

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235410	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/23/2024
NAME OF PROVIDER OR SUPPLIER Medilodge of Munising		STREET ADDRESS, CITY, STATE, ZIP CODE 300 W City Park Dr Munising, MI 49862	

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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49735</p> <p>This citation pertains to MI00145704 and MI00145755</p> <p>Based on interview and record review, the facility failed to investigate the root cause of injuries to three Residents (#5, #3, and #4) of three residents reviewed for resident safety/falls.</p> <p>Findings include:</p> <p>Resident #5 (R5)</p> <p>Review of R5's Minimum Data Set (MDS) assessment dated [DATE], revealed an admission to the facility on [DATE], with active diagnoses that included: cancer, anemia, hypertension, and renal insufficiency/renal failure/end stage renal disease. R5 scored a 2 of 15 on the Brief Interview for Mental Status (BIMS) assessment reflective of severe cognitive impairment.</p> <p>Review of R5's Incident report dated 6/29/24 revealed that R5 was found lying on her back on the bathroom floor in front of the toilet R5 was unable to give a description of incident. R5 was sent to the emergency room (ER) for x-ray of left hip/pelvis. The result of the x-ray revealed a left trochanter (hip) fracture.</p> <p>During an interview on 7/23/24 at 3:30 p.m., the Director of Nursing (DON) would not answer when queried about the root cause analysis of the fall. The DON would not answer when queried about the interventions or revisions to R5's care plan.</p> <p>Review of R5's care plan revealed no assessments for pain, no interventions for care following fractured left hip, nor interventions/revisions to minimize risks or hazards associated with falls.</p> <p>Resident #3 (R3)</p> <p>Review of R3's MDS assessment dated [DATE], revealed admission to the facility on [DATE], with active diagnoses that included: dementia, anxiety disorder, depression, and hypertension. R3 scored a 4 of 15 on the BIMS assessment reflective of severe cognitive impairment.</p> <p>Review of R3's Incident report dated 3/1/24 revealed that Certified Nursing Assistant (CNA) and R3 were in bathroom and R3 stopped standing. CNA helped R3 to the floor.</p> <p>(continued on next page)</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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 7/23/24 at 2:28 p.m., the DON acknowledge that a root cause analysis of the fall on 3/1/24 was not completed and there were no interventions or revisions to R3's care plan. The DON stated, the care plan is not up to date.</p> <p>Review of R3's Incident report dated 7/7/24 revealed that R3 was found on the floor on the far side of the bed and was lying on right side with a bloody nose. R3 had a hematoma (collection of blood that pools outside of a blood vessel) above the right eye, developed black eyes, and R3's nose was crooked. R3 was sent to the hospital for a Computer Axial Tomography (CAT) scan. The results of the CAT scan revealed a nasal bone fracture.</p> <p>During an interview on 7/23/24 at 2:28 p.m , the DON acknowledged that a root cause analysis was not completed for the fall on 7/7/23. The DON said that no approaches were added to the fall care plan and the care plan should have been updated.</p> <p>Review of R3's care plan revealed no interventions or assessments for pain or interventions/revisions to minimize risks or hazards associated with falls.</p> <p>Resident #4 (R4)</p> <p>Review of R4's MDS assessment dated [DATE], revealed admission to the facility on [DATE] with active diagnoses that included: traumatic brain injury, seizure disorder/epilepsy, dementia, and hypertension. R4 scored a 3 of 15 on the BIMS assessment reflective of severe cognitive impairment.</p> <p>Review of R4's incident report dated 2/16/24 revealed that R4 was found sitting on the floor next to the bed. R4 was able to straighten legs, extend arms, and denied pain.</p> <p>During and interview on 7/23/24 at 3:37 p.m., the DON acknowledged there was nothing in the care plan regarding the fall and a root cause analysis for the fall was not completed.</p> <p>Review of R4's incident report dated 6/3/24 revealed that R4 was observed on the floor near the nurse station and had a laceration about the right eye. The laceration required steri-strips (adhesive wound closure strips) and R3 was not sent to the hospital.</p> <p>During an interview on 7/23/24 at 3:37 p.m., the DON said I am not seeing a root cause analysis for the fall, and I can't tell if the care plan was updated.</p> <p>Review of R4's care plan revealed no interventions for care regarding the laceration above R4's right eye and no interventions or revisions to minimize the risks or hazards associated with falls.</p> <p>Review of facility policy titled Falls-Clinical Protocol last revised . dated 11/2/23, read in part . interventions should be developed and implemented per the assessed needs . determine if there are new or additional risk factors and address as appropriate .and update the plan of care with the new or revised interventions.</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49735</p> <p>This citation pertains to MI00145314 and MI00145704</p> <p>Based on observation, interview, and record review the facility failed to ensure adequate numbers of staff to meet the needs of four Residents (#1, #3, #7, and #11) of four residents sampled for sufficient staffing. This deficient practice resulted in the potential for a decline in resident quality of life and/or quality of care, not receiving medications timely, and unmet care needs for all seventy-seven residents. Findings include:</p> <p>Resident #11 (R11)</p> <p>Review of R11's Minimum Data Set (MDS) assessment, dated 7/1/24 revealed admission to the facility on [DATE], with active diagnoses that included: coronary artery disease, heart failure, hypertension, anxiety disorder, and depression. R11 scored a 15 of 15 on the Brief Interview of Mental Status (BIMS) assessment reflective of intact cognition.</p> <p>During an interview on 7/23/24 at 1:40 p.m., R11 stated I am on water pills twice a day .I turned my light on one night I waited and waited, and no one came . I peed the bed because there is no help .they didn't come fast enough . I felt horrible and embarrassed but what was I supposed to do . I don't get my medications on time and wait half the day to get them I am not able to go to activities on the weekend as there is only one staff on and I am not able to get up . It takes 2 people to take care of me sometimes and they can't help me with the lack of staff.</p> <p>Resident #7 (R7)</p> <p>Review of R7's MDS assessment, dated 6/18/24 revealed admission to the facility on [DATE], with active diagnoses that included: hypertension, diabetes mellitus, paraplegia, anxiety disorder, and post traumatic stress disorder (PTSD). R7 scored a 15 of 15 on the BIMS assessment reflective of intact cognition.</p> <p>During an interview on 7/23/24 at 8:52 a.m., R7 stated the facility is understaffed .there is not enough .I have to wait a long time to get help.</p> <p>Resident #1 (R1)</p> <p>Review of R1's MDS assessment, dated 6/9/24 revealed admission to the facility on [DATE], with active diagnoses that included: anxiety, depression, anemia, and hyperlipidemia. R1 scored a 15 of 15 on the BIMS assessment reflective of intact cognition.</p> <p>During an interview on 7/22/24 at 1:19 p.m., R1 stated There is not enough staff here, sometimes only one or two at night . you can't get help . The facility needs to do something but all they care about is money.</p> <p>Resident #3 (R3)</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Review of R3's MDS assessment, dated 5/25/24 revealed admission to the facility on [DATE], with active diagnoses that included: dementia, anxiety disorder, depression, and hypertension. R3 scored a 4 of 15 on the BIMS assessment reflective of severe cognitive impairment.</p> <p>During a phone interview on 7/22/24 at 2:00 p.m., Durable Power of Attorney (DPOA) L stated One Saturday not too long ago there was only one aide working and R3 was soaked with urine .they do not have enough staff.</p> <p>During an interview on 7/22/24 at approximately 2:15 p.m., Certified Nursing Assistant (CNA) G stated, I have 27 residents and I am stressed and I don't mean to cry but I am by myself .This past Thursday I was by myself and then mandated to stay over and I was by myself for 15 hours .I feel alone.</p> <p>During an interview on 7/22/24 at 3:22 p.m., CNA G stated there are 6 people who need 2 people to transfer . when I don't have someone to help me I do it myself .I cant see having people sit in there urine or feces or have to be in bed all day .I don't want to get into trouble .When I helped a resident that needed 2 CNA's I wiped her the best I could but I couldn't get her over enough to do a good job .I have not gotten people up because I cant get my work done .I cant give them showers when I am by myself .so I don't do them as I can't leave my hallway.</p> <p>During an interview on 7/23/24 at 12:09 p.m., CNA H stated I have cried five times today .I just don't feel like I can take care of the residents like they need to be .there should be two CNA's on this wing and I am by myself. They say there are six CNA's today, but one person didn't show up. I wish I could help the residents more .the lights are on, and I can't be everywhere.</p> <p>During an interview on 7/23/24 at 7:33 a.m., Admissions/CNA scheduler B stated I schedule CNA staff on 6 a. m.-2 p.m. shift on a ratio of 1 CNA to 8 residents, 2 p.m.-10 p.m. shift using a ratio of 1 CNA to 10 residents, and the 10 p.m.-6 a.m. shift using a ratio of 1 CNA to 12 residents.</p> <p>Review of Direct Care Staffing Hours for CNA's revealed the number of CNA's per shift:</p> <p>7/22/24 - 6 a.m.-2 p.m. shift there were 4 1/2 CNA's, 2 p.m.-10 p.m. there were 4 1/2 CNA's and 10 p.m.-6 a. m. there were 4 CNA's, to care for 77 residents.</p> <p>7/20/24 - 6 a.m.-2 p.m. shift there were 5 CNA's, 2 p.m.-10 p.m. shift there were 5 CNA's, and 10 p.m.-6 a.m. shift there were 3 CNA's, to care for 76 residents.</p> <p>7/19/24 - 6 a.m.-2 p.m. shift there were 5 CNA's, 2 p.m.-10 p.m. shift there were 5 CNA's, and 10 p.m.-6 a.m. shift there were 4 CNA's, to care for 74 residents.</p> <p>7/18/24 - 6 a.m.-2 p.m. shift there were 4 1/2 CNA's, 2 p.m.-10 p.m. shift there were 3 CNA's, and 10 p.m.-6 a.m. shift there were 2 CNA's, to care for 72 residents.</p> <p>6/28/24 - 6 a.m.-2 p.m. shift there were 5 CNA's, 2 p.m.-10 p.m. shift there were 5 CNA's, and 10 p.m.-6 a.m. shift there were 3 CNA's to care for 73 residents.</p> <p>6/18/24 - 6 a.m.-2 p.m. shift there were 6 CNA's, 2 p.m.-10 p.m. shift there were 6 CNA's and 10 p.m.-6 a.m. shift there were 4 CNA's to care for 76 residents.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Review of the facility policy titled Emergency Staffing, date implemented 7/1/21 read in part .the number of staff required for meeting resident needs on a daily basis are determined through the facility assessment.</p> <p>Review of the Facility Assessment (FA) Tool for the facility, dated 11/2022 through 10/2023 provided to this surveyor does not indicate the number of staff required for meeting resident needs on a daily basis.</p>		

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<p>F 0732</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Post nurse staffing information every day.</p> <p>49735</p> <p>This citation pertains to MI00145314 and MI00145704</p> <p>Based on observation, interview, and record review, the facility failed to complete and post the daily nurse staffing information. This deficient practice resulted in the inability of residents and visitors to determine the number of staff available to provide resident care and had the potential to affect all 77 residents in the facility. Findings include:</p> <p>During an interview on 7/22/24 at 2:50 p.m., the Nursing Home Administrator ((NHA) was asked where the daily staffing posting was located. The NHA stated I don't know.</p> <p>During an observation on 7/22/24 at 3:15 p.m., the Regional Director of Clinical Services K was filling out the daily nursing staffing sheet for 7/22/24 and asked the staff at the nurses station to post the staffing sheet for 7/22/24 on the wall near the nurses station located near the entrance of the facility.</p> <p>A review of the direct care staffing hours (nursing staffing sheets) on 7/22/24 revealed no staffing information for day shift or afternoon shift on 7/13/24, 7/11/24, 6/23/24, 6/15/24, and 6/10/24.</p> <p>During an interview on 7/22/24 at approximately 4:30 p.m., the NHA acknowledged the daily nurse staffing sheet was not posted at the beginning of the shift.</p> <p>During an interview on 7/23/24 at 9:16 a.m., the DON acknowledged that the nursing staffing information is supposed to be posted daily by the nurses station located near the entrance of the facility.</p>

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<p>F 0745</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide medically-related social services to help each resident achieve the highest possible quality of life.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49735</p> <p>This citation pertains to MI00145723</p> <p>Based on observation, interview and record review, the facility failed to provide adequate medically-related social services to one Resident #2 (R2) of one resident reviewed for social services care. This deficient practice resulted in the potential for psychosocial decline. Findings include:</p> <p>Resident #2 (R2)</p> <p>Review of R2's Minimum Data Set (MDS) assessment dated [DATE], revealed admission to the facility on [DATE], with active diagnoses that included: multiple sclerosis, depression, legal blindness, and neurogenic bladder. R2's MDS assessment revealed R2 is understood and understands and has clear comprehension.</p> <p>Review of a Facility Reported Incident revealed on 7/9/24 at 9:50 a.m., R2 was yelled at and cursed at by another resident when he was looking for his room.</p> <p>During an interview on 7/23/24 at 9:38 a.m., R2 revealed I was pretty upset when it happened .I was pretty worried about what could happen to me .the staff talked to me about it initially, but they haven't talked to me in quite a while .they offered for me to move to another room but it throws me off to move as I am legally blind . I just want to keep my area the same as I can get around easier.</p> <p>During an interview on 7/23/24 at 10:17 a.m., Social Services Designee (SSD) A stated I haven't talked with R2 about the incident since it happened . I did not add anything to the care plan regarding the incident .I did not do any trauma assessment. Social Services Designee A stated I do not see any interventions in the care plan for R2 and someone should have added something to the care plan.</p> <p>Review of facility policy titled Social Services date implemented 10/18/20, read in part ., the facility .will provide medically related social services to each resident, to attain or maintain the residents highest practicable physical, mental, and psychosocial well-being .providing or arranging for needed mental and psychosocial counseling services . meeting the needs of residents who are .coping with stressful events.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49735</p> <p>This citation pertains to MI00145314</p> <p>Based on observation, interview, and record review the facility failed to</p> <ol style="list-style-type: none"> 1. Provide Personal Protective Equipment (PPE) that was readily available for staff 2. Don PPE prior to entering a transmission-based precaution room. This deficient practice resulted in the potential for contamination and the spread of illness to residents and staff. Findings include: <p>During an observation on 7/22/24 at approximately 12:45 p.m., the following resident rooms had signage regarding Transmission Based Precautions (TBP) related to active COVID-19 infection: 109, 110, 204, 206, 209, 210, and 214.</p> <p>During an observation on 7/22/24 at approximately 1:00 p.m., Licensed Practical Nurse (LPN) J entered a room of a resident on Transmission Based Precautions (TBP) with a gown, gloves, and a surgical mask. LPN J came out of the resident's room with the surgical mask around her ears and the mask pulled down under the chin.</p> <p>During an observation on 7/22/24 at 1:04 p.m., LPN J entered the same resident's room without wearing any PPE.</p> <p>During an observation on 7/22/24 at 1:28 p.m., Social Services Designee (SSD) A entered a residents room on TBP without donning any PPE. SSD A came out of room [ROOM NUMBER] with water mugs and placed them on a cart, grabbed another water mug, and entered another room to pass water to a resident in room [ROOM NUMBER] with TBP without donning PPE.</p> <p>During a phone interview on 7/22/24 at 2:00 p.m., the Durable Power of Attorney (DPOA) L stated No one wears a mask .my [confidential resident] is under quarantine. And this is day 8 without any masking and no staff were gowning up . I have been sitting with [confidential resident] without a mask .this was the first day they said I should wear one but it is at my discretion. I don't know why I have not been encouraged to wear one before .today a nurse told me that they did not have any masks available and then all of a sudden, they are wearing them.</p> <p>During an interview on 7/22/24 at approximately 2:15 p.m., Certified Nurses Assistant (CNA) F stated We do not have enough PPE supplies .especially on the weekends . it has been very hard .the PPE for Enhanced Barrier Precautions (EBP) is supposed to be in the residents' rooms but that doesn't always happen.</p> <p>During an interview on 7/22/24 at 2:20 p.m., CNA G stated I have been looking for PPE and I have to look around before I go in rooms . I had to look for masks this morning and we don't have anymore.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During an observation on 7/22/24 at 2:24 p.m., A PPE supply cart had one gown left on the 200 wing with no N95's available. A second PPE cart on the 200 wing had no face shields and no N95's available. A third PPE cart on the 200 wing had no gowns or N95's available. A PPE cart on 100 wing did not have gowns or N95's available. A second cart on 100 wing did not have any face shields or N95's available.</p> <p>During an interview on 7/22/24 at 2:25 p.m., Registered Nurse (RN) H stated We are really not using PPE because we don't have any .we have told the Director of Nursing (DON) but nothing gets done .we wear gloves for EBP as it is the best we can do.</p> <p>An interview on 7/22/24 at 2:50 p.m., with the Nursing Home Administrator (NHA) and Regional Director of Clinical Services (RDCS) K revealed the following regarding PPE use. Regional Director of Clinical Services K stated we follow the guidance of the CDC and use gowns, face shields, N95's and gloves with residents that have COVID.</p> <p>A review of the facility policy titled COVID-19 Prevention, Response, and Reporting date implemented 8/20/20, read in part . it is the policy of this facility to ensure that appropriate interventions are implemented to prevent the spread of COVID-19 .HCP (health-care personnel) who enter the room of a resident with suspected or confirmed SARS-CoV-2(COVID) infection should adhere to standard precautions and use a NIOSH (National Institute for Occupational Safety and Health)-approved particulate respirator with N95 filters or higher, gown, gloves, and eye protection.</p> <p>A review of the facility policy titled Personal Protective Equipment date implemented 7/28/20, read in part . the central supply clerk is responsible for ordering and maintaining adequate PPE supplies and stocking in appropriate facility locations to ensure access to staff who need them .</p>		