unstageable [Obscured full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because the wound bed is obscured by slough or eschar]. RN K said the wound on R32's right ankle should be evaluated as being a possible vascular wound and not a pressure injury. However, RN K was unable to produce any documentation of an evaluation, pending testing or physician notification requesting evaluation as a vascular ulcer. RN K was asked why she consistently documented the wound as a stage 2 pressure injury if she did not think the wound was caused by pressure. RN K said the wound was a stage 2 pressure injury when it was first identified. The DON and RN K were asked for physician assessment and documentation on the wound. The DON said, Our provider doesn't assess wounds unless there's an infection or changes with the wounds. The DON was asked if residents who had wounds were placed on EBP. The DON said all residents with wounds were in EBP unless the wound was a surgical wound or skin tear. The DON said signage for EBP is placed on the door of residents who are on EBP. The DON said a physician's order and care plan were needed to place a resident in EBP. The DON was asked to review R32's medical record and confirmed there was no physician's order or care plan for EBP. The DON confirmed PPE should be worn by staff when performing high-contact activities. The DON agreed incontinence care, transferring a resident, and dressing changes on wounds constituted high-contact activities. The policy Wound Treatment Management dated as reviewed/revised 10/26/23 read, in part: .Wound treatments will be provided in accordance with physician orders, including the cleansing method, type of dressing, and frequency of dressing change .Treatment decisions will be based on: a. Etiology of the wound: i. Pressure injuries will be differentiated from non-pressure ulcers . The policy Enhanced Barrier Precautions (EBP) dated as reviewed/revised 3/26/24 read, in part: .It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms .Enhanced barrier precautions refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and gloves use during high-contact resident care activities . Even if the resident is not known to be infected or colonized with a MDRO, an order for enhanced barrier precautions will be obtained for residents with any of the following: i. Wounds . High-contact resident care activities to consider include .Transferring d. Providing personal hygiene .f. changing briefs or assisting with toileting .h. Wound care .

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34568 Based on observation, interview, and record review, the facility failed to provide proper infection control measures pertaining to indwelling catheters (a tube inserted into the bladder to accommodate emptying of the bladder) for one Resident (#44) of four residents reviewed for indwelling catheters. This deficient practice resulted in the potential for infections and illness. Findings include: Resident #44 (R44) Review of R44's electronic medical record (EMR) revealed an admitted [DATE] with diagnoses including neuromuscular dysfunction of bladder. R44's 11/28/24 Minimum Data Set (MDS) assessment revealed a Brief Interview for Mental Status (BIMS) score of 15/15 indicating no cognitive impairment. R44 was also marked on the MDS for the use of an indwelling catheter. On 1/28/25 at 1:19 p.m., R44 was observed sitting in a recliner chair located in her room. An indwelling catheter urinary collection bag was observed uncovered and on the floor with the drainage tube completely flat on the ground. Approximately 300 cc (cubic centimeters) of urine was visible inside the bag. On 1/29/25 at 9:17 a.m., R44 was observed sleeping in her recliner chair in her room. An indwelling catheter urinary collection bag was observed uncovered and on the floor with the drainage tube tip touching the ground. On 1/29/25 at 1:03 p.m. an observation of R44's indwelling urinary catheter bag on the floor was conducted with Registered Nurse (RN) K. RN K confirmed R44's catheter bag should not be on the floor because of the concern for infections. On 1/30/25 at 11:53 a.m. an interview was conducted with the Director of Nursing (DON). The DON confirmed indwelling urinary catheter bags should remain off the floor and in a privacy bag. Review of the facility's Catheter Care Procedure - Urinary revised 12/28/23 read, in part, It is the policy of this facility to provide catheter care to all residents that have an indwelling catheter in an effort to reduce bladder and kidney infections . The policy did not identify that urinary catheter bags should remain off the floor.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41978 Based on observation, interview and record review, the facility failed to ensure completion of respiratory assessments for one Resident (R10) receiving supplemental oxygen and to ensure supplemental oxygen was administered per physician order for one Resident (R32) of two residents reviewed for oxygen administration, resulting in the potential for unidentified worsening of condition and administration of unwarranted respiratory treatments. Based on observation, interview and record review, the facility failed to: 1. Ensure completion of respiratory assessments for residents receiving supplemental oxygen, and 2. Ensure oxygen was administered per physician orders, for two Residents (#10) of two residents reviewed for respiratory care and services, resulting in the potential for unidentified worsening of condition and administration of unwarranted respiratory treatments. Findings include: Resident #10 (R10) Review of the Minimum Data Set (MDS) assessment, dated 11/2/2024, revealed R10 was admitted to the facility on [DATE] and had diagnoses including esophageal cancer, coronary artery disease (CAD), heart failure, diabetes, and dementia. Review of Sections J and O of the MDS assessment revealed R10 had no shortness of breath and did not use supplemental oxygen or require any respiratory treatments. On 1/28/2025 at 11:28 a.m. R10 was observed sleeping in bed. R10 was not using supplemental oxygen, and no portable oxygen concentrator or tank was observed in R10's room. On 1/30/2025 at 8:01 a.m., R10 was observed lying in bed. R10 was receiving supplemental oxygen via a nasal cannula with the oxygen concentrator set to deliver 3 L/min (three liters per minute). During an interview on 1/30/2025 at 8:22 a.m., RN C stated he received report from the previous shift indicating R10's blood pressure and oxygen saturation level dropped overnight and R10 was now requiring administration of supplemental oxygen to keep his oxygen saturation within an acceptable range. RN C stated he was unsure if a complete respiratory assessment of R10 was performed on the previous shift in response to the change in condition requiring administration of supplemental oxygen. RN C stated the process was to treat the resident, then notify the provider of the situation and obtain an order for treatment. RN C reported he was unsure if a provider was notified regarding R10's need for supplemental oxygen. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235243	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/30/2025
NAME OF PROVIDER OR SUPPLIER Medilodge of Gtc		STREET ADDRESS, CITY, STATE, ZIP CODE 2950 Lafranier Rd Traverse City, MI 49686	

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R10's EMR including vital sign documentation, conducted on 1/30/2025 at 12:15 p.m., revealed R10's oxygen saturation was recorded as 90% on oxygen via nasal cannula on 1/30/2025 at 2:09 a.m. with a prior reading noted of 90% on 1/28/2025 at 8:04 p.m. There was no documentation of R10's vital signs from 1/28/2025 at 8:04 p.m. or on 1/29/2025 prior to the administration of supplemental oxygen on 1/30/2025. The EMR did not contain documentation of a complete respiratory assessment, including lung sounds and the Resident's response to the oxygen administration. There was no documentation in the EMR of provider notification of R10's need for the administration of supplemental oxygen. 49310 Resident #32 (R32) R32 was admitted to the facility on [DATE] with a diagnosis of chronic obstructive pulmonary disease. An MDS assessment dated [DATE] documented R32 was not admitted on supplemental oxygen but was placed on supplemental oxygen while a resident in the facility. R32 had a physician's order dated 11/15/24 for supplemental oxygen at one liter per minute (lpm). On 1/28/25 at 12:06 PM, R32's oxygen concentrator was observed set at three and a half lpm of supplemental oxygen. Multiple observations were made of R32's oxygen concentrator set at three and a half lpm on 1/28/25 at 2:27 PM, 1/29/25 at 10:22 AM, and 1/29/25 at 11:22 AM. On 1/29/25 at 11:54 AM, Registered Nurse (RN) G was asked the prescribed flow rate of supplemental oxygen for R32. RN G said, I think it's two [lpm], but I'd have to check. RN G was informed the flow rate was prescribed for one lpm per the physician's order. The care plans for R32 included a care plan initiated on 11/15/24 for impaired pulmonary/respiratory status. An intervention on the care plan read: oxygen as ordered. An oxygen saturation summary report was reviewed from R32's date of admission to the facility through 1/29/25. The report documented R32 received supplemental oxygen at two lpm on 12/5/24, 12/25/24, 1/1/25, 1/6/25, 1/9/25, 1/13/25, and 1/27/25. A review of R32's physician's order history did not reveal any discontinued, amended, or additional oxygen orders. The only order in the record was for one lpm of supplemental oxygen. The Director of Nursing (DON) was interviewed on 1/30/25 at 11:32 AM. The DON said supplemental oxygen is to be administered in accordance with physicians' orders. The DON said the facility does not have standing orders for supplemental oxygen. The DON confirmed there were no standing orders or parameters when oxygen flow rates or delivery can be modified by nurses. The DON agreed supplemental oxygen delivery rates cannot be amended in the absence of a physician's order to do so. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235243	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/30/2025
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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The policy Oxygen Administration dated as reviewed/revised 10/26/23 read, in part: .Oxygen is administered under orders of a physician . Staff shall document the initial and ongoing assessment of the resident's condition warranting oxygen and the response to oxygen therapy .Staff shall notify the physician of any changes in the resident's condition, including changes in vital signs, oxygen concentrations, or evidence of complications associated with the use of oxygen .