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	01/30/2025

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 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37668 This Citation Pertains to Intake Number MI00149747. Based on observation, interview and record review, the facility failed to ensure comprehensive assessment and timely implementation of a plan of care and interventions for one resident (Resident #703) of three residents reviewed, resulting in the lack of facility and staff knowledge of the resident's situation, history of inappropriate sexual behaviors, and the potential for unmet care needs and Resident #703 and other facility Residents to experience psychosocial injury. Findings include: Review of intake documentation, dated as received on 1/21/25, revealed staff were not notified a Resident admitted to the facility had a history of sexually deviant behavior with a law enforcement ordered tether monitoring device. The intake indicated the facility did not comprehensively assess the Resident to ensure their needs were identified and met upon admission and did not notify staff to ensure interventions and monitoring were in place for safety. Resident #703: On 1/29/25, Resident #703 was sitting on the edge of their bed in their room. The Resident was listening to music. A black colored device was observed on the Resident's ankle. An interview was completed at this time. When queried how long they had been at the facility, Resident #703 was slow to respond and revealed they had been there a few weeks. Record review revealed Resident #703 was admitted to the facility on [DATE] with diagnoses which included Parkinson's disease, dementia with mood disturbance, heart disease, depression, and anxiety. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the Resident was severely cognitively impaired and needed partial-to-total assistance to complete Activities of Daily Living (ADL). The MDS detailed the Resident displayed no behaviors and had no hallucinations and/or delusions. Review of Resident #703's Electronic Medical Record (EMR) revealed the following care plans and interventions upon admission to the facility: (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 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Care plan: Resident takes psychotropic/mood stabilizer medication as evidenced by use of antipsychotic, antidepressant and antianxiety medications (Initiated: 1/9/25; Revised: 1/13/25). This care plan included the interventions: - Administer medications as ordered (Initiated: 1/9/25) - Refer to psychologist/psychiatrist as needed (Initiated: 1/9/25) - Observe for and report to Physician/NP/PA adverse effects of antidepressant medication use . (Initiated: 1/9/25) - Observe for and report to Physician/NP/PA adverse effects of antipsychotic/mood stabilizer medication use . (Initiated: 1/9/25) Care plan: Resident is at risk for impaired skin integrity related to incontinence, decreased mobility, tether to right ankle (Initiated: 1/9/25; Revised: 1/13/25). The care plan did not include any specific information pertaining to the tether. On 1/13/25, a care plan entitled, Resident has an impaired mood/psychiatric status related to visual and auditory hallucinations r/t (related to) Parkinson's Disease, Dementia with anxiety/depression/moods/behaviors (Initiated and Revised: 1/13/25). The care plan included the interventions: - Administer medications and treatments as ordered (Initiated: 1/13/25) - Behavioral health consults as needed (psycho-geriatric team, psychiatrist, etc.) (Initiated: 1/13/25) - Encourage on-going involvement with family and friend(s) (Initiated: 1/13/25) (Initiated: 1/13/25) A care plan entitled, Resident has behavior(s) related to hx (history) of sexual deviant behavior as evidenced by: Sexually inappropriate conversations with staff was initiated on 1/20/25. This care plan included the interventions: - Give non-judgmental support (Initiated: 1/20/25) - Observe and document episodes of inappropriate behaviors . (Initiated: 1/20/25) - Observe behavior episodes and attempt to determine underlying cause . (Initiated: 1/20/25) - Behavior: Sexually inappropriate conversations with staff. Intervention: Redirect conversation to socially appropriate content (Initiated and Revised: 1/20/25) - Male caregivers only for showers (Initiated and Revised: 1/20/25) Review of Resident #703's EMR revealed the following: (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 1/9/25 at 3:31 PM: Nursing Evaluation Summary . verbal report from (hospital) . RLE (Right Lower Extremity) 'tether'; do NOT remove per law enforcement . Speech deficit: stutters, slow to respond. HOH . No s/s (signs/symptoms) anxiety/depression. 3 MAX assist transfer. w/c (wheelchair) primary locomotion . - 1/10/25 at 12:40 PM: Initial Social Service History . Admission . Does the resident have a spouse or significant other? Yes . Ended in divorce, now won't speak to him .Recollection of relationship with children: 1 son doesn't consider him his dad at all . Behavior, Medical, and Psychiatric History . No major health occurrences or behavioral concerns . admitted on a psychoactive medication(s)? Yes . behaviors or mood disorders: Anxiety, depression, dementia . Things that make you become anxious/agitated: Ex-wife won't talk to him . Anticipated length of stay: Long Term Stay . The Trauma assessment within the admission assessment indicated the Resident did not have a diagnosis of Post-Traumatic Stress Disorder (PTSD) and/or a history of trauma. - 1/19/25: Progress Notes . seen for pain in low back and left side . Reports has chronic back pain and was on Norco (narcotic pain medication), MS (Morphine Sulfate- narcotic pain medication) continue in past. Unsure why med was discontinued. May have stopped when in prison . There was no documentation of completion of a criminal background check completed in the EMR. Review of the Michigan Sex Offender Registry and the Offender Tracking Information System ([NAME]) revealed Resident #703 was convicted of two separate counts of Criminal Sexual Conduct (CSC) in the second degree on 10/20/16. The Resident was sent to prison and discharged on [DATE]. Record review revealed Resident #703 was seen by a Behavioral Health Care Provider on 1/16/25. The Behavioral Health Care Provider note detailed, Initial evaluation: depression/ anxiety/ psychosis/ dementia; medication review . (Resident #703) admits to a long history of psychiatric illness . managed on multiple psychotropic medication . unsure of actual diagnosis' . (Resident #703) admits to being unhappy with situation . admits to hallucinations . Psych Exam . Judgement: Marginal . Insight: Marginal . Thought Process: Organized . Thought content: + auditory and visual hallucinations . Review of Point of Care (POC) task documentation in Resident #703's EMR revealed documentation of Sexually inappropriate conversations on 1/20/25 at 10:13 PM. An interview was conducted with Certified Nursing Assistant (CNA) A on 1/29/25 at 1:35 PM. When queried regarding Resident #703's behaviors, CNA A stated, (Resident #703 said) they raped their daughters. When queried regarding the context in which that was said, CNA A responded that the Resident had been telling the staff why they were in prison. CNA A verbalized staff were unaware that Resident #703 had been incarcerated and/or that they had a tether. When queried if the Resident had displayed any inappropriate behaviors at the facility, CNA A revealed the Resident called them pet names such as love and sweetheart and made them feel uncomfortable. CNA A revealed they looked the Resident up on the State Sex Offender website and were concerned that the information had not been passed on to staff. With further inquiry, CNA A verbalized they were concerned because there are children that visit the facility, and the Resident did not have a care plan in place to ensure increased supervision. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with the facility Administrator and Director of Nursing (DON) on 1/29/25. When queried regarding the facility admission process, including background check completion, the Administrator indicated admissions are screened in a central location for multiple facilities within the organization prior to the referral information being received at the facility. The Administrator verbalized that background checks are completed for residents prior to admission. When queried regarding Resident #703, the Administrator revealed they were aware the Resident had a history of CSC. When queried if other staff were aware, the Administrator responded that it had been discussed during the facilities morning meeting. The Administrator was asked who is included in the morning meeting and replied, Leadership. When queried why the care plan related to Resident #703 having sexual deviant behaviors was implemented on 1/20/25, the Administrator and DON relayed the Resident had verbalized inappropriate sexual comments to staff. The Administrator and DON were then asked why Resident #703 had a tether from law enforcement in place and what the conditions of the tether were, and both verbalized they did not know. With further inquiry, the Administrator and DON relayed that Resident #703 told staff they were in prison because they had sex with their stepdaughters, but they did any other information. When queried if they asked Resident #703 why they had a tether and/or the condition in place for the tether, both the DON and Administrator stated they had not. When asked how they comprehensively assessed and created a meaningful care plan for the Resident without knowing the Resident's history and current situation/needs, the DON confirmed they could not. When queried if children entered the facility, the Administrator confirmed school age children come to the facility as part of the Activities program. When asked if the facility had assessed and implemented interventions to ensure adequate supervision and monitoring of Resident #703 during times when children were in the facility, the Administrator and DON indicated the Resident had required significant assistance when they first arrived at the facility and had not attended activities. When asked about the Resident's current mobility and level of assistance required, the Administrator and DON revealed the Resident had made great improvements in therapy and were able to move around more independently now. When asked how the facility was ensuring adequate supervision of Resident #703 to ensure safety for staff, other residents, and visitors, the Administrator indicated they would need to reevaluate. No further explanation was provided. An interview was conducted with Resident #703 and the DON on 1/29/25. Resident #703 was asked why they had a tether in place and responded they were not sure. The Resident revealed the tether was put on when they got out of prison and their Probation Officer (PO) had replaced it several times. When asked, Resident #703 was unable to recall the full name of their PO. Resident #703 was asked if they were still on probation and did not provide a clear response. When queried regarding the conditions and reason for the tether, the Resident said they liked to bounce their granddaughters on their lap and indicated that was the reason had the tether. The Resident then expressed denial of any wrongdoing and blamed others for their conviction and imprisonment. Resident #703 became very sexually focused and began making statements regarding their daughter in laws sexual life and behaviors. The interview was concluded at this time. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	After exiting the Resident's room, a follow up interview was conducted with the DON. When queried, the DON confirmed Resident #703 made inappropriate sexual comments and was hyper sexually focused during the interview. When queried regarding Resident #703's behavioral history including what they stated during the interview and what they had told staff, the DON revealed they did not know what the crime and/or the Resident's behavioral history was. When queried if the mental health provider was aware of the Resident's history and tether when they evaluated Resident #703, the DON revealed the mental health provider seen the Resident for a medication evaluation. When queried how staff were able to meet Resident #703's needs and ensure safety of staff and visitors, when they did not know and had not comprehensively assessed the Resident, the DON verbalized agreement. Review of facility policy/procedure entitled, Behavior Management Program (Revised 10/27/23) did not address comprehensive assessment and care planning. Review of facility policy/procedure entitled, Baseline Care Plan (Reviewed/Revised: 12/28/23) revealed. The facility will develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care . The facility may develop a comprehensive care plan in place of the baseline care plan during the first 48 hours of admission .