STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235379	A. Building B. Wing	07/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Tawas City	400 North Street West Tawas City, MI 48763

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39056 This Citation pertains to Intake Number MI00145682 Based on observation, interview, and record review, the facility failed to ensure that residents were treated with dignity and respect and failed to ensure that residents' concerns/grievances were promptly reviewed for 7 of 9 residents (Resident #24, #8, #7, #11, #12, #13, and #14) and residents in attendance at a Resident Council Meeting, reviewed for dignity and respect, resulting in feelings of anxiety and frustration. Findings include: Resident #24 (R24) Review of an Admission Record revealed R24 was an [AGE] year-old male, admitted to the facility on [DATE], with pertinent diagnoses which included: debility and heart disease. Review of a Minimum Data Set (MDS) assessment for R24, with a reference date of 8/23/23 revealed a Brief Interview for Mental Status (BIMS) score of 11, out of a total possible score of 15, which indicated R24 was moderately cognitively impaired. Review of R24's Quality Assistance Form dated 11/10/23 revealed, Re: (Certified Nursing Assistant (CNA) G) Doesn't like that he eats in his room for breakfast, dinner bcuz (sic) says (R24) is on his call light all the time. When pushes call light (CNA G) asks what do you want. Been using his cell phone to call for help . There was no additional follow-up documented under Findings, Plan/Actions, or Resolution. There were no signatures to identify who completed the follow-up or by the resident. The form was located in CNA G's employee file. Resident #8 (R8) Review of an Admission Record revealed R8 was a [AGE] year-old female, admitted to the facility on [DATE], with pertinent diagnoses which included: cerebral infarction (stroke). Review of a Minimum Data Set (MDS) assessment for R8, with a reference date of 5/15/24 revealed a Brief Interview for Mental Status (BIMS) score of 14, out of a total possible score of 15, which indicated R8 was cognitively intact. (continued on next page)

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235379	A. Building B. Wing	07/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Tawas City	400 North Street West Tawas City, MI 48763

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R8's Quality Assistance Form dated 11/10/23 revealed, .When (R8) needs changed (CNA G) acts like it's an inconvenience. Wouldn't let her help with showering which is part of her PT (physical therapy). Goal is to go home. On her cell a lot. Always says how busy she is + how much xtra (sic) work she always has xtra (sic) but no one (sic) else does. Says what do you want when answering call ligh (sic) . There was no additional follow-up documented under Findings, Plan/Actions, or Resolution. There were no signatures to identify who completed the follow-up or by the resident. The form was located in CNA G's employee file. Review of R8's Quality Assistance Form dated 2/12/24 revealed, .(R8) called for a brief change. (CNA G) came in mad because (R8) needed help and she wanted a break. (CNA G) moved sliding bored (sic) too soon and took away to quick. (R8) almost fell and her upper arm hit the wall .Findings: Spoke with (R8) about CNA rushing with cares. (R8) reported her bumping her arm. She reported to me her bicep was tender . Education provided to CNA r/t (related to) rushing cares .(CNA G) was assigned and has completed education module (regarding) caregiver conduct . Resident #7 (R7) Review of an Admission Record revealed R7 was a [AGE] year-old female, admitted to the facility on [DATE], with pertinent diagnoses which included: kidney disease, heart disease, and respiratory disease. Review of a Minimum Data Set (MDS) assessment for R7, with a reference date of 6/20/24 revealed a Brief Interview for Mental Status (BIMS) score of 15, out of a total possible score of 15, which indicated R7 was cognitively intact. Review of R7's Quality Assistance Form dated 2/7/24 revealed, .from day 1 feels like (CNA G) personally doesn't like her. Possibly (because) of her size? She is rude + slams things down in the room. She doesn't feel like she has given her any reason for the (attitude) .Findings: I (R7) am not afraid of (CNA G), I just want her to slow down. She has been fine this afternoon. Plan/Actions: Educated CNA with PIP (Performance Improvement Plan) on professionalism .Describe: DON/NHA (Director of Nursing/Nursing Home Administrator) met with resident who expressed that she did not feel abused. Simply reported that (CNA G) seems rushed and not professional. DON/NHA met with staff member (CNA G) for formal discipline. Staff member identified that she at times can appear frustrated/unhappy when she feels stressed. DON/NHA provided support solutions to assist with minimizing job stressors and encouraged staff to request help when needed . Resident Council Review of the Resident Council Minutes dated 6/18/24 revealed an issue with CNAs being rude and a grievance form given to DON (Director of Nursing). During an interview on 07/23/2024 at 12:29 PM, NHA reported the employee named in the Resident Council Meeting was CNA G. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235379	A. Building B. Wing	07/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Tawas City	400 North Street West Tawas City, MI 48763

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Quality Assistance Form dated 6/18/24 revealed, .CNA (G) being rude to Residents and short tempered. Resident told CNA I wouldn't talk to my dog the way you are talking to me .Findings: CNA can be rough with tone of voice. Plan/Actions: PIP put in place for CNA .Describe: Will continue to monitor. NHA review conducted indicated Resident Council identified particular staff member in this concern (no other implicated). Council did not report abuse, however that staff member was at times verbally unprofessional (no profanity or derogatory statements; simply not as pleasant and kind as required) .Validated customer service concern re; CNA. Formal disciplinary action (PIP) now in place .Investigation conducted with alleged complainant (anonymous) and current Resident Council President indicated improved staff performance following disciplinary action (PIP). No indication of past or current abuse from this staff member, however prior unprofessional behavior (seeming hurried and rude when providing/responding to care needs) . Resident #11 (R11) Review of an Admission Record revealed R11 was a [AGE] year-old female, admitted to the facility on [DATE], with pertinent diagnoses which included: low back pain and a history of collapsed vertebra and fractures with routine healing. Review of R11's Nursing Readmission Evaluation-Part 2 dated 7/24/24 revealed R11's short-term memory and long-term memory were intact. R11's cognitive skills for decision making were Independent-decisions consistent/reasonable. Confirming R11 was cognitively intact. Review of R11's Skilled Daily note dated 7/24/24 revealed that R11 was alert and oriented to person, place, date, and time and was able to make needs known. During an interview on 7/24/24 at 12:08 PM, R11 reported she recently had to interact with a nasty aide and identified the staff member as CNA G. R11 reported that she had a toilet riser in her bathroom and did not want to use it and CNA G refused to assist her or follow up with getting the riser removed. R11 reported CNA G was rude and disrespectful and later came to apologize for the negative interaction not because she wanted to, it was because she knew her job was on the line. R11 reported that CNA G was consistently rude and disrespectful and was not going to change her ways. R11 reported that other staff and residents had concerns with her ongoing disrespectful/rude behavior and nobody knows why they keep her. Review of R11's Quality Assistance Form dated 7/12/24 revealed, .(R11) says a CNA wouldn't take the toile riser off. (R11) got upset + removed it herself, throwing it on the floor .Findings: Spoke with (R11) to get more details + she explained the CNA was refusing to remove the toilet riser + lied to her about it .Root cause of concern: staff unfamiliar with ability to remove toilet riser per (resident) request if not care planned specifically for its use . During an interview via email on 7/24/24 at 1:37 PM, Nursing Home Administrator (NHA) confirmed CNA G was the employee referenced in R11's Quality Assistance Form. Resident #12 (R12) Review of an Admission Record revealed R12 was a [AGE] year-old male, admitted to the facility on [DATE], with pertinent diagnoses which included: vascular Parkinsonism (small strokes in brain areas that control movement cause Parkinson's-like symptoms), chronic pain, and weakness. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235379	A. Building B. Wing	07/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Tawas City	400 North Street West Tawas City, MI 48763

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a Minimum Data Set (MDS) assessment for R12, with a reference date of 6/9/24 revealed a Brief Interview for Mental Status (BIMS) score of 15, out of a total possible score of 15, which indicated R12 was cognitively intact. During an interview on 07/23/2024 at 8:31 AM, R12 reported his concerns with CNA G began back in November of 2023 and had not improved. R12 reported there was a time where he did not allow her to provide care due to her very disrespectful treatment towards R12. R12 reported CNA G often displayed a bad attitude and would rush care and referenced a specific time in which he required assistance with boosting up in bed and CNA G told R12 to do it yourself, left his room, and did not return. R12 reported that residents had reported concerns with CNA G to management and in resident council meetings. R12 reported residents had most recently reported concerns in the June 2024 Resident Council Meeting. R12 reported that CNA G's disrespectful behavior had not improved and felt that management would not terminate her employment due to staffing concerns/shortages. R12 reported he felt anxious knowing that CNA G was working because he felt that he wouldn't receive good care. On 7/23/24 at 11:27 AM a request for R12's Concern/Grievance forms (Quality Assistance Form) from October 2023-present were requested. 1 Quality Assistance Form dated 7/15/24 was received (unrelated to CNA G). Resident #13 (R13) Review of an Admission Record revealed R13 was an [AGE] year-old female, admitted to the facility on [DATE], with pertinent diagnoses which included: muscle weakness and pain. Review of a Minimum Data Set (MDS) assessment for R13, with a reference date of 4/26/24 revealed a Brief Interview for Mental Status (BIMS) score of 15, out of a total possible score of 15, which indicated R13 was cognitively intact. During an interview on 07/23/2024 at 8:58 AM, R13 reported that CNA G would have bad days and felt that it was due to her personal life. R13 reported that CNA G had a child with a medical condition and on the days, she was rude/disrespectful and/or rough might be a day she's having trouble with him. R13 reported that when she had reported concerns to management regarding CNA G rude/rough care previously but no longer had concerns with CNA G providing her care. R13 reported she did have ongoing concerns with CNA G being disrespectful to other residents residing across the hall and reported CNA G was verbally just kinda rough with them. R13 reported she could hear in CNA G's voice that she would get upset because she would have to answer the call light and help and felt that CNA G sounded irritated that she would have to assist residents with care. On 7/23/24 at 11:27 AM a request for R13's Concern/Grievance forms (Quality Assistance Form) from October 2023-present were requested. No Quality Assistance Forms were received prior to survey exit. Resident #14 (R14) Review of an Admission Record revealed R14 was a [AGE] year-old female, admitted to the facility on [DATE], with pertinent diagnoses which included: muscle weakness and heart failure. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235379	A. Building B. Wing	07/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Tawas City	400 North Street West Tawas City, MI 48763

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a Minimum Data Set (MDS) assessment for R14, with a reference date of 4/18/24 revealed a Brief Interview for Mental Status (BIMS) score of 13, out of a total possible score of 15, which indicated R14 was cognitively intact. During an interview on 07/23/2024 at 9:11 AM, R14 reported that CNA G has her days where she would be disrespectful and rough and in and out and onto the next task. R14 reported that in October and November of 2023 CNA G's behavior was really bad but was slowly improving at least with me. R14 reported that her poor attitude and performance would depend on if she's having trouble with her son. R14 reported many details of CNA G's personal life, legal issues, and her child's diagnosis. R14 stated, she (CNA G) just got some fairly good news from the courts and maybe she'll (CNA G) be able to settle down a little (related to her behaviors and the care she provided). R14 stated that if CNA G was extra rough I'll ask her what's going on at home which would result in CNA G providing more compassionate care. R14 reported that CNA G would benefit from a mentor and reported she felt that she (R14) was understanding and was willing to listen to and offer advice to CNA G. On 7/23/24 at 11:27 AM a request for R14's Concern/Grievance forms (Quality Assistance Form) from October 2023-present were requested. No Quality Assistance Forms were received prior to survey exit. During an observation on 7/25/24 revealed CNA G was working with residents in the capacity of a CNA and was scheduled to work the B Wing from 6 AM-6 PM. CNA G was working independently (without the oversight of a preceptor/mentor). During an interview on 07/22/2024 at 3:42 PM, CNA C reported that for months CNA G had been providing rough care and was rude and disrespectful to residents. CNA C reported that staff and residents had been reporting concerns regarding CNA G to management and still nothing gets done. During an interview on 07/23/2024 at 11:48 AM, Resident Advocate (RA) B reported that she had written up Quality Assistance Forms multiple times related to CNA G's care and stated residents had complained that she was short (tempered) and rough with care. RA B reported that CNA G's behaviors had being going on for a long time but management was aware. During an interview on 07/23/2024 at 2:45 PM, CNA F reported that she and other staff had identified concerns with the care that CNA G provided to residents for months since well before Christmas (2023). CNA F reported that multiple concerns had been reported to the DON by staff as well as residents, but CNA G continued to work at the facility with a poor attitude and poor care. CNA F reported that CNA G was rude and disrespectful to residents and would bring her personal life to work. During an interview on 07/23/2024 at 12:29 PM, NHA reported it was not appropriate for CNA G to be sharing her personal life troubles with residents. NHA reported that CNA G was on a PIP and was on managements radar related to concerns with providing care that was rushed and continued unprofessional behavior. NHA reported that while CNA G was not meeting professional standards of care, her care/behavior and not risen to the level of abuse. Review of CNA G's employee file revealed a hire date of 6/21/23. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235379	A. Building B. Wing	07/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Tawas City	400 North Street West Tawas City, MI 48763

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of CNA G's Performance Improvement Form dated 2/8/24 revealed, Reason for Counseling/Corrective Action: Poor attitude with residents and other staff. Residents reporting rushed treatment during cares, rudeness, slamming things and being unprofessional with them .Has this concern been previously Discussed with the Employee? (Yes) .Employee has been given verbal counseling previously for these same actions .Expected Level of Performance: Employee will be courteous at all times. Employee will slow down with cares so as to not be rushed. Employee will have a positive attitude with all residents and staff .Time Frame For Improvement: 30 days-Follow Up Review Date: 3/8/24 . The Quality Assistance Form dated 2/12/24 was not reflected on this PIP. There was no other follow-up documentation related to the review date of 3/8/24 reflected. Review of CNA G's Performance Improvement Form dated 6/24/24 revealed, Reason for Counseling/Corrective Action .Using obscene, inappropriate, abusive or threatening language .Has this concern been previous discussed with the Employee? (Yes) .Informal education provided about professional and kind language in the workplace .Expected Level of Performance: Professional at all times. Addressing resident with dignity and respect and using kind language .CNA will demonstrate professional language during work hours by using kind and respectful language with residents and co-workers. Time Frame For Improvement: 30 days, 7/25/24 . The Quality Assistance Form dated 7/12/24 was not reflected on this PIP. Resident Council Minutes from November 2023 were not available for review. Review of the facility policy Resident Council last reviewed/revised 10/30/23 revealed, .1. Purpose of the Resident Council a. Allow residents to have input in the operation of the facility b. Discussion of concerns c. Consensus building and communication between residents and facility staff d. Forum for staff to disseminate information and gather feedback from interested residents . 4. Responsibilities of the Resident Council may include . b. Assist in the development of resident group grievance and concern procedures . d. Make recommendations for the improvement of resident services provided by the facility. e. Review reports submitted to the council and make recommendations and/or taking appropriate action f. Study problem areas and make recommendations for solution g. Serve as an advisory group between the residents and management . 9. Utilization of Response Forms (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235379	A. Building B. Wing	07/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Tawas City	400 North Street West Tawas City, MI 48763

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a. A resident Council Minutes and Quality Assistance Form will be utilized to track issues and their resolution b. The facility department related to any issues will be responsible to address the item(s) of concern . 11. Administration Review of Council Minutes a. The administrator reviews the minutes to ensure i. all group concerns and grievances are investigated ii. any responses from departments within the facility are provided back to the council . c. Individual concerns may be processed through the grievance procedure 12. Relationship Between Resident Council and Quality Assurance . b. Issues documented on Quality Assistance forms may be referred to the Quality Assurance Committee, if applicable (i.e., the issue is of serious nature or if there is a patter, etc.) .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235379	A. Building B. Wing	07/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Tawas City	400 North Street West Tawas City, MI 48763

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29073 This Citation pertains to Intake Numbers MI00136715 and MI00137985. Based on interview and record review, the facility failed to ensure that one resident (Resident #3), who had been deemed incompetent to make medical decisions, had a legal guardian in place to guide medical decision making according to the resident's Advanced Directives. Findings include: Resident #3 (R3) Review of an Admission Record reflected R3 admitted to the facility on [DATE] with diagnoses that included heart disease, kidney disease, type 2 diabetes, major depressive disorder, anxiety and a history of transient ischemic attack (TIA) and cerebral infarction without residual deficits. The admission record indicated R3 had a Responsible Party-Financial Conservator. Review of Letters of Conservatorship dated 6/15/2018 reflected that a conservator had been appointed with authority with respect to all assets of the estate. The Order Regarding Appointment of Conservator indicated Upon presentation of clear and convincing evidence, the adult individual is in need of a conservator because s/he is unable to manage his/her property and business affairs effectively because of Mental deficiency; dementia. The document did not grant authority to the conservator over medical and/or treatment decisions. Review of a Care Plan initiated on 6/8/2021 reflected a Focus for R3 was Self-determination related to advanced directive. The Goal was Resident's right to formulate an Advanced Directive will be honored. Interventions included Document when resident does not have the capacity to make decisions and refer to legal representative; Implement resident decisions. Review of a Decision Making Determination Form dated 8/26/2022, signed by a physician and a psychologist, indicated R3 was incapable of making decisions regarding medical treatment based upon On 6/3/2022 (R3) scored a 7 (severe cognitive impairment) on BIMS (Brief Interview for Mental Status) and a diagnosis of dementia. Review of a Decision Making Determination Form dated 6/28/2023, signed by R3's attending physician and a second physician, indicated R3 was again deemed Incapable of making decisions regarding medical treatment due to R3's mental status demonstrating mild to severe cognitive impairment and diagnoses of mild dementia and neurocognitive disorder. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235379	A. Building B. Wing	07/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Tawas City	400 North Street West Tawas City, MI 48763

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of an Advanced Care Planning note dated 7/17/2023 reflected R3's son was present at a meeting on this day but did not have Durable Power of Attorney (DPOA) or guardianship of R3. According to the note, R3 indicated she wanted her son to make medical decisions for her in the event of a medical emergency. Initially thought that this patient has a guardian appointed by the state, but apparently the person noted on the chart is simple a conservator and not a guardian and patient currently does not have a legal guardian. The narrative indicates that R3's son inquired about what needed to be done to clarify R3's capacity. R3's incapacity to make medical decisions was again documented, however the social worker was not able to effectively connect with the family regarding applying for guardianship for (R3). During an interview on 7/22/2024 at 3:25 PM, Family Member K reported that R3's son was not R3's legal guardian at this time. FM K reported that the facility did not consistently inform them of any changes in R3's care during R3's stay at the facility and did not respond to concerns that were reported to the facility on behalf of R3's clinical status or custodial care. During an interview on 7/23/2024 at 2:30 PM, the Director of Nursing (DON), Activity Director/Temporary Social Services Director L and Staff Development Coordinator/Medical Records Clerk J reviewed the clinical record of R3 for evidence the facility attempted to obtain legal guardianship for R3 and confirmed the facility did not have evidence of arranging legal guardianship services for R3 despite being deemed incapable of making medical decisions since 8/2022. Review of a policy Residents' Rights Regarding Treatment and Advanced Directives dated 1/1/2022 reflected It is the policy of this facility to support and facilitate a resident's right to request, refuse and/or discontinue medical or surgical treatment and to formulate an advance directive. The policy indicated that 4. The facility will periodically assess the resident for decision-making abilities and approach the healthcare proxy or legal representative if the resident is determined not to have decision making capacities. 5. The facility will identify or arrange for an appropriate representative for the resident to serve as primary decision maker if the resident is assessed as unable to make relevant health care decisions.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235379	A. Building B. Wing	07/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Tawas City	400 North Street West Tawas City, MI 48763

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 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 This Citation pertains to Intake Numbers MI00136509 and MI00142061. Based on interview and record review the facility failed to follow professional standards of nursing practice for medication administration for 6 residents (Resident #17, #18, #19, #23, #14, and #21), out of 10 residents reviewed for the provision of nursing services, resulting in the lack of assessments, medications administered outside of the physician ordered parameters, and medication errors. Findings include: Resident #17 (R17) Review of an Admission Record revealed R17 was a [AGE] year-old male, admitted to the facility on [DATE], with pertinent diagnoses which included: hypertension. Review of R17's Order Summary revealed Hydrocodone-Acetaminophen Tablet 5-325 MG Give 1 tablet by mouth every 6 hours as needed for pain Take medication with food -Start Date- 07/02/2024 -D/C Date- 07/06/2024 . Review of R17's Controlled Substance Record revealed a dose of Hydrocodone-Acetaminophen was documented as administered on 7/7/24 at 8:00 AM. Review of R17's electronic July Medication Administration Record revealed the Hydrocodone-Acetaminophen had been discontinued on 7/6/24 and the dose of Hydrocodone-Acetaminophen was not documented as administered. Resident #18 (R18) Review of an Admission Record revealed R18 was a [AGE] year-old male, admitted to the facility on [DATE], with pertinent diagnoses which included: pain and heart disease. Review of R18's Order Summary revealed HYDROcodone-Acetaminophen Oral Tablet 5-325 MG (Hydrocodone-Acetaminophen) Give 1 tablet by mouth two times a day for pain -Start Date- 02/29/2024. To be administered at 8:00 AM and 8:00 PM. Review of R18's Controlled Substance Record on 7/22/24 at 2:20 PM revealed R18's HYDROcodone-Acetaminophen was not signed out (indicating the medication was not pulled from the locked narcotic box and administered.) Review of R18's electronic Medication Administration Record revealed R18's 7/22/24 8:00 AM dose of HYDROcodone-Acetaminophen was documented as administered. Confirming the licensed nurse did not follow the facility policy/standards of nursing practice for the administration and documentation of controlled drugs. Review of R18's Order Summary revealed: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235379	A. Building B. Wing	07/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Tawas City	400 North Street West Tawas City, MI 48763

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Lisinopril Oral Tablet 5 MG (Lisinopril) Give 5 mg by mouth one time a day for Heart health .Do not give if SBP (systolic blood pressure/top number) < (less than)110 -Start Date- 04/04/2024. To be administered at 8:00 AM. Propranolol HCl Oral Tablet 10 MG (Propranolol HCl) Give 10 mg by mouth one time a day for Heart health . Do not give if SBP <110 -Start Date- 04/04/2024. To be administered at 8:00 AM. Review of R18's July Blood Pressure Summary and July Medication Administration Record revealed R18's blood pressure was not assessed prior to the administration of lisinopril and propranolol and the medications were administered on the following dates: 7/5/24, 7/6/24, 7/9/24, 7/13/24, 7/17/24, 7/18/24, 7/19/24, and 7/20/24 Resident #19 (R19) Review of an Admission Record revealed R19 was an [AGE] year-old female, admitted to the facility on [DATE], with pertinent diagnoses which included: pain. Review of R19's Order Summary dated 6/2/24 revealed, HYDROcodone-Acetaminophen Tablet 5-325 MG Give 1 tablet by mouth two times a day for Pain. To be administered at 8:00 AM and 8:00 PM. Review of R19's Controlled Substance Record on 7/22/24 at 2:25 PM revealed R19's HYDROcodone-Acetaminophen was not signed out. Review of R19's electronic Medication Administration Record revealed R19's 7/22/24 8:00 AM dose of HYDROcodone-Acetaminophen was documented as administered. Resident #23 (R23) Review of an Admission Record revealed R23 was a [AGE] year-old male, admitted to the facility on [DATE], with pertinent diagnoses which included: atrial fibrillation (abnormal beating of the heart). Review of R23's Order Summary dated 6/27/24 revealed: Metoprolol Tartrate Oral Tablet 50 MG (Metoprolol Tartrate) Give 1 tablet by mouth two times a day for htn (hypertension) Hold if SBP under 100 or HR (heartrate) under 60. To be administered at 8:00 AM and 8:00 PM. Diltiazem HCl Tablet 30 MG Give 1 tablet by mouth two times a day for htn hold if SBP less than 100 or HR less than 60. To be administered at 8:00 AM and 8:00 PM. Review of R23's electronic Medication Administration Record, Pulse Summary, and Blood Pressure Summary from 7/1/24-7/17/24 revealed R23 received 2 doses each day of diltiazem and metoprolol daily without a blood pressure or pulse assessment. Resident #14 (R14) (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235379	A. Building B. Wing	07/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Tawas City	400 North Street West Tawas City, MI 48763

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of an Admission Record revealed R14 was a [AGE] year-old female, admitted to the facility on [DATE], with pertinent diagnoses which included: muscle weakness and heart failure. Review of R14's Order Summary dated 3/20/24 revealed, HydrALAZINE HCl Tablet 10 MG Give 1 tablet by mouth two times a day for hypertension Do not give if SBP <150, To be administered at 8:00 AM and 8:00 PM. Review of R14's electronic Medication Administration Record and Blood Pressure Summary revealed: *On 7/3/24 R14's blood pressure was 125/65 and R14's 8:00 PM dose of hydralazine was administered. *On 7/4/24 R14's blood pressure was 143/57 and R14's 8:00 AM dose of hydralazine was administered. *On 7/5/24 R14's blood pressure was 148/51 and R14's 8:00 AM dose of hydralazine was administered. *On 7/10/24 R14's blood pressure was 137/60 and R14's 8:00 PM dose of hydralazine was administered. *On 7/11/24 R14's blood pressure was 116/56 and R 14' s 8:00 PM dose of hydralazine was administered. *On 7/14/24 R14's blood pressure was 146/60 and R14's 8:00 AM dose of hydralazine was administered. Review of R14's Order Summary dated 3/28/24 revealed, cloNIDine HCl Oral Tablet 0.1 MG (Clonidine HCl) Give 0.1 mg by mouth every 8 hours as needed for Htn Give 0.1 mg if SBP is > (greater than) 160. Review of R14's electronic Medication Administration Record and Blood Pressure Summary revealed: *On 7/1/24 R14's blood pressure was 173/54 and the as needed clonidine was not administered. *On 7/2/24 R14's blood pressure was 195/60 and the as needed clonidine was not administered. *On 7/8/24 R14's blood pressure was 186/60 and the as needed clonidine was not administered. *On 7/13/24 R14's blood pressure was 166/70 and the as needed clonidine was not administered. *On 7/13/24 R14's blood pressure was 170/67 and the as needed clonidine was not administered. Resident #21 (R21) Review of an Admission Record revealed R21 was an [AGE] year-old female, admitted to the facility on [DATE], with pertinent diagnoses which included: hypertension. Review of R21's Order Summary dated 12/2/23 revealed, hydrALAZINE HCl Oral Tablet 50 MG (Hydralazine HCl) Give 50 mg by mouth every 8 hours as needed for HTN Give for SBP >160. Review of R21's electronic Medication Administration Record and Blood Pressure Summary revealed: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235379	A. Building B. Wing	07/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Tawas City	400 North Street West Tawas City, MI 48763

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*On 7/3/24 R21's blood pressure was 190/94 and the as needed hydralazine was not administered. *On 7/5/24 R21's blood pressure was 183/93 and the as needed hydralazine was not administered. *On 7/7/24 R21's blood pressure was 178/88 and the as needed hydralazine was not administered. *On 7/8/24 R21's blood pressure was 162/64 and the as needed hydralazine was not administered. *On 7/17/24 R21's blood pressure was 166/62 and the as needed hydralazine was not administered. During an interview on 07/24/2024 at 11:21 AM, Staff Development Coordinator (SDC) J reported the expectation for the licensed nurses was for them to follow the physician ordered parameters and administered medications as ordered and hold medications as ordered. SDC J reported that controlled drugs are to be signed out at the time they are pulled from the lock box. During an interview on 07/24/2024 at 12:45 PM, Director of Nursing (DON) confirmed the medication administration concerns/medication errors for R17, R18, R19, R23, R14, and R21. DON reported all nurses would be re-educated on the nursing standards of practice for medication administration immediately. Review of the facility policy Medication Administration last reviewed/revised 1/17/23 revealed, .8. Obtain and record vital signs, when applicable or per physician orders. When applicable, hold medications for those vital signs outside the physician's prescribed parameters .17. Sign MAR after administered. For those medications requiring vital signs, record the vital signs onto the MAR. 18. If medication is a controlled substance, sign narcotic book . Review of Fundamentals of Nursing ([NAME] and [NAME]) 11th edition revealed, (Nurses) are also responsible for documenting any preassessment data required with certain medications such as a blood pressure measurement for antihypertensive medications or laboratory values, as in the case of warfarin, before giving the medication. After administering a medication, immediately document which medication was given on a patient's MAR per agency policy to verify that it was given as ordered. Inaccurate documentation, such as failing to document giving a medication or documenting an incorrect dose, leads to errors in subsequent decisions about patient care. [NAME], [NAME] A.; [NAME], [NAME] G.; Stockert, [NAME] A.; Hall, [NAME]. Fundamentals of Nursing - E-Book (pp. 643-644). Elsevier Health Sciences. Kindle Edition. Review of Fundamentals of Nursing ([NAME] and [NAME]) 11th edition revealed, The seven rights of medication administration include the right medication, right dose, right patient, right route, right time, right documentation, and right indication. [NAME], [NAME] A.; [NAME], [NAME] G.; Stockert, [NAME] A.; Hall, [NAME]. Fundamentals of Nursing - E-Book (p. 705). Elsevier Health Sciences. Kindle Edition. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235379	A. Building B. Wing	07/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Tawas City	400 North Street West Tawas City, MI 48763

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Fundamentals of Nursing ([NAME] and [NAME]) 11th edition revealed, The National Coordinating Council for Medication Error Reporting and Prevention (2021) 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] G.; Stockert, [NAME] A.; Hall, [NAME]. Fundamentals of Nursing - E-Book (p. 639). Elsevier Health Sciences. Kindle Edition.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235379	A. Building B. Wing	07/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Tawas City	400 North Street West Tawas City, MI 48763

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** 39056 This Citation pertains to Intake Number MI00142331. Based on interview and record review, the facility failed to ensure a resident who experienced a fall was assessed timely with adequate monitoring, assessments, and physician notification for 1 of 10 residents (R#11) reviewed for quality of care, resulting in a delay in care and treatment for an acute T11 spinal fracture. Findings include: Resident #11 (R11) Review of an Admission Record revealed R11 was a [AGE] year-old female, admitted to the facility on [DATE], with pertinent diagnoses which included: low back pain and a history of collapsed vertebra and fractures with routine healing. Review of R11's Nursing Readmission Evaluation-Part 2 dated 7/24/24 revealed R11's short-term memory and long-term memory were intact. R11's cognitive skills for decision making were Independent-decisions consistent/reasonable. Confirming R11 was cognitively intact. Review of R11's Skilled Daily note dated 7/24/24 revealed that R11 was alert and oriented to person, place, date, and time and was able to make needs known. Review of R11's diagnostic study ct scan dated 6/1/24 revealed, There is a chronic fracture at the L2 Vertebral body .Chronic appearing wedging is also present at the superior endplate of L3. There is chronic wedging at the superior endplate of T11. Chronic fracture is present at the T7 vertebral body containing augmentation cement .An acute fracture is not seen. IMPRESSION: Chronic changes without acute traumatic findings. (Vertebral wedging occurs when the front of a vertebrae collapses. Typically occurs in people with osteoporosis.) Review of R11's diagnostic study x-ray dated 7/3/24 revealed, .FINDINGS THORACIC SPINE: Examination reveals mild demineralization and degenerative arthritic changes with old compression deformities of the bodies of T8 and T12 and anterior wedging with no evidence of recent fracture or dislocation .Old compression of T8 and T12 with no recent fracture or dislocation. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235379	A. Building B. Wing	07/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Tawas City	400 North Street West Tawas City, MI 48763

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	Review of R11's Incident Report dated 7/15/24 at 6:20 PM revealed an unwitnessed fall .Resident was observed on the floor, discussed what happened. Completed ROM (Range of Motion) Resident complained of upper back pain (thoracic region). Assessed was a skin abrasion 1.5 inches X 1/8 inch red abrasion . Completed VS (vital signs), ROM, Perrla (pupils equal round reactive to light and accommodation) assisted resident to bed via Hoyer lift .Resident states she hit her head assessed no red areas. PERRLA completed . Agencies/People Notified .Nurse Practitioner (NP) A .Witnesses .(Licensed Practical Nurse (LPN) H) Was called to residents room from CNA (certified nursing assistant), resident was on the floor. Resident stated she was trying to walk around her bed and lost her balance. Took VS (vital signs) all within normal limits. Resident stated she hit her back assessed and was a 1.5 inch X 1/8 inch abrasion. Resident state (sic) she hit her head assessed no red areas, PERRLA completed. Assisted resident back to her bed via Hoyer . Notes: 7/18/24-(R11) is a [AGE] year old female that came to us from the hospital for falling at home and UTI (urinary tract infection). While here (R11) was treated for pneumonia and UTI. (R11) did have a prior fall to which the NP ordered x-ray and the results showed chronic compression fractures with chronic wedging to the L 2-3, T7 and T11 . Review of R11's Fall-Initial evaluation dated 7/15/24 at 6:20 PM revealed, .Pain Evaluation-Does resident have new complaint of pain? (Yes) .Resident has c/o (complaints of) back pain. Resident has chronic back pain . The physical evaluation was as follows Is there a noted or suspected injury related to the incident? (No) .New onset of change in physical functioning? (No) . The evaluation did not include an assessment of R11's spine/back despite the upper back pain documented in the incident report and R11's history of spinal compression/wedging and the new complaint of pain. Review of R11's telehealth Encounter dated 7/15/2024 Date of Service: 7/15/2024 (no time) .Resident was observed on the floor of her room. Resident states that she was walking around the foot of the bed and fell . Resident states that struck the back of her head against the wall, no injuries noted. Vitals wnl (within normal limits). No change in ROM (range of motion). Rounding team notified . Review of R11's telehealth Encounter time stamped 7/16/2024 at 06:05 AM written by Nurse Practitioner (NP) I revealed, Date of Service: 7/15/2024 .nurse reports, Resident was observed on the floor of her room. Resident states that she was walking around the foot of the bed and fell . Resident states that struck the back of her head against the wall, no injuries noted. Vitals wnl (vital signs within normal limits). No change in ROM Requested information regarding Neuro assessment and offered Telemed visit - did not hear back by end of shift. Rounding notified and f.u (follow-up) scheduled . Review of R11's Electronic Health Record revealed no comprehensive physical assessments following R11's fall to identify an acute injury (palpation of R11's spine to identify any specific areas of acute pain and/or deformities), no comprehensive pain assessments to identify the quality of pain (sharp, dull, achy), aggravating factors (repositioning/moving), or behavioral effects of pain (moaning, grimacing, restlessness, immobilization), and no documentation of ongoing neurological assessments despite R11 reporting she had hit her head during the unwitnessed fall. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235379	A. Building B. Wing	07/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Tawas City	400 North Street West Tawas City, MI 48763

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	During an interview on 7/25/24 at 8:24 AM, LPN H reported that she was the nurse on duty for R11 on 7/15/24 at the time of her fall. LPN H reported that R11 had an unwitnessed fall which resulted in an abrasion on her right shoulder from hitting her back against the door hinge. LPN H reported she completed an assessment on R11 which included a physical assessment, vital sign assessment, and a neurological assessment and found R11 to have no new areas of concern identified. R11 was then put to bed utilizing a Hoyer lift. LPN H the assessments she completed were documented in R11's Electronic Health Record and reported that R11 had chronic back pain from a history of compression fractures, and she did not believe R11 was suffering from any new acute injuries. LPN H reported that she notified the on-call provider of the fall and received no new orders. LPN H reported she did not receive a phone call from any on-call provider during her shift from 7/15/24 at 6PM-7/16/24 at 6AM and did not have any further communication with a provider. LPN H reported that she did not complete any additional comprehensive assessments (physical, pain, neurological) throughout her shift but reported she did periodically visualize R11 to ensure she was resting comfortably. Review of R11's Fall-Follow-up dated 7/16/24 at 9:36 AM revealed that vital signs were assessed, a numeric pain evaluation was conducted (pain rating on a scale from 0-10), and a neurologic evaluation was completed. The physical evaluation was as follows Is there a noted or suspected injury related to the incident? (No) .New onset of change in physical functioning? (No) . There were no additional comprehensive physical assessment findings recorded. Review of R11's physician Progress Note dated 7/16/24 (no time evaluation was completed) revealed, XXX[AGE] year-old female patient is seen today for fall occurring yesterday. Nurse reports patient was observed on the floor in her room, she was reporting upper back pain at time of incident. Patient was seen at bedside today, she is alert and oriented, able to make her needs known. She is able to recall the incident, stating that she was reaching for something and lost her balance falling backwards hitting the wall with her back. She states she does not want to try to sit up or roll to the side because it will start hurting again. Nursing reports patient has an abrasion on her back, this provider was unable to see related to patient not wanting to sit up. Patient is noted with fall that is unwitnessed. Nursing reports patient was doing fine this morning with no reports of back pain, she had been sitting up in her wheelchair. Patient reported hitting her head on the wall . Patient has increased worsening back pain that worsens with movement. She is unable to sit up or roll over related to worsening pain. Patient was sent to ED for evaluation, she was then transferred to Saginaw for reinjured thoracic fracture . The note was documented as created on 7/18/2024 at 8:19 PM. (Director of Nursing confirmed there was no documentation to identify what time the provider assessed R11 and reported the evaluation was around noon.) Review of R11's Order Details dated 7/16/24 at 1:04 PM revealed, Back/spine xray post fall for worsening pain one time only for Post fall/worsening pain. Confirming R11's pain was worsening, and follow-up treatment/testing was not ordered for approximately 18 hours following her fall. Review of R11's Order Details dated 7/16/24 at 2:26 PM revealed, OK to send to Tawas ER (emergency room) for increased back pain r/t fall. Review of R11's Fall-Follow-up dated 7/16/24 at 2:47 PM revealed, .Resident stated pain is in her upper back but unable to pinpoint exact place .Per shift report resident was up in wheelchair for breakfast and lunch. Resident wanted to lay down and then pain episode began. Resident was unable to move her head per prior shift. Resident sent to ER for further evaluation. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235379	A. Building B. Wing	07/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Tawas City	400 North Street West Tawas City, MI 48763

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	Review of R11's Transfer Notice dated 7/16/24 revealed R11 was transferred to the local emergency room for Back pain-uncontrolled. Review of R11's Hospital Record revealed, admitted : 7/16/24 (5:52 PM) .Problem 1: Compression fracture of spine .CT (Ct scan)-acute T11 compression fracture .After she had gotten from her wheelchair she fell . She has known history of previous back injuries but had more pain and worsened back discomfort. She underwent evaluation at (hospital name omitted) and found to have compression fracture of T11. She subsequently was transferred to (hospital name omitted) for further care. She has undergone evaluation and recommendation for T11 kyphoplasty is planned for Friday .Pain to palpation of upper thoracic spine. Reports pain in her back that is chronic in nature but with new acute changes .she reported back pain after falling .MRI Imaging revealed acute T11 fractures. As pain was not managed with conservative management we recommended kyphoplasty for T11 . MRI Thoracic Spine ordered 7/17/24 revealed, There is an acute compression deformity of T11 (approximately 50% loss of the vertebral body height) .There is very mild edema along the superior endplate of T12 consistent with recent trauma. Review of R11's Surgical Note dated 7/20/24 revealed, Problem/Assessment Plan .Problem 1: Compression fracture of spine-Plan 1 .presented to (hospital name omitted) after sustaining a fall from her wheelchair. She reported back pain after falling .new T11 compression fracture, Chronic L2/3 compression fractures with no change .Pain to palpation of upper thoracic spine. Reports pain in her back that is chronic in nature but with new acute changes. MRI Lumbar Spine: Acute compression deformity T11 .MRI imaging revealed acute T11 fractures. As pain was not managed with conservative management we recommended kyphoplasty (surgical treatment to stabilize vertebra) for T11 .On 7/20/24 she underwent T11 vertebral body augmentation with balloon assisted methyl acrylic kyphoplasty . During an interview on 7/24/24 at 12:08 PM, R11 reported she could vividly recall her fall on 7/16/24 and reported she had not experienced pain that severe in her [AGE] years. R11 reported that following her fall she was put back to bed and subsequently experienced insurmountable pain that was unbearable. R11 reported she was in extreme pain and but could not recall how long it took to transfer to the hospital but stated it seemed like a long time to me because I was in pain. During an interview on 07/24/2024 at 3:55 PM, DON reported that R11 did not have a new T11 fracture and reported that it was previously identified in a diagnostic study referencing the ct scan dated 6/1/24. Review of the MRI completed on 7/17/24 confirmed R11 experienced a new and acute fracture resulting from her fall on 7/15/24. On 7/25/24 at 8:56 AM all documentation pertaining to R11's fall on 7/15/24 was requested. On 7/25/24 at 9:27 AM, Nursing Home Administrator (NHA) provided the complete fall investigation. No other records received prior to survey exit. (Refer to Incident Report dated 7/15/24 at 6:20 PM). On 7/25/24 at 8:56 AM a request to speak to NP I was made. No return call was received prior to survey exit. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235379	A. Building B. Wing	07/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Tawas City	400 North Street West Tawas City, MI 48763

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	During an interview on 07/24/2024 at 12:45 PM, Director of Nursing (DON) reported she would obtain documentation/clarification of the communication between NP I and the licensed nurses that were working following R11's fall on 7/15/24. No documentation was received prior to survey exit confirming the lack of communication between NP I and the licensed nurses (refer to Encounter note time stamped 7/16/2024 at 06:05 AM). Review of the facility policy Fall Prevention Program last reviewed/revised 10/26/23 revealed, .6. When any resident experiences a fall, the facility will: a. Assess the resident. b. Complete a post-fall assessment. c. Complete an incident report. d. Notify physician and family. e. Review the resident's care plan and update as indicated. f. Document all assessments and actions. g. Obtain witness statements in the case of injury . Review of Fundamentals of Nursing ([NAME] and [NAME]) 11th edition revealed, Assessing the characteristics of pain allows you to understand the type of pain, its pattern, and the types of interventions that bring relief .Quality: People use a variety of words to describe the quality of their pain (e.g., pain, ache). Ask patients to describe their discomfort using their own words whenever possible; then use these words consistently to obtain an accurate report. For example, say, Tell me what your discomfort feels like. What do you call it? The patient may describe the pain as aching, crushing, throbbing, sharp, or dull. If the patient reports the pain as dull, ask if it is still dull or if it has changed when you return to assess the patient's pain . Aggravating and precipitating factors: Various factors or conditions bring on or make pain worse. Ask a patient to describe activities that cause or aggravate pain, such as physical movement, positions, drinking coffee or alcohol, urination, swallowing, eating food, or psychological stress. Also ask them to demonstrate actions that cause a painful response, such as coughing or turning a certain way .Behavioral effects: When a patient has pain, assess verbalization, vocal response, facial and body movements, and social interaction. A verbal report of pain is a vital part of assessment. You need to be willing to listen and understand. When a patient is unable to communicate pain, it is especially important for you to be alert for behaviors that indicate it (Box 44.9). [NAME], [NAME] A.; [NAME], [NAME] G.; Stockert, [NAME] A.; Hall, [NAME]. Fundamentals of Nursing - E-Book (p. 1141-1143). Elsevier Health Sciences. Kindle Edition. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235379	A. Building B. Wing	07/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Tawas City	400 North Street West Tawas City, MI 48763

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	Review of Fundamentals of Nursing ([NAME] and [NAME]) 11th edition revealed, When a patient is in pain, conduct a focused physical examination and observe for nonverbal responses to pain (e.g., grimacing, rigid body posture, limping, frowning, or crying) (see Chapter 30). Examine painful areas to see whether palpation or manipulation of the site increases pain. Determine whether movement affects the pain. Assess the effects pain has on a patient's mobility/balance, especially in older adults with persistent pain ([NAME] et al., 2020). Mobility assessment is critical because of the potential effect of pain and some analgesics on the risk for falling. Patients with chest or back pain may have a decrease in chest excursion. A neurological assessment includes determining whether the pain is also associated with changes in sensation and level of a patient's responsiveness. [NAME], [NAME] A.; [NAME], [NAME] G.; Stockert, [NAME] A.; Hall, [NAME]. Fundamentals of Nursing - E-Book (p. 1141). Elsevier Health Sciences. Kindle Edition. Review of Fundamentals of Nursing ([NAME] and [NAME]) 11th edition revealed, Pain is dynamic; it can change frequently. Thus, you need to assess pain accurately on a regular basis along with other vital signs. Some health care agencies treat pain as the fifth vital sign. Pain assessment is not simply a number. Relying solely on a number fails to capture the multidimensionality of pain and may be unsafe, particularly when the number fails to reflect the entire pain experience or when a patient does not understand the use of the selected pain-rating scale .Factual, timely, and accurate pain assessment allows you to identify an appropriate nursing diagnosis, determine interventions, and evaluate a patient's response (outcomes) to interventions. The core of this complex activity is to explore the pain experience through the eyes of the patient. [NAME], [NAME] A.; [NAME], [NAME] G.; Stockert, [NAME] A.; Hall, [NAME]. Fundamentals of Nursing - E-Book (p. 1139). Elsevier Health Sciences. Kindle Edition.