STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235336	A. Building B. Wing	05/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Traverse City	2585 S 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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. 49397 Based on observation, interview, and record review the facility failed to assess for self administration safety in two residents (#67 & #8) of seven residents reviewed for safety with self medication administration. Findings include: Resident #67 (R67) On 4/30/25 at approximately 8:00 AM, during a medication administration, Registered Nurse A (RN A) was observed handing R67 a medication cup containing multiple medications. R67 then walked away without RN A verifying ingestion or providing supervision. R67 was left alone in their room with the medications. Review of R67's chart indicated that they had not been assessed for self-administration of medications. Resident #8 (R8) During an interview of R8 on 4/30/25 at 8:54 AM, the medication Trelegy, a prescription inhaler used for long term management of chronic obstructive pulmonary disease and asthma (respiratory conditions causing difficulty in breathing) was observed on the bedside table. R8 stated that they had administered the medications earlier in the morning. R8 stated that the nurse had left the medication there and had not come back to get it. Review of R8's chart indicated that they had not been assessed for self-administration of medications. During review of medication storage with the Director of Nursing (DON) on 5/2/25 at 10:31 AM, the DON stated that residents that were self-administering medication, did need to have an assessment. On 5/2/25 the medication administration policy was requested from the Nursing Home Administrator; it was not provided.

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 34568 Based on observation, interview and record review, the facility failed to prevent Resident to Resident physical abuse for four Residents (R34, R54, R63, and R68) of four residents reviewed for abuse. Findings include: R63 On 4/29/25 at approximately 2:00 p.m., R63 was observed pacing the hallway of the memory care unit without staff supervision. R63 was attempting to find someone, using derogatory language in her description and getting near residents and visitors faces. R63 then was observed grabbing the hand of R68 and stated, Come on! Come on! while attempting to redirect R68 down the hallway. R68 told R63, No!, when R63 began pinching R68's hand in between her thumb and index finger. R68 began to yell out when R63 closed her right hand to make a fist and hit R68 in the right upper arm, making R68 scream. Two staff members came from the hallway and from another resident room to separate the two residents with one staff member leading R68 into her room. R63 was then left unsupervised in the hallway and took another resident's hand, leading her towards the front door. A request for R63's Incident and Accident reports for the last six months. The following incidents were noted as not reported to the SA (State Agency); 10/28/24 - Resident to Resident Altercation; Resident was asked repeatedly to stop touching other resident (Resident Initials). She first was tapping his shoulder and then starting [sic] his stomach. Resident was unable to be redirected. (Resident Initials) then pushed (R63) into a dining room chair which she fell into. 10/28/24 - Resident to Resident Altercation; (R63) and other resident (Resident Initials) were at the locked exit doors exchanging words that could not be heard when it was observed that (R63) hit (Resident Initials) in the right side of her face. (Resident Initials) then retaliated and hit (R63) in the left side of her face. 11/12/24 - Resident to Resident Altercation; Resident was pushing a napkin with eaten oranges to (Resident Initials). (Resident Initials) asked her to stop and (R63) did not. (Resident initials) then smacked (R63) left hand open palmed with force with her right hand. 11/12/24 - Resident to Resident Altercation; (R63) was near the back door by the med cart attempting to push (R54) in her wheelchair. (R54) asked her to stop and she didn't. (R54) then reached and hit (R63's) left shoulder with her right arm. 3/23/25 - Resident to Resident Altercation; (Resident name) was sitting in her wheelchair in her doorway. (R63) attempted to push into the room. (Resident name) was yelling. (R63) starting [sic] hitting her in the head and pulling her hair. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4/19/25 - Resident to Resident Altercation; (R63) attempted to take a baby doll away from female res. (resident) other female res continued holding on and (R63) made contact with open hand on other female res arm several times. 4/27/25 - Resident to Resident Altercation; Observed resident in hallway making contact with closed hand with another resident who was seated in wheel chair. Observed closed hand contact to side of head and shoulder. R54 A request for R63's Incident and Accident reports for the last six months. The following incidents were noted as not reported to the SA; 11/12/24 - Resident to Resident Altercation; (R63) was near the back door by the med cart attempting to push (R54) in her wheelchair. (R54) asked her to stop and she didn't. (R54) then reached and hit (R63's) left shoulder with her right arm. 11/26/24 - Resident to Resident Altercation; Heard resident (R34) screaming in her room. (R54) found sitting in her wheelchair in front of other resident. Resident stated that (R54) slapped her. 12/15/24 - Resident to Resident Altercation; Resident was sitting at dinning room table when another resident approached on her left. (R54) then turned her wheelchair towards the other resident yelled at her and then hit her with a closed fist on the left side of her face/neck. 4/19/25 - Resident to Resident Altercation; Female Res attempted to take a baby doll away from (R54). (R54) continued holding on and Female Res slapped her several times causing a right forearm skin tear. 4/27/25 - Resident to Resident Altercation; Observed resident seated in wheelchair in hallway receiving closed hand contact from another resident. Other resident was standing and facing (R54). Other resident made closed hand contact to side of (R54's) head and both shoulders. R34 A request for R63's Incident and Accident reports for the last six months. The following incidents were noted as not reported to the SA; 11/26/24 - Resident to Resident Altercation; Heard resident (R34) screaming in her room. (R54) found sitting in her wheelchair in front of other resident. Resident stated that (R54) slapped her. An interview was conducted with the Nursing Home Administrator (NHA) on 5/2/25 at 8:53 a.m. regarding the numerous resident to resident altercations inside the memory care unit. The NHA confirmed all the resident to resident altercations were investigated by staff but continue to happen and believed there was no willful attempt. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's Abuse, Neglect and Exploitation Policy reviewed 10/24/22 read, in part, .It is the policy of this facility to provide protections for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation, and misappropriation of resident property .

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 34568 Based on observation, interview and record review, the facility failed to report timely allegations of abuse (resident to resident), within two hours, to the State Agency (SA) for four Residents (R34, R54, R63, and R68) of four residents reviewed for abuse reporting. Findings include: R63 On 4/29/25 at approximately 2:00 p.m., R63 was observed pacing the hallway of the memory care unit without staff supervision. R63 was attempting to find a male, using derogatory language in her description and getting near residents and visitors faces. R63 then was observed grabbing the hand of R68 and stated, Come on! Come on! while attempting to redirect R68 down the hallway. R68 told R63, No! when R63 began pinching R68's hand in between her thumb and index finger. R68 began to yell out when R63 closed her right hand to make a fist and hit R68 in the right upper arm, making R68 scream. Two staff members came from the hallway and from another resident room to separate the two residents with one staff member leading R68 into her room. R63 was then left unsupervised in the hallway and took another resident's hand, leading her towards the front door. A request for R63's Incident and Accident reports for the last six months. The following incidents were noted as not reported to the SA; 10/28/24 - Resident to Resident Altercation 11/12/24 - Resident to Resident Altercation 11/12/24 - Resident to Resident Altercation 3/23/25 - Resident to Resident Altercation 4/19/25 - Resident to Resident Altercation 4/27/25 - Resident to Resident Altercation R54 A request for R63's Incident and Accident reports for the last six months. The following incidents were noted as not reported to the SA; 11/12/24 - Resident to Resident Altercation 11/26/24 - Resident to Resident Altercation 12/15/24 - Resident to Resident Altercation 4/19/25 - Resident to Resident Altercation (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4/27/25 - Resident to Resident Altercation R34 A request for R63's Incident and Accident reports for the last six months. The following incidents were noted as not reported to the SA; 11/26/24 - Resident to Resident Altercation An interview was conducted with the Nursing Home Administrator (NHA) on 5/2/25 at 8:53 a.m. regarding the numerous resident to resident altercations inside the memory care unit. The NHA confirmed that the facility did not report any resident-to-resident altercations and was under the assumption that resident to resident altercations were only reportable if there was an injury. Review of the facility's Abuse, Neglect and Exploitation Policy reviewed 10/24/22 read, in part, .Reporting of all alleged violations to the .state agency .immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse .

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34568 Based on interview and record review, the facility failed to ensure staff reviewed residents medical record for code status, ensure code status orders were signed by the physician, and ensure code status was uploaded to the resident chart in a timely manner for two Residents (R72 and R500) of three residents reviewed for advance directives. Findings include: R72 R72 was admitted to the facility on [DATE] with diagnosis of right femur head and neck fracture without operation. R72 was her own responsible party. Review of R72's progress notes revealed the following entry dated [DATE], This nurse entered resident's room to obtain blood glucose reading, Resident was observed in bed laying on right side, not responding to verbal stimulus. This nurse attempted to rouse resident by movement, but resident was still not responding. No pulse was observed when checking radial and carotid arteries. This nurse notified (Nurse Practitioner [NP]) of status. Absence of pulse was confirmed by this nurse and (NP). Family notified by provider, funeral home contacted for release of resident. A DNR (Do Not Resuscitate [Type of Code Status]) physician order was placed in R72's Electronic Medical Record (EMR) on [DATE] but there was no signed Do-Not-Resuscitate (DNR) Order Declarent (Resident) Consent or Advance Directive scanned into R72's EMR. An interview was conducted with Registered Nurse (RN) C on [DATE] at 1:20 p.m. RN C confirmed that she was the nurse on [DATE] who discovered R72 unresponsive, I was the nurse who found her. I called for help but she was a newer admit to me and I didn't know her code status. I had to run back to my computer and saw she was a DNR, and at that time the NP came in to assess (R72). I did not look for a signed advance directive (code status). A request was made for R72's Advance Directive/Code Status. An interview was conducted with the Director of Nursing (DON) on [DATE] at 9:35 a.m. who confirmed the facility could not find R72's signed Advance Directive/Code Status form. R500 R500 was admitted to the facility on [DATE] with diagnosis of orthostatic hypotension. R500 was her own responsible party. (continued on next page)

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R500's progress notes revealed the following entry, dated [DATE], at appx. (approximately) 0445 (4:45 a.m.) CNA (Certified Nurse Aide) answered residents call-light and began to assist resident to bathroom, resident stood from bed and became short of breath then fell back on bed and stopped breathing, CNA called down hall for this nurse and I ran down to residents room and observed resident laying on her back on the bed with face gray and not breathing, called loudly in residents ear and did sternal rub and checked for pulse with none found and no response from resident. Nurse yelled down hall for other nurse to grab crash cart and paged overhead for all staff assist to residents room, this nurse and CNA lifted resident to the floor reapplied her NC (nasal cannula) O2 (oxygen) and started CPR (cardiopulmonary resuscitation [Type of Code Status]) and once crash cart arrived hooked up high flow O2 to bag resident then other nurse ran to check code status in the computer. Other nurse returned and informed this nurse that resident was a DNR and cpr was stopped immediately. Resident then took two agonal breaths (irregular gasps) so this nurse propped up resident in my lap and with assist from CNA positioned resident head to straighten airway and used ambu bag (respiratory support equipment) with O2 to deliver breaths to resident. Other nurse then went to call emergent EMS (Emergency Medical System), and this nurse continued to deliver rescue breaths only, with ambu bad [sic] hooked to O2 until EMS arrived. Resident was taking no breaths once EMS arrived and was hooked to ekg (electrocardiogram) and minimal activity observed so rescue breaths continued until resident vital signs ceased completely. EMS requested code status paper work but was unable to obtain from digital chart so [Hospital Name] called to obtain from previous hospital stay. Once hitting 20 minutes since resident fully down and resident having no further vital signs resident was pronounced by [Hospital] physician as TOD (time of death) of 0515 (5:15 a.m.) on [DATE]. A request was made for R500's Advance Directive/Code Status. An interview was conducted with the Director of Nursing (DON) on [DATE] at 9:35 a.m. who confirmed the facility could not find R500's signed Advance Directive/Code Status form. Review of the facility's Cardiopulmonary Resuscitation (CPR) & Basic Life Support (BLS) policy reviewed/revised on [DATE] read, in part, .Facility staff should verify the presence of advance directives or residents' wishes regarding CPR upon admission. Physician orders to support these choices should be obtained as soon after admission as possible or after a change in preference or condition . During an interview on [DATE] at 9:45 AM, this Surveyor was presented a Past Noncompliance (PNC) document. During the onsite survey, PNC was cited after the facility implemented actions to correct the noncompliance which included: 1. Blanket audit for current residents to assure that advance directives were formulated, orders were correct and physician had signed the DNR order. 2. Education for Licensed Nurses on looking in the chart prior to initiating CPR. 3. IDT (interdisciplinary team) will audit new admissions with AM (morning) clinical M-F (Monday - Friday) to assure all interventions and documentation is completed per policy. 4. DON will review findings and report trends to the QAPI (Quality Assurance and Performance Improvement) committee monthly times 3 months with further monitoring per QAPI committee recommendations (continued on next page)

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility successfully demonstrated monitoring of the corrective action and maintained compliance by completing weekly audits of residents identified with Code Status/Advance Directives concerns, to ensure established protocol was followed. The PNC was granted with a Plan of Corrections (POC) date of [DATE].

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34568 Based on observation, interview and record review, the facility failed to follow interventions to prevent further falls for one Resident (R54) of three residents reviewed for falls. Findings include: R54 Review of the Electronic Medical Record (EMR) revealed R54 admitted to the facility on [DATE] with diagnoses including Alzheimer's disease. Review of R54's Incident and Accident reports revealed the following incident dated 11/20/24 and read, in part, Resident sitting on dining room chair. She had slid onto the floor. Assessed for injury. No c/o (complaint of) pain .Care plan updated to have Dycem nonslip mat in her wheelchair and dinning room chair . On 5/2/25 at 9:45 a.m. an observation was made of the dining room in the Memory Care Unit which R54 resides. R54 was observed coming out of her room after receiving care from Certified Nurse Aide (CNA) D and was wheeled into the dining room. R54 did not appear to have Dycem underneath her in the wheelchair. An interview was conducted with CNA D who stated that she did not believe she placed Dycem in R54's wheelchair after cares because the Dycem was soiled. R54 was then wheeled back into her bathroom by CNA D who assisted R54 to stand up out of the wheelchair and confirmed there was no Dycem in R54's wheelchair. Review of R54's care plans read, in part, .at risk for falls/injury .interventions: (R54) is to have a dycem nonslip mat in her wheelchair and dining room chair. Date Initiated: 11/22/24.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 34568 Based on observation, interview, and record review, the facility failed to ensure adequate staffing to promote the physical, mental, and psychosocial well-being in a locked memory care unit. This deficient practice resulted in the continuation of numerous resident to resident altercations and falls. Findings include: On 4/29/25 at approximately 2:00 p.m., R63 was observed pacing the hallway of the memory care unit without staff supervision. R63 was attempting to find someone, using derogatory language in her description and getting near residents and visitors faces. R63 then was observed grabbing the hand of R68 and stated, Come on! Come on! while attempting to redirect R68 down the hallway. R68 told R63, No! when R63 began pinching R68's hand in between her thumb and index finger. R68 began to yell out when R63 closed her right hand to make a fist and hit R68 in the right upper arm, making R68 scream. Two staff members came from the hallway and from another resident room to separate the two residents with one staff member leading R68 into her room. R63 was then left unsupervised in the hallway and took another resident's hand, leading her towards the front door. On 5/2/25 at approximately 9:30 a.m. an observation was made of the locked Memory Care Unit. 12 residents were located in the dining room of that unit without any staff members present. During this observation, R63 was observed attempting to push R54 in her wheelchair, with R54 becoming visibly upset. Other residents were observed standing up without assistance and furniture surfing around the dining room. R68 was observe down the hallway going into other resident rooms without staff supervision. An interview was conducted with Certified Nurse Aide (CNA) D on 5/2/25 at approximately 9:45 a.m. CNA D stated, the Memory Care Unit usually has 2 CNA's, a nurse and an activity aide, but due to call in's of staff, it doesn't always work out. An interview was conducted with Family Member (FM) E who was visiting in the Memory Care Unit on 5/2/25 at approximately 10:00 a.m FM E stated, she does not feel there are enough staff down in the unit to assist with resident needs and there are often times when residents are left unsupervised. An interview was conducted with the Nursing Home Administrator (NHA) on 5/2/25 at approximately 10:45 a.m. The NHA confirmed that there should be 2 CNA's, a nurse and an activity aide down in the Memory Care Unit. Review of the Facility Assessment reviewed February 2025 read, in part, .22 beds secured dementia unit all long term residents .The unit has an enclosed outdoor space with raised garden beds. The unit includes a dining room/activity area .[Facility Name] has deemed that dementia care has more relative importances as it is a specialty area for the facility .the facility has dementia/memory care is used for marketing purposes to differentiate the facility in the community .

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F 0923 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have enough outside ventilation via a window or mechanical ventilation, or both. 34568 Based on observation and interview, the facility failed to ensure exhaust ventilation was functioning in resident bathrooms, on three halls, serving 22 of a total 74 residents. This deficient practice resulted in noxious odors permeating the resident environment, with the potential to cause unpleasant and uncomfortable living conditions. Findings include: On 4/30/25 at 10:45 AM, noxious odors were noted throughout the D hall. On 4/30/25 at 2:15 PM, in response to the presence of continued noxious odors on the D hall, an investigation was initiated into determining the functioning of the exhaust ventilation system for resident bathrooms. The bathrooms serving the following rooms were inspected for functioning exhaust by placing a paper towel over the ceiling mounted duct cover and determining if there was adequate negative pressure to hold the paper in place. The failure to hold the towel in place deemed a failure for that bathroom's exhaust system. This failure was noted in the bathrooms serving the following resident rooms: D Hall; 1, 5, 6 On 4/30/25 at 2:35 PM, an interview was conducted with Maintenance Director (MD) B who conducted a similar test for bathroom exhaust function and confirmed there was not any negative pressure in the duct resulting a failure of exhaust from the bathroom. MD B stated I don't think these have ever worked.