STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235280	A. Building B. Wing	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Alpena	301 Long Rapids Rd Alpena, MI 49707

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 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** 45123 Based on observation, interview, and record review, the facility failed to ensure quality of care was provided for two Residents (R8, and R9) of nine residents reviewed for quality of care by failing to: 1. provide diabetic foot care and 2. perform proper assessments and charting for new admissions. Findings include: This citation pertains to intake: MI00149326. Resident #8 (R8) Review of R8's MDS assessment dated [DATE], revealed admission to the facility on [DATE], with active diagnoses that included: heart failure, depression, diabetes mellitus, and hypertension. R8 scored a 15 of 15 on the BIMS assessment reflective of intact cognition. On 2/5/25 at 9:10 AM, an observation was made of R8 in her room sitting up on the side of her bed leaning over her bedside table. R8 was not wearing any socks or shoes. R8 was asked how she was doing and why her toenails were so long and replied, I know they are long and ugly. R8 was observed to have bilateral great toenails to be an inch long, her left foot second through fifth toes were a half an inch long, and her right foot second and third toenails were a half an inch long. R8 was asked if she had diabetes mellitus and replied, Yes, I really would like them cut. I need to get them cut. Review of R8's care plan, dated 4/11/24, read in part .Resident has an impaired metabolic status related to diabetes .Diabetic foot checks every evening, monitor for impairments with skin and nails . On 2/6/25 at 11:45 AM, this Surveyor, the DON, and Nurse Manager / LPN J went to see R8 in her room to observe her toenails. Both the DON and LPN J agreed that R8's toenails were too long. R8 stated that she was never offered podiatry services when she was admitted . (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/6/25 at 12:00 PM, the DON stated podiatry services were just at the facility on 1/29/25, but R8 was not on the list to be seen. The DON could not find any documentation that R8 was offered podiatry services upon admission to the facility. The DON was asked why R8 was not added to the podiatry list after daily diabetic foot assessments. The DON did not have an answer when asked about why podiatry services were not offered on admission. The DON also stated, I'm not sure why they [nursing] wouldn't cut R8's toenails with her being diabetic and they are very long. Review of policy Skin Integrity - Foot Care, dated 10/26/23, read in part Policy: It is the policy of this facility to ensure residents receive proper treatment and care to maintain mobility and good foot health. This policy pertains to maintaining the skin integrity of the foot. Policy Explanation and Compliance Guidelines: 1. The facility will provide foot care and treatment in accordance with professional standards of practice, including the prevention of complications from the resident's medical conditions .3. Interventions for Prevention and to Promote Healing: a. Interventions will be based on specific factors identified in the risk assessment, skin assessments, and assessments of any foot ulcers. i. As needed, licensed nurses with adequate training may perform nail care to non-diabetic residents, or diabetic residents who are low risk as determined by podiatrist or physician . Resident #9 (R9) Review of R9's MDS assessment dated [DATE], revealed admission to the facility on [DATE], with active diagnoses that included: hypertension, atrial fibrillation (abnormal beating of the heart), depression, diabetes mellitus, and anxiety. On 2/6/5 at 8:25 AM, a phone interview was conducted with MD E regarding R9's lab results. MD E stated he was contacted via phone on 2/6/25 by nursing staff with reports of abnormal labs for R9. MD E advised the facility to send R9 to the hospital for further evaluation. MD E stated he was upset the facility did not make him aware of R9's wishes to change providers to them. MD E stated he would have handled laboratory diagnostics sooner and indicated it may have made a difference in the outcome. On 2/6/25 at 9:00 AM, a review of R9's medical record was conducted, and the following was identified: a. R9 was originally admitted to the facility on [DATE] for rehabilitation and was receiving skilled nursing services. b. Admission weights for three consecutive days were ordered but no weight was obtained for R9 on 2/2/25. c. R9 was ordered to have vital signs for each 12-hour shift as part of the new admission process, but no vital signs were recorded on 2/2/25 or 2/3/25. d. No skilled nursing assessment was documented for R9 on 2/3/25. e. R9's skilled nursing assessments completed on 2/2/25 and 2/4/25 were completed using vital signs from 2/1/25. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R9's progress note, dated 2/6/25 at 1:00 AM, read in part Resident's labs were reviewed with provider, received orders to ship out resident based on plenty of abnormal labs .and resident's status of being a full code .Resident stated 'I haven't felt good for the past few days' . On 2/6/25 at 9:30 AM, an interview was conducted with the DON who was asked the reason a comprehensive vital assessment was not recorded every 12 hours in R9's EMR. The DON replied, I am not sure. Let's look at the vital sign sheets to see if staff added her to get a full set of vitals each shift. Review of vital sign sheets, dated 2/2/25 and 2/3/25, revealed that R9's name was not added to the sheets to have her vital signs taken for any of the three shifts over the course of two days. Review of R9's Prehospital Care Report Summary, dated 2/6/25 at 12:39 AM, read in part .Chief Complaint: Abnormal labs. Secondary Complaint: Abdominal pain .Vital Signs .pulse: 145 . atrial fibrillation . On 2/6/25 at 9:45 AM, the DON confirmed R9 should have had vital signs taken on 2/2/25 and 2/3/25 and a weight should have been obtained on 2/3/25. The DON agreed that the expectation for nursing is to ensure there is a new set of vital signs with each skilled nursing assessment and not use vital signs from prior days. The DON stated the expectation was for staff to perform three consecutive weights as part of the new admission process, and if one was missed, then staff were expected to start the process over until there were three consecutive weights. The DON stated R9 originally had a different physician on admission, but then decided to change physicians and MD E was never notified of the change until he was notified of the abnormal labs.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45123 Based on observation, interview, and record review, the facility failed to ensure medications were dispensed and destroyed per standards of practice and per facility policy for two Residents (#1 and #4) of nine residents reviewed for pharmacy services. Findings include: This citation pertains to intake: MI00149326. Resident #1 (R1) Review of R1's Minimum Data Set (MDS) assessment dated [DATE], revealed admission to the facility on [DATE], with active diagnoses that included: heart failure, asthma, diabetes mellitus, and anxiety. R1 scored a 15 of 15 on the Brief Interview of Mental Status (BIMS) assessment reflective of intact cognition. On [DATE] at 8:45 AM, R1 was observed in her room, finishing breakfast at her bedside table. An empty disposable medication cup labeled with R1's last name was observed next to her breakfast tray. R1 stated the floor nurse had recently dropped off her morning medications. When asked if the nurse ensured R1 had taken their medication before leaving the room, R1 replied, No, she just left it, and I have not seen her since. Review of R1's nursing quarterly evaluation, dated [DATE], revealed under section O, self-administration of medications: a. select option that reflects resident's wishes for self-administration of medication: Does not wish to start self-administration. R1's care plan had no goals/interventions for self-administration of medications. On [DATE] at 2:20 PM, an interview was conducted with the Director of Nursing (DON) who was asked the purpose of labeling medication cups. The DON replied, If they (nursing) were pre popping pills or if a resident was not available at the time of administration. Resident #4 (R4) Review of R4's Minimum Data Set (MDS) assessment dated [DATE], revealed admission to the facility on [DATE], with active diagnoses that included: diabetes mellitus, seizures, arthritis, and falls. R4 scored a 11 of 15 on the BIMS assessment, reflective of moderately impaired cognition. On [DATE] at 1:30 PM, several pills were observed on the floor and were picked up. During an interview at the same time, Licensed Practical Nurse (LPN) D was given the pills upon entry to R4's room. LPN D acknowledged the pills should not have been on the floor and threw the pills away in R4's trash. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 2:00 PM, an interview was conducted with the DON who was asked if she was aware of the loose pills found in R4's room. The DON replied, Yes, I talked to the nurse yesterday and took the trash out of R4's room. I asked (LPN D) why she threw them in the trash, and (LPN D) was not sure why she did that. The nurses know that they either dispose of them in the drug buster or the sharps container. Review of R4's physician order, dated [DATE], revealed the following order: phenobarbital (controlled schedule IV barbiturate medication) 64.8 mg, give one tablet by mouth two times a day for history of seizures. Review of the policy Medication Administration, dated [DATE], read in part Policy: Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection. Policy Explanation and Compliance Guidelines .15. Observe resident consumption of medication . Review of policy Medication-Destruction of Unused Drugs, dated [DATE], read in part Policy: All unused, contaminated, or expired prescription drugs shall be disposed of in accordance with state laws and regulations (refer to any state-specific requirements). Policy Explanation and Compliance Guidelines: 1. Drugs will be destroyed in a manner that renders the drugs unfit for human consumption and disposed of in compliance with all current and applicable state and federal requirements .6. Schedule II, III, and IV controlled drugs must be destroyed by the Director of Nursing Services and another licensed nurse .

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F 0776 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, approved x-ray services, or have an agreement with an approved provider to obtain them. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45123 This citation pertains to intake: MI00149326. Based on interview and record review, the facility failed to ensure radiology exams were obtained as ordered for one Resident (#7) of 9 residents reviewed for radiology services. Findings include: Resident #7 (R7) Review of R7's Minimum Data Set (MDS) assessment dated [DATE], revealed admission to the facility on [DATE], with active diagnoses that included: hypertension, depression, diabetes mellitus, and gout. R7 scored a 15 of 15 on the Brief Interview of Mental Status (BIMS) assessment reflective of intact cognition. On 2/5/25 at 11:20 AM, an interview was conducted with Medical Doctor (MD) E who stated he was displeased with the nursing staff at the facility because he ordered a bilateral [both side] foot x-ray for R7 on 1/20/25 and when he returned to the facility on [DATE] his x-ray was never ordered. On 2/26/25 at 2:45 PM, an interview was conducted with R7 in his room who was asked about his toes being run over by another female resident and replied, Yes, it was about two weeks ago. We were all lined up to go outside to smoke at the end of C-hall. This lady came by in her wheelchair and ran over my toes. She never realized that she did it and I never made a big deal out of it. We were going to smoke. R7 was asked if his toes hurt and replied, Just a little. Not as bad as they did when it first happened. Review of physician progress note, dated 1/20/25, read in part: The following is a summary of today's visit .1. Assessment: Pain in toe. Provider Plan: Will get x-ray of bilateral toes and appointment with podiatry . Review of physician progress note, dated 1/23/25, read in part: The following is a summary of today's visit .1. Assessment: Pain in toe. Provider Plan: Bilateral toe pain/cellulitis - x-rays pending, will start [name brand antibiotic] 875 mg (milligrams) po (by mouth) bid (twice daily) x ten days . Review of physician progress note, dated 1/27/25, read in part: The following is a summary of today's visit .1. Assessment: Cellulitis of unspecified toe. Provider Plan: Continue with clinda (sic) (antibiotic name brand abbreviated) po tid (three times daily) and appointment with podiatry pending . Review of R7's radiology exam dated 1/25/25, revealed there was no fracture to R7's toes with a report date of 1/26/25. Review of R7's progress note, dated 1/27/25 at 9:30 AM, read Bilateral tarsal XRs (x-rays) have resulted - negative for fracture or trauma. (continued on next page)

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F 0776 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/6/25 at 3:00 PM, an interview was conducted with Licensed Practical Nurse (LPN) F who was asked if he recalled receiving orders from the physician for R7 to obtain an x-ray for bilateral feet. LPN F replied, No, I do not recall receiving an order for x-rays. On 2/6/25 at 4:00 PM, an interview was conducted with Registered Nurse (RN) H regarding the accident report she made following the incident. RN 'H recalled, I am not sure when R7's toes got ran over, but it was prior to 1/24/25. The physician came in and asked me the results of the x-ray on 1/23/25. I said, 'What x-ray?' It was brought to my attention there should have been one [x-ray] ordered so I ordered it on that day [1/23/25]. Review of R7's incident and accident report, dated 1/24/25, read in part .Resident states that his big toes got run over by 'a lady in a wheelchair who didn't know where she was going.' .Provider aware, who orders bilateral foot x-rays to rule out abnormalities. Order placed .Order also procured for wound monitoring and skin prep to scabbed area on right hallux .Prophylactic antibiotics are in place for these areas as well. Resident states his toes were run over by a lady while waiting to go smoke . On 2/6/25 at 4:10 PM, an interview was conducted with the Director of Nursing (DON) who was asked why there was a delay in obtaining the x-ray for R7. The DON replied, I don't know. If it was ordered on the 20th then it should have been performed that day. Review of policy Laboratory and Diagnostic Guidelines, dated 10/26/23, read in part Policy: This guideline is set up to track the timely completion, reporting and monitoring of laboratory and diagnostic tests, results, and notifications which are used to monitor resident status and/or therapeutic medication levels. Policy Explanation and Compliance Guidelines: 1. The facility may consider tracking laboratory (lab) and diagnostic test through various sources. The system is based on the lab provider and facility efficiency. a. Tracking log, b. Electronic portal, c. Calendar, d. Other 2. Routine laboratory or diagnostic test may be placed on a calendar or schedule, or other mechanism. The mechanism should allow for ease of the facility staff to recognize upcoming lab and diagnostic tests .