

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235379	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/10/2024
NAME OF PROVIDER OR SUPPLIER Medilodge of Tawas City		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>22347</p> <p>This Citation pertains to Intake Number MI00146574.</p> <p>Based on observation, interview and record review, the facility failed to ensure that the A-Hall (the Memory Care/Dementia/Behavioral secured unit) eliminated lingering odors, resulting in unsanitary environment, lingering foul odors, angry staff, with the likelihood of embarrassment from residents and staff.</p> <p>Findings Include:</p> <p>Observation of A-Hall locked unit was done on 9/3/24 at 10:53 a.m. The carpet starting at the door down to the main dining/activity room had a very strong odor of urine.</p> <p>During an interview done on 9/4/24 at 10:10 a.m., Staff K stated You have to use hot water and disinfectant and it will deactivate the glue, it will be deactivated (carpet will come up). It was stained on the first day it was put down with (BM).</p> <p>During an interview done on 9/4/24 at 10:11 a.m., Housekeeper J said when they have to keep cleaning the carpet daily, it would take time away from their other housekeeping duties.</p> <p>During an interview done on 9/4/24 at 10:12 a.m., CNA L stated It makes no sense; it gets dirty daily. We have one resident who (BM's) on it and two that pee on it. We told them not to put carpet down before they did it.</p> <p>During an interview done on 9/4/24 at 10:50 a.m., the Director of Nursing stated, I don't agree with it (carpet down on a A-Hall, Memory Care/Dementia/Behavioral secured unit).</p> <p>During an interview done on 9/3/24 at 11:00 a.m., Nursing Assistant/CNA B stated It's the carpet that smell, they (resident's) pee on it.</p> <p>During an interview done on 9/10/24 at 11:45 a.m., Director of Housekeeping M stated It was a bad idea (putting carpet on A-Hall); I am going to have to use my carpet machine every morning.</p> <p>Review of the facility Safe and Homelike Policy dated 7/28/20, said the facility would minimize odors, and report lingering odors., and maintain a sanitary, and comfortable environment.</p>

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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<p>F 0636</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22927</p> <p>Based on observation, interview and record review, the facility failed to include a Post Traumatic Stress Disorder (PTSD) diagnosis in the comprehensive admission assessment noted on the CMS 802 form, dated 9/3/2024 and on 9/5/2024, for one resident (Resident #178) out of 19 residents reviewed for assessments, resulting in the likelihood for an inaccurate assessment of the resident's abilities, treatments and unmet needs.</p> <p>Findings include:</p> <p>Record review of the facility 'MDS (Minimum Data Set) 3.0 Policy' dated 1/24/2024 revealed it is the policy of the facility to utilize the Minimum Data Set (MDS) 3.0 Resident Assessment Instrument (RAI) Manual as the source document for any/all MDS scheduling, encoding, completion, submission, correction, and retention requirements as outlined in chapters 2 through 6 of the RAI manuals. Chapter 4: provides guidance on Care Area Assessment (CAA) triggers, completion requirements, and care plan development.</p> <p>Resident #178:</p> <p>Record review of Resident #178's referral packet paperwork dated 8/20/2024 (prior to admission) identified that the resident used home oxygen. Record review of the referral medical diagnosis included: Post Traumatic Stress Disorder (PTSD).</p> <p>Record review of Resident #178's electronic medical record revealed that the resident was admitted on [DATE] as a respite care admission for 10 to 16 days. Medical diagnosis included Chronic Obstructive Pulmonary Disease (COPD), dementia and Post Traumatic Stress Disorder (PTSD).</p> <p>Observation on 9/3/2024 at the beginning of the annual recertification survey revealed that Resident #178 was in a semi-private room and resided closest to the room door. Resident #178 was able to sit up on the edge of the bed and talk with the surveyor about his care.</p> <p>Record review on 09/04/24 at 02:10 PM of facility provided the CMS 802 form dated 9/3/2024 at 11:22 AM revealed for Resident #178 diagnosis of Post Traumatic Stress Disorder (PTSD) was not identified on the CMS 802 form.</p> <p>In an interview on 09/05/24 at 09:47 AM with Registered Nurse N the Minimum Data Set (MDS) assessment nurse stated that the MDS assessment starts with resident entry/upon arrival, and an admission within 19 days we do a 5 day. It captures the first 5 days of stay. Respite is the same way, His 5 day is due today 9/5/2024, when I finish it today, I'll bring it to you.</p> <p>Record review on 9/5/2024 at 10:29 AM of the newly provided CMS 802 form revealed that Resident #178 was identified for PTSD/trauma on the revised form.</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22927</p> <p>This Citation pertains to Intake Number MI00146574.</p> <p>Based on observation, interview and record review, the facility failed to develop a comprehensive and individualized care plan related to Resident #178 required oxygen therapy at bedtime and Activities of Daily Living (showers) of 19 residents reviewed, resulting in Resident #178 to have the likelihood of unmet needs.</p> <p>Findings include:</p> <p>Record review of the facility 'Admission to Facility' policy dated 1/1/2022 revealed that the primary purpose of our admission policies is to establish uniform guidelines for personnel to follow in admitting residents to the facility. Prior to or at the time of admission, the resident's attending physician must provide the facility with information needed for the immediate care of the resident . Care orders to maintain or improve the resident's function until the physician and care planning team can conduct a comprehensive assessment and develop a more detailed interdisciplinary care plan.</p> <p>Record review of the facility 'Oxygen Administration' policy dated 10/26/2023 revealed oxygen is administered to residents who need it, consistent with professional standards of practice, the comprehensive person-centered care plans, and the resident's goals and preferences. Compliance guidelines: Oxygen is administered under the orders of a physician . Staff shall document the initial and ongoing assessment of the resident's condition warranting oxygen and the response to oxygen therapy . The resident's care plan shall identify the interventions for oxygen therapy.</p> <p>Record review of the facility 'Activity of Daily Living (ADL)' policy dated 12/28/2023 revealed the facility takes measures to minimize the loss of residents functional abilities, including activities of daily living (ADL). Activities of daily living include the ability to: (1.) Bathe, dress and groom . A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene .The facility ,maintains individual objectives of the care plan through periodic review and evaluation.</p> <p>Resident #178:</p> <p>Record review of Resident #178's electronic medical record revealed that the resident was admitted on [DATE] as a respite care admission for 10 to 16 days. Medical diagnosis included Chronic Obstructive Pulmonary Disease (COPD), dementia and Post Traumatic Stress Disorder (PTSD).</p> <p>In an interview on 09/03/24 at 12:37 PM with Resident #178 revealed that he did not get a shower for over a week and that the showers are not at regular times.</p> <p>Record review on 09/04/24 at 12:19 PM Resident #178's Care plans pages 1 through 17 revealed that intervention for bathing initiated 8/27/2024 consisted of one person assist, twice weekly and as needed. There were no set days for showers in the care plan.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #178's Tasks: Showers/bathing Wednesday morning and Sunday evening. 30 days look back revealed resident was admitted on [DATE] and did not receive any bathing until 8/28/2024 consisting of a bed bath.</p> <p>Record review of Resident #178's referral packet paperwork dated 8/20/2024 (prior to admission) identified that the resident used home oxygen. Record review of the referral medical diagnosis included: Chronic Obstructive Pulmonary Disease (COPD) with home oxygen at 3 liters for nighttime use.</p> <p>Observation on 09/03/24 at 10:19 AM while in Resident #178's room revealed a concentrator to the head of the bed on the right-hand side with oxygen tubing dated and set at 3 liters of oxygen.</p> <p>Record review of Resident #178's physician order dated 8/27/2024 revealed Oxygen via nasal cannula at HS (bedtime) at 2 liters was ordered four days after admitted [DATE].</p> <p>Record review of Resident #178's Medication Administration Record (MAR) and Treatment Administration Record (TAR) for the month of August 2024 revealed on 8/27/2024 at 8:00 AM Oxygen via nasal cannula was administered.</p> <p>Record review on 9/3/2024 of Resident #178's care plans pages 1 through 17 revealed there was no oxygen therapy care plan or interventions for monitoring of nighttime oxygen saturation levels noted.</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22927</p> <p>This Citation pertains to Intake Numbers MI00146271 and MI00146574.</p> <p>Based on observation, interview and record review, the facility failed to provide assistance with Activities of Daily Living (ADL) care (showers, nail care, hair care, general hygiene) in a timely manner for six residents (#6, #25, #27, #29, #31, and #178) of 19 residents reviewed, resulting in a lack of hygiene with showers, nail care, hair washing, and general hygiene of six residents to have unmet needs, anger/frustration, embarrassment, and complaints.</p> <p>Findings include:</p> <p>Record review of the facility 'Activity of Daily Living (ADL)' policy dated 12/28/2023 revealed the facility takes measures to minimize the loss of resident's functional abilities, including Activities of Daily Living (ADL). Activities of Daily Living include the ability to: (1) Bathe, dress and groom . A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene .The facility, maintains individual objectives of the care plan through periodic review and evaluation.</p> <p>Resident #29:</p> <p>Record review of Resident #29's progress note dated 9/9/2024 at 3:37 PM noted: Resident is long term. Resident has long and short-term memory loss, he is legally blind, has some of his own teeth. Resident depends on staff for locomotion and is not an elopement risk. Resident needs assistance with his ADL (Activities of Daily Living). Resident uses a mechanical lift for transfers and a wheelchair for locomotion and mobility .</p> <p>Observation and interview on 09/03/24 at 01:21 PM with Resident #29 stated that he gets a shower or bath every couple of days or weeks he gets a shower. Observed of Resident #29 to be seated in a high back Broda chair in the library area of the facility with his hair to be sticking up at odd angles.</p> <p>Observation on 09/05/24 at 08:22 AM of Resident #29 to be seated up in high back Broda chair in the dining room seated at the assist dining table. The resident was assisted with the meal.</p> <p>Observation on 09/05/24 at 08:58 AM of Resident #29 to be seated in Broda chair in the library area with 9 other residents to watch funny videos on TV with no volume and then the Rise and Shine group activity was to begin. Resident noted to have his hair sticking up and appeared unkempt. Clothing was changed from the previous days' clothes.</p> <p>in an interview on 09/10/24 at 09:22 AM with Resident #29 stated that they don't do anything with him. No, he did not get his shower yesterday. He could not state why he did not get the shower.</p> <p>Record review of Resident #29's Task: Bathe/Showers 30 day look back revealed:</p> <p>8/15/2024 Response not required.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>8/15/2024 bed bath</p> <p>8/19/2024 Bed bath</p> <p>8/22/2024 Bed bath</p> <p>8/26/2025 shower</p> <p>8/29/2024 Response not required.</p> <p>9/2/2024 Response not required.</p> <p>9/5/2024 Response not required.</p> <p>9/9/2024 Response not required.</p> <p>Resident #178:</p> <p>Record review of Resident #178's electronic medical record revealed that the resident was admitted on [DATE] as a respite care admission for 10 to 16 days. Medical diagnosis included Chronic Obstructive Pulmonary Disease (COPD), dementia and Post Traumatic Stress Disorder (PTSD).</p> <p>In an interview on 09/03/24 at 12:37 PM with Resident #178 revealed that he did not get a shower for over a week and that the showers are not at regular times.</p> <p>Record review on 09/04/24 at 12:19 PM Resident #178's Care plans pages 1 through 17 revealed that intervention for bathing initiated 8/27/2024 consisted of one person assist, twice weekly and as needed. There were no set days for showers in the care plan.</p> <p>Record review of Resident #178's Tasks: Showers/bathing Wednesday morning and Sunday evening. 30 days look back revealed resident was admitted on [DATE] and did not receive any bathing until 8/28/2024 consisting of a bed bath.</p> <p>22347</p> <p>Resident #27:</p> <p>Review of Resident #27's electronic record including the Activity of Daily Living/ADL care plan, revealed diagnosis that included dementia and post traumatic stress. The resident required 24-hour supervision and assistance with all ADL's.</p> <p>Observation of Resident #27 was made on 9/4/24 at 10:50 a.m. The resident was sitting at the dining table on A-Hall having her nails done. The resident's hair was matted on the back and sides. It looked like it had not been combed at all. There were staff, activity aide and other residents in the room at the time. The resident was talking appropriately and showing no behavioral signs at the time.</p> <p>39059</p> <p>(continued on next page)</p>

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Resident #6:</p> <p>On 9/03/24, at 11:38 AM, Resident #6 was propelling in their wheelchair. Their face was unshaven.</p> <p>On 9/04/24, at 9:00 AM, a record review of Resident #6's electronic medical record revealed an admission on 06/22/2024 with diagnoses that included cognitive impairment, weakness and visual impairment. Resident #6 required assistance with all Activities of Daily Living (ADL's) and had impaired cognition.</p> <p>A review of the . ADL self-care performance deficit care plan . revealed . BATHING: 1 assist. Twice weekly and as needed. Date Initiated: 09/01/2023 . PERSONAL HYGIENE/ORAL CARE: Requires set up assist Date Initiated: 09/01/2023 .</p> <p>A review of the 30 day look back task list . Type of bath provided Shower . revealed the resident did not receive the twice weekly showers that were care planned and revealed the following:</p> <p>8/9/2024 The Shower column was check marked.</p> <p>8/16/2024 Response Not Required</p> <p>8/17/2024 The Shower column was check marked.</p> <p>On 9/04/24, at 9:58 AM, Resident #6 was up in their wheelchair and remained unshaven.</p> <p>Resident #25:</p> <p>On 9/03/24, at 10:17 AM, Resident #25 was in their room in their wheelchair. Their nails were long, unclipped and slightly jagged. Resident #25 was unshaven and offered, they shower themselves and cut their own nails.</p> <p>On 9/04/2024, at 9:30 AM, a record review of Resident #25's electronic medical record revealed an admission on 05/11/2023 with diagnoses that included Dementia, impaired vision and Parkinson's disease. Resident #25 required assistance with all ADL's and had impaired cognition.</p> <p>A review of the . ADL self-care performance deficit . care plan revealed . BATHING: 1 assist. Twice a week and as needed. Date Initiated: 06/11/2024 . PERSONAL HYGIENE/ORAL CARE: 1 person assist Date Initiated: 09/01/2023 .</p> <p>A review of the 30 day look back task list . Type of bath provided Shower . revealed the resident did not receive the twice weekly showers that were care planned and revealed the following:</p> <p>8/23/2024 Shower was check marked.</p> <p>8/30/2024 Response Not Required</p> <p>8/31/2024 Shower was check marked.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 9/04/24, at 10:00 AM, Resident #25 was sitting in their wheelchair and their nails remained unclipped.</p> <p>Resident #31:</p> <p>On 9/03/24, at 12:56 PM, Resident #31 was sitting in their room. Resident #31 was unshaven.</p> <p>On 9/03/24, at 3:20 PM, a record review of Resident #31's electronic medical record revealed and admission on 11/11/2022 with diagnoses that included Schizophrenia, weakness and failure to thrive. Resident #31 required assistance with ADL's and had intact cognition.</p> <p>A review of the ADL self-care performance deficit revealed . PERSONAL HYGIENE: 1 assist Date Initiated: 09/29/2023 .</p> <p>On 9/04/24, at 10:08 AM, Resident #31 was in their room. Family member was present and complained that the resident can't use their left hand. Family member further complained that hygiene is very important. Family member complained they are supposed to make sure he has his splint on but the use the excuse, he refuses.</p>

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22927</p> <p>This Citation pertains to Intake Number MI00146574.</p> <p>Based on observation, interview and record review, the facility failed to order and ensure the administration of oxygen at bedtime for one resident (Resident #178) out of 2 residents reviewed, resulting in the likelihood for oxygen desaturation at nighttime, confusion, and shortness of breath/hypoxia.</p> <p>Findings include:</p> <p>Record review of the facility 'Oxygen Safety' policy dated 1/1/2022, revealed the facility is to provide a safe environment for residents, staff and public. licensed staff using oxygen equipment will be trained in its operation.</p> <p>Record review of the facility 'Oxygen Administration' policy dated 10/26/2023 revealed oxygen is administered to residents who need it, consistent with professional standards of practice, the comprehensive person-centered care plans, and the resident's goals and preferences. Oxygen therapy is the administration of oxygen at concentrations greater than that in ambient air with intent of treating or preventing the symptoms and manifestations of hypoxia. Compliance guidelines: Oxygen is administered under the orders of a physician . Staff shall document the initial and ongoing assessment of the resident's condition warranting oxygen and the response to oxygen therapy . The resident's care plan shall identify the interventions for oxygen therapy.</p> <p>Resident #178:</p> <p>Record review of Resident #178's referral packet paperwork dated 8/20/2024 (prior to admission) identified that the resident used home oxygen. Record review of the referral medical diagnosis included: Chronic Obstructive Pulmonary Disease (COPD) with home oxygen at 3 liters for nighttime use.</p> <p>In an interview on 09/03/24 at 10:19 AM with Resident #178 stated the use of Oxygen at times and use's 3 liters. Resident #178 stated using (oxygen) it all the time at night, because oxygen level drops off at night. Resident #178 stated was in the hospital when they found that (resident) dropped oxygen levels, they shook him and shook him till he woke-up. When I first came to the home (facility), I told them I needed oxygen at night.</p> <p>Observation on 09/03/24 at 10:19 AM while in Resident #178's room revealed a concentrator to the head of the bed on the right-hand side with oxygen tubing dated and set at 3 liters of oxygen.</p> <p>Record review of Resident #178's physician order dated 8/27/2024 revealed Oxygen via nasal cannula at HS (bedtime) at 2 liters was ordered four days after admitted [DATE].</p> <p>Record review of Resident #178's Medication Administration Record (MAR) and Treatment Administration Record (TAR) for the month of August 2024 revealed on 8/27/2024 at 8:00 AM Oxygen via nasal cannula was administered.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review on 9/3/2024 of Resident #178's care plans pages 1 through 17 revealed there was no oxygen therapy care plan or interventions for monitoring of nighttime oxygen saturation levels noted.</p> <p>In an interview on 09/05/24 at 11:09 AM with Licensed Practical Nurse (LPN) I the A-hall Unit manager, revealed that the floor nurse input the referral orders into the computer. the referral process is being updated; I review all the admission orders. Referrals are reviewed by the Director of Nursing (DON), and she accepts or declines the referrals. Resident #178 has oxygen in his room, and he will tell you that he uses it when he needs it usually at night. Record review of Resident #178's medical record revealed admitted on [DATE] and had no oxygen to use until 8/27/2024, (4 days and nights) without oxygen.</p> <p>In an interview on 09/05/24 at 11:47 AM with the Director of Nursing (DON) revealed admission referral paperwork are reviewed by central intake office and then sent to the facility, were she looks at the referral and decides what room is appropriate for the resident. Resident #178's home oxygen was missed. The daughter brought him in here, he walked using his cane with no oxygen. His room was not dirty, it had just been cleaned, we had 2 residents that were discharged from that room and the room was cleaned. He was the only person originally until the roommate came. There was nothing said about a private room by resident or family. Air conditioning- comes from the ceiling in the hallways. Oxygen was administered on 8/27/2024 evening per order.</p>		

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NAME OF PROVIDER OR SUPPLIER Medilodge of Tawas City		STREET ADDRESS, CITY, STATE, ZIP CODE 400 North Street West Tawas City, MI 48763	
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>22347</p> <p>Based on observation, interview and record review, the facility failed to ensure that three medication carts and one treatment cart were clean and sanitary of 5 medication carts and 2 treatment carts, resulting in the unsanitary condition of medication carts, cross contamination, and the unaccounted for loss of 1 medication.</p> <p>Findings Include:</p> <p>Observation of medication cart C and cart D was done on 9/3/24 at 9:48 a.m. and at 9:55 a.m., accompanied by Nurse, LPN J.</p> <p>During observation of medication cart C, drawers second and third were noted to have crushed medications and papers in the back of the drawers.</p> <p>During observation of medication cart D, the second drawer had white crushed medications and papers in the back of the drawer.</p> <p>During an interview done on 9/3/24 at 9:55 a.m., Nurse J stated Night's cleans it (6:00 p.m. to 6:00 a.m., cleans medication carts).</p> <p>During observation of the treatment cart for C and D hall done on 9/3/24 at 10:03 a.m., accompanied by Nurse J, a large container of ketoconazole shampoo was found to have an excessive amount of dried shampoo drippings on the sides and top.</p> <p>Observation of medication cart A back done on 9/3/24 at 10:48 a.m., and cart A front was done on 9/3/24 at approximately 11:40 a.m., accompanied by Nurse, LPN I.</p> <p>During observation of medication cart A back done on 9/3/24 at 10:48 a.m., revealed</p> <p>In the second and third drawers, crushed medications, papers and white sprinkles (medication) on the bottom of the drawers.</p> <p>During observation of medication cart A front done on 9/3/24 at approximately 11:40 a.m., revealed the second drawer had an orange-colored loose pill in the back of the drawer.</p> <p>During an interview done on 9/3/24 at 10:48 a.m., Nurse I revealed the night shift was supposed to clean the medication carts.</p> <p>Review of the facility Medication Storage policy dated 10/30/2020, stated It is the policy of this facility to ensure all medications housed on our premises will be stored according to the manufacturer's recommendations and sufficient to ensure proper sanitation, temperature, light, ventilation, moisture control, segregation, and security.</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>39059</p> <p>Based on observation, interview and record review, the facility failed to provide palatable meals for four residents (Resident #7, Resident #9, Resident #36, Resident #57) of 30 residents reviewed for the dining task, resulting in complaints of dried food items and soggy bread with the likelihood of decreased food consumption.</p> <p>Findings include.</p> <p>On 9/03/24, at 12:58 PM, Resident #36 complained they had to cut the top off the sweet potato because it was too dry to eat and was only able to eat the inside.</p> <p>On 9/03/24, at 1:16 PM, Resident #57 was in their room with their lunch meal which consisted of ham, bread, cauliflower and half of a yam potato. Resident #57 complained they had to cut off the dried top of the yam that was dried and crusted. Resident #57 picked up their bread which was soggy from the ham juice.</p> <p>On 9/03/24, at 1:38 PM, Certified Dietary Manager (CDM) A was interviewed regarding the provided lunch meal. CDM A was asked to explain how the yam was cooked and CDM A offered they cut in half and baked it. CDM A was asked if they used any butter or oil to keep it moist and CDM A no, we just cut it in half and put it in the oven. CDM A was asked how they serve bread and butter and CDM A stated, they put it on the plate.</p> <p>On 9/03/24, at 2:05 PM, Resident #9 complained the yam provided at lunch was too dry to eat.</p> <p>On 9/03/24, at 2:15 PM, Resident # 7 complained the potato served for lunch was too dry.</p> <p>On 9/4/24, at 12:45 PM, Resident #36 was eating in their lunch. They complained they could only eat 1 half of buttered bread as the other half was soggy from the baked beans the bread was sitting on.</p>		

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<p>F 0806</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options.</p> <p>39059</p> <p>Based on observation, interview and record review, the facility failed to follow food preferences and food dislikes for two residents (Resident #31, Resident #57) of 2 residents reviewed for preferences and food dislikes, resulting in decreased food intake, and frustration with the possibility of hunger.</p> <p>Findings include:</p> <p>On 9/03/24, at 12:56 PM, Resident #31 was in their room with their lunch meal. Their meal ticket had tomato soup and grilled cheese on it. Resident #31 complained they didn't get those items and could only eat the ham with mustard. There was no mustard provided.</p> <p>On 9/03/24, at 1:16 PM, Resident #57 was in their room with their lunch meal which consisted of ham, bread, cauliflower and half of a yam potato.</p> <p>A record review of their meal ticket which revealed cottage cheese written on it. There was no cottage cheese provided. Resident #57 offered, no, I didn't get any cottage cheese.</p> <p>On 9/03/24, at 1:38 PM, A record review along with CDM A of Resident #31's meal ticket along was conducted which revealed grilled cheese and tomato soup typed on it. CDM A offered, they get what's on the menu plus the extra items and that it was a standing order so they should have gotten them.</p> <p>A record review of Resident #57's meal ticket along with CDM A was conducted which revealed cottage cheese circled. CDM A was asked what that meant and CDM A offered, they get what's on the menu plus the extra circled items. CDM A was alerted, the cottage cheese, grilled cheese and tomato soup was not provided for the two residents and CDM A offered, they ran out of cottage but the grilled cheese and tomato soup should have been provided. CDM A was asked why the facility ran out of cottage cheese and CDM A offered, Sysco was out of stock. CDM A was asked if they could have gone to the local grocery stores for cottage cheese and CDM A offered, they were cooking and couldn't go.</p> <p>On 09/05/24, at 9:00 AM, Resident #31 was in their room. Their breakfast meal was still at their bedside. The plate had scrambled eggs that were untouched. Resident #31 was asked why they didn't eat the eggs and Resident #31 stated, I don't like eggs.</p> <p>A record review of the breakfast meal ticket revealed Dislikes Eggs.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22347</p> <p>Based on observation, interview and record review, the facility failed to ensure a clean and sanitary kitchen, serve food sanitarily and discard expired foods for a census of 71 residents who consume food from the kitchen, resulting in the likelihood for food borne illness with possible hospitalization .</p> <p>Findings Include:</p> <p>Review of the U.S. Public Health Service 2009 Food Code, as adopted by the Michigan Food Law, effective [DATE], revealed all potentially hazardous foods must have an open and use-by date. The food items must be disposed of on or after the use-by date.</p> <p>During the initial kitchen walk through done on [DATE] at 10:30 a.m., accompanied by Registered Dietitian A, the following concerns were observed:</p> <p>Kitchen initial tour:</p> <p>On [DATE] starting at 10:15 a.m., the initial tour of the kitchen accompanied by Registered Dietitian/RD A the following observations were made:</p> <p>-At 10:16 a.m., in the middle refrigerator was found sliced ham with the open date of [DATE], and the use-by date of [DATE]; it was past it's use-by date (unsafe).</p> <p>-At 10:17 a.m., in the middle refrigerator was found lettuce dated ,d+[DATE], with a use-by of ,d+[DATE].</p> <p>-At 10:18 a.m., 3 clean and ready for use small plastic bowels with dried food particles inside were found.</p> <p>During an interview done on [DATE] at 10:18 a.m., RD A stated we will wash them.</p> <p>-At 10:27 a.m., 1 clean and ready for use plastic coffee cup was found with dried on food particles inside.</p> <p>-At 10:30 a.m., 4 white plates were found on the plate warmer, clean and ready for use with dried food particles on them.</p> <p>During an interview done on [DATE] at 10:32 a.m., RD A informed this surveyor that they did not have enough staff, they were short.</p> <p>39059</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On [DATE], at 12:13 PM, During dining task, Dietary [NAME] O was observed with gloved hands which were resting on their bilateral hips. Dietary [NAME] O walked to the serving line and began to serve the lunch meal with no hand hygiene performed. Dietary [NAME] O picked up butter bread with their gloved hands and placed the bread directly on the plate.</p> <p>On [DATE], at 12:30 PM, Infection Control (IC) Nurse P was alerted of the observation of the Dietary [NAME] P not performing hand hygiene and serving lunch with dirty gloves. IC Nurse P planned to provide education.</p>		