STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235292	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Sault Ste Marie	1011 Meridian Rd Sault Sainte Marie, MI 49783

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 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** 40383 This citation pertains to MI000145229: Based on interview, and record review, the facility failed to implement its policy and assure the timely administration and physician notification of unavailable ordered medications for two residents (R1 and R11) from a total sample of 3 residents reviewed for medication administration. This deficient practice resulted in delayed administration of ordered antibiotics without physician notification to combat known infections. Findings include: On 6/21/24, the State Agency (SA) received a complaint regarding the administration of antibiotics for urinary tract infections for Resident #1 (R1). The Electronic Medical Record (EMR) of R1 revealed an admitted [DATE] with diagnoses which included a personal history of urinary tract infections (UTI). The physician orders for R1 included Nitrofurantoin Macrocrystal Capsules (an antibiotic) to be given twice a day for seven days with a start date of 6/18/24 at 20:00 (8:00 PM). The Medication Administration Record (MAR) indicated the medication was not available and was not given on 6/18/24 at 8:00 PM or 6/19/24 at 8:00 AM. The first administration of this medication was on 6/19/24 at 8:00 PM. The nursing progress notes of 6/18/24 at 20:04 (8:04 PM) read in part: Late Entry: Note Text; Resident to start abx (antibiotic) for UTI, medication that was ordered is not the same med that we had in back up . Writer called pharmacy to see if meds were interchangeable and was told no they were not the same . Med on delivery for Wednesday (6/19/24) . The nursing progress notes of 6/19/24 at 04:27 (AM) read in part: .c/o (complaint of) urinary frequency, urgency. Will start on (antibiotic) BID (twice per day) x 7 days, awaiting delivery from pharmacy. The nursing progress notes of 6/19/24 at 08:48 (AM) read in part: Note text: . (antibiotic) for 7 days MED NA (Medication not available). The nursing progress notes of 6/19/24 at 16:04 (4:04 PM) read in part: Note text: . Treatment starting tonight as Abx just arrived from pharmacy. (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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/26/24 at 2:20 PM, the Director of Nursing (DON) stated she was aware the floor nurse contacted the pharmacy, but did not contact the physician. She said notification of the provider was an expectation to discuss the delay and if another medication should be used in place of the missing medication. The EMR for R11 revealed an admitted [DATE] with a primary diagnosis of enterocolitis (inflammation of the intestines) due to clostridium difficile (a bacteria). On 6/26/24 the physician progress notes written at 14:59 (2:59 PM) revealed, Patient is seen for a followup (sic) of continued loose stools. She will resume vancomycin (antibiotic) as she has a recent history of such . Orders given for vancomycin oral solution 250 mg (milligrams) QID (four times per day) x 30 days follow up with provider for continued need. The medication was on the MAR to be administered at 1600 (4:00 PM), 2000 (8:00 PM), 0800 (8:00 AM) and 1200 (noon). The MAR revealed the antibiotic ordered was not given at 4:00 PM or 8:00 PM on 6/26/24. The medication was not given until the following day 6/27/24 at 8:00 AM. The nursing progress notes of 6/26/24 at 23:43 (11:43 PM) read in part: Note Text: Vancomycin .Give 5 ml (milliliters) by mouth four times a day related to ENTEROCOLITIS .Not yet delivered by pharmacy. During an interview on 6/27/24 at 12:19 PM, Licensed Practical Nurse (LPN) C stated she had administered vancomycin this morning at 8:00 AM and it was the first dose delivered for this order as it had just come in from the pharmacy. The EMR was reviewed for R11 and no documentation indicated the physician had been alerted that there would be a delay in the administration of the medication. The facility policy titled: Medications - Unavailable dated as reviewed/revised on 1/31/24 was obtained from the Nursing Home Administrator (NHA). This policy read in part: Medications may be unavailable for a number of reasons. Staff shall take immediate action when it is known that the medication is unavailable: a. Determine reason for unavailability . b. Notify physician of inability to obtain medication upon notification or awareness that medication is not available. Obtain alternative treatment orders and/or specific orders for monitoring resident while medication is on hold.

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. 40383 This citation pertains to MI00145233. Based on observation, interview, and record review, the facility failed to provide meals at regular times in accordance with resident preferences and expectations for five residents (R2, R4, R6, R12 and R13) of 8 residents reviewed for timely meal delivery. This deficient practice resulted in frustrated hungry residents. Findings include: On 6/25/24 a complaint was filed with the State Agency (SA) which alleged the meals were not served in a timely manner with the evening meal arriving as late as 7:00 PM. On 6/26/24 at 12:15 PM, an observation of the noon meal revealed the main dining room trays were being served. Several residents on the A Hall had chosen to eat in their rooms and were waiting for their meals. On 6/26/24 at 12:22 PM, Resident #2 (R2) was visiting with his wife in his room. His wife stated she was here daily and said the facility serves the dining room first and then the hall trays are served. Sometimes R2 goes to the dining room, but often prefers to eat in his room. R2's wife stated, there is often a long wait. R2's wife stated, He gets frustrated. R2 was observed to receive his lunch at 1:15 PM. On 6/26/24 at 12:26 PM, R4 was in his room on A Hall and stated, Where is lunch? I have been waiting for it. The A Hall lunch cart was delivered to the hall at 1:10 PM. On 6/26/24 at 1:22 PM, R6 was in his room on B Hall and after answering several questions said, Where is my lunch anyway? His lunch was delivered minutes later, and his roommate received his lunch at 1:26 PM. During an interview on 6/26/24 at 1:09 PM, the Registered Dietitian (RD) F stated the cart order changes so no hall has to be last every time. The main dining room is always served first and then the rehab hall but the other three halls are rotated in order. The main dining room service starts around noon and the trays should be out to the halls by around 12:30 PM. RD F said there was not a policy, but there was a schedule posted that the facility would provide. On 6/27/24 at 11:24 AM, 11 residents were in the main dining room. When asked what they were doing, R12 responded they were waiting for lunch. There were no beverage service or other activities going on. The TV was off, and the residents were just sitting at the dining room tables. Later on 6/27/24 at 11:45 AM, 24 residents were waiting for lunch. Two residents had a beverage, but another unidentified resident asked, Where is the coffee? R12 said We have to wait quite a while to get meals. R12 went on to say, Maybe they are short of help? Other residents at the table did not have beverages and nodded their heads in agreement. (continued on next page)

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/27/24 at 12:48 PM, the first hall cart was delivered. The last food cart was delivered to the hall at 1:15 PM. The last tray on that cart was delivered at 1:31 PM by Certified Nurse Aide (CNA) K to R13. CNA K said the meal trays often arrived a bit late. R13 interrupted CNA K and said, The food is always late. It is extremely late. The posted facility meal schedule was presented and was titled: DINING ROOM MEAL SERVING TIMES. The schedule was as follows: BREAKFAST 7:15 am Room Trays to Follow LUNCH 12:00 pm Room Trays to Follow DINNER 5:15 pm Room Trays to Follow