

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 01/29/2025
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 0624</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Prepare residents for a safe transfer or discharge from the nursing home.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35981</p> <p>This citation pertains to Intake #MI00149352.</p> <p>Based on interview and record review the facility failed to implement and follow their policy to ensure a safe and orderly discharge was provided for 1 Resident (#2) of 2 residents reviewed for discharge/transfers. This deficient practice resulted in an involuntary discharged into the community without sufficient preparation and orientation with the potential to disrupt the necessary care and services and the potential for homelessness.</p> <p>Findings include:</p> <p>Resident #2 (R2)</p> <p>Review of an Admission Record revealed R2 was originally admitted to the facility on [DATE] with pertinent diagnoses which included: type 2 diabetes. Review of a Minimum Data Set (MDS) assessment for R2 with a reference date of 12/17/24 revealed a Brief Interview for Mental Status (BIMS) score of 15/15 which indicated R2 was cognitively intact.</p> <p>Review of a State Agency-Complaint Intake dated 1/7/2025 from Confidential Informant (CI) U revealed: CI U stated R2 left the facility on [DATE] to travel to Texas to visit family for a vacation and confirmed with the Business Office Manager (BOM) there would be no issue with returning to the facility because R2 was self-pay. CI U stated acting Nursing Home Administrator (NHA) Regional Director of Operations (RDO) [Staff] T called R2 and informed him he would not be able to return to the facility due to his bill and was officially discharged on [DATE] when R2 left for Texas. CI U stated he was discharged without any discharge paperwork or medications. CI U stated it took a week of calling the facility before R2 was able to contact a nurse to get his medications called into a local pharmacy, and indicated R2 was beginning to feel ill without having his medications for a week.</p> <p>The Electronic Medical Record (EMR) revealed the facility initiated a Notice of Involuntary discharge which was served to R2 on 10/15/24, indicating there was no longer a need for services provided by the facility and for non-payment of services. A progress noted date 10/15/24 indicated this notice was provide to the resident, physician, and state Ombudsman.</p> <p>Review of the EMR revealed multiple progress notes indicating R2 had problems with cellulitis of the lower extremities which required multiple rounds of antibiotics and wound care.</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 0624</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Email correspondence between the Previous NHA (S), Staff T and the facility's legal department dated 11/15/24 revealed NHA S communicated the facility had lost the Involuntary Discharge appeal. The facility legal department then responded to NHA S on 11/18/24, that the facility had failed to provide sufficient evidence to support the Involuntary Discharge and advised to start the process over.</p> <p>The EMR for R2 revealed a progress note dated 12/14/24 indicating the physician approved the resident to be on a leave of absence on vacation to (Out of State) from 12/17/24-12/30/24 and medications were called into his pharmacy so R2 could take his medications with him.</p> <p>An EMR progress note written by Staff T, dated 12/27/24, subsequently indicated R2 was discharged from the facility because he was private pay and did not wish to hold a bed at the facility while he was on vacation. The facility indicated R2 did not wish to consider it a therapeutic leave but rather a discharge. According to this note R2 was educated, to come back to the facility there would have to be readmit orders obtained from a physician. However, Staff T wrote this note 10 days after R2 had left the facility indicating these actions were not completed prior to the LOA. Staff T was unable to provide documentation to show R2 was educated and provided with appropriate follow-up and discharge instructions to ensure continuity of care was provided.</p> <p>On 1/30/25 at 1:15 PM., during an interview, CI V reported R2 left for a pre-approved (LOA) vacation to Texas on 12/17/24 and indicated while R2 was gone, he was somehow discharged . CI V reported R2 had planned on returning at the end of the month (December 2024), and he had been planning on looking at apartments and/or other living arrangements after his return. CI V reported R2 was very independent, but not quite ready or educated on caring for his catheter and was not set up to be discharged while he was on vacation. CI V reported his room, and belongings were as they were when he left, so there was no indication he wasn't coming back.</p> <p>(continued on next page)</p>		

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<p>F 0624</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 1/30/25 at 3:15 PM., during an interview, Staff T reported R2 had been discussing a discharging from the facility with staff in the months leading up to 12/17/25 when R2 went to see his sister in Texas. Staff T reported the facility did not have R2 listed on an LOA. However, the EMR reflected a doctor approved LOA from 12/17/24-12/30/24. Staff T stated there was no process set up for the facility to allow residents to leave for that length of time. Staff T reported she had called R2 (while he was in Texas) and told him he would not be able to come back to the facility without being considered a new admission to the facility and he would need to have doctors' orders to readmit. Staff T stated he was technically discharged to his sisters, and that was considered a Safe discharge. However, the facility could not provide any discharge instructions received and signed by R2. Staff T reported R2 came back from Texas and called before he returned to the facility asking about the process for readmitting to the facility and Staff T reported she told R2 he needed to see his physician. Staff T stated R2 came to the facility to collect his belongings and confirmed R2 was not able to come into the facility on ce he was back. Staff T stated she believed R2 ended up staying at a hotel for a few nights. Staff T reported a few days later a local hospital Social Worker called to inform Staff T, R2 was homeless. Staff T stated they didn't see it as a planned discharge and stated it was more of an AMA (Against Medical Advice) situation. However, Staff T was unable to provide any AMA paperwork or notes reflecting this was an AMA discharge. Staff T stated it was an odd scenario and unfortunately, there was a lot of change over with the management and indicated the former DON and NHA failed to document properly. Staff T acknowledged previous management had not done an Involuntary Discharge before, so they failed to follow up with some of the requirements. Staff T stated the facility attorney suggested they start over, then the whole management change happened, then R2 went to Texas. Staff T acknowledged the Involuntary Discharge process was never restarted. Staff T confirmed the hospital had to help him with getting an apartment close to the facility. Staff T reported R2 had his own funds; he just chose to spend it differently rather than to pay the facility. Staff T reported R2 had a total unpaid amount of \$100,000 write off for the facility. Staff T acknowledged previous management should have started the involuntary discharge planning long before it got that bad.</p> <p>Review of a facility Policy titled Involuntary Transfer and Discharge with a revision date of 1/1/2022 revealed: Policy: The purpose of this policy is to establish uniform guidelines relating to the involuntary transfer/discharge process, to ensure the resident's rights are properly observed and that proper notifications to all interested parties occurs . 1. Facility initiated transfers and discharges are permitted when : . b. The transfer or discharge is appropriate because the Resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; . e. The resident has failed, after reasonable and appropriate notice to pay for (services); . 2. Before an involuntary discharge or transfer notice may be issued, the facility will verify that the reason for the discharge or transfer is one of those listed above, and that there is appropriate and adequate documentation in the resident file supporting the transfer or discharge. As appropriate this shall include documentation from the physician or medical specialist supporting the need for transfer or discharge. 5. The notice shall be in writing that the resident/resident representative can understand, and shall include:</p> <p>a. An explanation of the reason for the transfer or discharge</p> <p>b. Whether the resident is expected to return to the facility</p> <p>c. The transfer or discharge location</p> <p>d. The expected transfer or discharge date ; and</p> <p>(continued on next page)</p>		

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<p>F 0624</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>e. An explanation of the resident's rights of appeal.</p> <p>6. Unless it is an emergency situation, the resident shall be provided a minimum of 30 days' notice before the transfer or discharge shall occur. 7. The resident/resident representative shall be provided an opportunity to view the discharge location and may refuse the location, provided the reason for doing so is reasonable. 8. While the facility may issue an involuntary discharge notice for non-payment, the facility shall not act on the discharge for any resident who has filed a Medicaid application and awaiting a decision. 9. If the resident/resident representative has timely and properly filed an appeal, the facility shall not discharge the resident and shall contact the Legal Department for further guidance. 12. The facility will work with home health, hospice and other support agencies as needed to coordinate a safe discharge</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35981</p> <p>Based on observation, interview and record review, the facility failed to:</p> <ol style="list-style-type: none"> 1. Securely store an insulin pen following use for 1 Resident (#1), and 2. Secure 1 of 2 treatment carts reviewed for medication storage <p>This deficient practice resulted in the potential misuse of resident medications and/or treatment supplies.</p> <p>Findings include:</p> <p>Resident #1 (R1)</p> <p>Review of an Admission Record revealed R1, was originally admitted to the facility on [DATE] with pertinent diagnoses including: type 2 diabetes.</p> <p>Review of the Minimum Data Set (MDS) assessment for R1 with a reference date of 12/19/24 revealed a Brief Interview for Mental Status (BIMS) score of 00/15 which indicated R1 was severely cognitively impaired.</p> <p>On 1/29/25 at 12:50 PM., a pre-filled Lantus SoloStar Subcutaneous injectable pen with a marker date of 1/7/25, was observed laying on the bedside table of R1. The injectable pen had R1's name on it and approximately 150 units of insulin was observed remaining.</p> <p>Review of R1's Physicians Order dated 9/26/24 revealed: . Lantus SoloStar Subcutaneous Solution Pen-injector 100 UNIT/ML (Insulin Glargine) Inject 8 unit subcutaneously in the morning related to TYPE 2 DIABETES MELLITUS .</p> <p>On 1/29/25 at 1:00 PM., Licensed Practical Nurse (LPN) C was observed entering the room to check on R1 and removed her lunch tray off the bedside table. LPN C failed to notice or pick-up the insulin pen laying on the bedside table.</p> <p>In an interview on 1/29/25 at 1:10 PM., LPN C reported the insulin pen on R1's bedside table was most likely left there from earlier in the morning during medication pass. LPN C stated she did not recall leaving the medication there, and acknowledged no medications should ever be left on any of the residents bedside tables.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 1/30/25 at 9:50 AM., a treatment cart near the nurse's station on the end of the 200 hall near room [ROOM NUMBER] was observed unlocked. Numerous prescription powders and creams for individual residents were observed in the cart. Each drawer was completely accessible which contained different types of medical supplies, including wound supplies such as tapes, gauzes, prescription creams, prescription powders, individual normal saline, and band-aids. In the 2nd drawer down were prescription creams and powders including. Mupirocin 2%-for cellulitis, Imiquimod cream 5% for neoplasm of vulva, Triamcinolone 0.1% cream for redness itching, Diclofenac sodium 1% for pain, Clotrimazole 1 % cream, and Triple Antibiotic Cream, Muscle Rub.</p> <p>In an interview on 1/30/25 at 9:55 AM., LPN K reported the treatment and medication carts should always be locked when a nurse leaves them unattended. LPN K reported she was unsure who used the treatment cart on the 200 hall last.</p> <p>Review of a facility Policy titled Medication Storage with a revision date of 1/30/24 revealed: Policy: 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. Policy Explanation and Compliance Guidelines 1. General Guidelines: a. All drugs and biologicals will be stored in locked compartments (i.e., medication carts, cabinets, drawers, refrigerators, medication rooms) under proper temperature controls. b. Only authorized personnel will have access to the keys to locked compartments c. During a medication pass, medications must be under the direct observation of the person administering medications or locked in the medication storage area/cart .</p>		

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<p>F 0813</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Have a policy regarding use and storage of foods brought to residents by family and other visitors.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35981</p> <p>This citation pertains to Intake #MI00149718</p> <p>Based on observation, interview and record review, the facility failed to remove expired foods from the mini-fridge for one Resident (#1) of one resident reviewed for storage of foods brought to residents by family and other visitors. This deficient practice resulted in the potential for expired food to be consumed and increasing the risk of food borne illness.</p> <p>Findings include:</p> <p>Resident #1 (R1)</p> <p>Review of an Admission Record revealed R1, was originally admitted to the facility on [DATE] with pertinent diagnoses which included: type 2 diabetes. Review of a Minimum Data Set (MDS) assessment for R1 with a reference date of [DATE] revealed a Brief Interview for Mental Status (BIMS) score of ,d+[DATE] which indicated R1 was severely cognitively impaired.</p> <p>On [DATE] at 12:50 PM., a personal mini refrigerator in R1's room was observed containing numerous food items which were expired including: (Brand Name) yogurt 4 pack expired [DATE], a block of [NAME] jack cheese expired [DATE], a jar of mustard expired [DATE], a (Brand Name) cream raspberry yogurt expired [DATE], a container of spreadable butter expired on [DATE], a container of (Brand Name) spreadable butter expired on [DATE]. There was also a baggie observed with a package of (Brand Name) smoked soft spreadable sausage marked with an open date of [DATE]. There were pieces of meat outside of the original package which were molded inside the baggie. The open end of the original package with exposed meat product had green mold observed on it. There was also a single yogurt off brand raspberry with a best by [DATE], and fruit cups with peaches or oranges with a white substance on the bottom use by date of [DATE]. There was no noted temperature log clipped on or near R1's mini-fridge.</p> <p>On [DATE] at 1:00 PM., a shelf was observed next to R1's mini fridge containing multiple snacks, including: 2 pieces of white bread in a bread bag with an expiration date of [DATE], 2 pieces of bread noted in a clear plastic garbage bag (noted to be the same garbage bag used by the facility for small garbage cans) the bread appeared to be white bread and was not labeled or dated. On the shelf were the following: a bag of plain ruffles chips with an expired date of [DATE], a bag of fritos expired on [DATE], a full bag of cheetos expired on [DATE], a small can of coffee expired on [DATE], a full unopened bag of pork rinds expired [DATE]. The bedside table was observed heavily soiled with numerous open protein shakes with no open date observed on them and straws remaining in them. There was a quarter (,d+[DATE]) stick of butter, discolored, and nearly melted flat in its wrapper open to air with no date sitting on the visibly soiled nightstand. The nightstand drawer, which was slightly open, contained the following: Cherry (Brand Name) gelatin individual packs which had expired on [DATE], a 25-ounce bottle of (Brand Name) drink which expired on [DATE], and 9 small cans (Brand Name) juices which expired on [DATE].</p> <p>(continued on next page)</p>		

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<p>F 0813</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an observation/interview on [DATE] at 1:10 PM., Licensed Practical Nurse (LPN) C was observed entering the room of R1 and removed her lunch tray off the bedside table. LPN C reported she was unsure who kept track of R1's snacks and mini fridge food items, but thought it might be the kitchen staff or housekeeping staff.</p> <p>In an interview on [DATE] at 1:20 PM., [NAME] E reported she was unsure who kept track of temperatures, refrigerated food items and snacks brought in by family or visitors of residents. [NAME] E reported she thinks the floor staff (Certified Nurse Aides CNA) or Housekeepers (Hsk) were responsible because typically dietary staff do not enter resident rooms.</p> <p>In an interview on [DATE] at 1:30 PM., Hsk F reported she was unsure who cleans and keeps track of residents who have mini fridges in their rooms and/or a lot of food items/snacks from outside sources. Hsk F reported she has not done this, or to her knowledge was it a housekeeping task.</p> <p>In an interview on [DATE] at 1:35 PM., R1 reported she was unsure who kept track of her foods in her room and refrigerator. R1 reported her daughter sends her snacks and she gets them in the mail. R1 reported she does not know what is expired in her room.</p> <p>In an interview on [DATE] at 1:45 PM., CNA H reported housekeeping staff was suppose to keep track of the residents refrigerators and food items brought in by family, visitors or when residents get food on their own. CNA H reported there were not many residents who have their own mini fridges in their rooms, but she has never been told it was part of her daily task. CNA H reported if she were to notice something expired she would let the resident know and discard it. CNA H reported R1 has a lot of food items in her room, and gets a lot of snacks in packages in the mail. CNA H reported R1 was particular about her food, and not sure if she would be able to notice if something was expired by the date on the package, but she (CNA H) thinks R1 would be able to tell if something was expired by the taste or appearance of the food.</p> <p>In an interview on [DATE] at 1:50 PM., Hsk Manager G reported the housekeeping department was not responsible for the mini fridges in resident rooms. Hsk Manager G reported he was unsure how many residents have mini fridges in their rooms, and/or how often they are checked for cleanliness and expired food items. Hsk Manager G reported he believes the CNAs keep track, but he was unsure.</p> <p>On [DATE] at 10:00 AM., R1's mini refrigerator in the room was observed with the same food items still inside as previously observed on [DATE] with the exception of the (Brand Name) spreadable sausage, which was no longer there. The shelf next to the mini fridge was noted with the same expired items as previously observed on [DATE]. The bedside table remained heavily soiled with numerous open protein shakes with no open date, with straws in them. The same quarter (,d+[DATE]) stick of discolored butter, nearly melted flat in its original wrapper was open to air with no date, sitting on the visibly soiled nightstand. The nightstand drawer contained the same expired food items as observed on [DATE].</p> <p>(continued on next page)</p>		

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<p>F 0813</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of a facility Policy titled Resident Refrigerators with a revision date of [DATE] revealed: Policy: This facility does not provide a refrigerator in a resident's room. However, it is the policy of this facility to ensure safe and sanitary use of any resident-owned refrigerators when approved by the administrator for use in the facility. Policy Explanation and Compliance Guidelines: 1. Dormitory-sized refrigerators are allowed when approved by the administrator prior to admission in a resident's room under the following conditions: a. The refrigerator is inspected by maintenance personnel and deemed safe prior to use and upon routine inspections. b. The refrigerator maintains proper temperatures. c. The electrical cord is without damage and the grounding prong is intact. d. Sufficient space exists in the resident's room to accommodate the refrigerator without requiring the use of extension cord or multi-plug adapter. e. The resident complies with the facility's policy for use of the refrigerator. 2. Housekeeping staff shall record refrigerator temperatures daily on a temperature log attached to the refrigerator. a. A thermometer shall remain in the refrigerator. b. Temperatures will be at or below 41° F, and freezers will be cold enough to keep foods frozen solid to the touch (or in accordance with state regulations).c. If temperatures are out of range, maintenance staff shall be notified. All foods that require refrigeration will be discarded immediately, and remedies will be put into place. d. If problems persist with maintaining proper temperatures, the refrigerator shall be removed from use and the resident/family notified. 3. Housekeeping staff (or department assigned) shall clean the refrigerator daily and discard any foods that are out of compliance. Nursing staff shall clean up spills as needed or refer to housekeeping staff</p>		

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35981</p> <p>This citation pertains to Intake #MI00149352.</p> <p>Based on observation, interview, and record review the facility failed to maintain equipment in good working order and failed to clean and sanitize resident equipment, resulting in an increased potential for spread of infections for residents utilizing equipment.</p> <p>Findings include:</p> <p>On 1/29/25 at 11:00 AM., 4 resident wheelchairs were observed in the bay side day room . All 4 wheelchairs were noted to be heavily soiled on the seat, arms, legs and overall components of the wheelchair. 1 motorized wheelchair was observed heavily soiled with food crumbs, dried spillage, and the seat cushion was noted to have holes in it.</p> <p>On 1/29/25 at 11:10 AM., a hooyer lift was observed outside of room [ROOM NUMBER]. The bag holding the sanitizing wipes was observed heavily soiled with dried crusted substances. The legs of the mechanical lift, and lift in general was observed with a heavy accumulation of dust and debris on it.</p> <p>In an interview on 1/29/25 at 1:45 PM., CNA H reported CNA staff and nurses are suppose to clean and sanitize resident equipment after each use. CNA H reported 3rd shift is responsible for cleaning and sanitizing wheelchairs.</p> <p>On 1/30/25 at 10:53 AM., a hooyer lift was observed on the 300 unit parked in an alcove. The lift was observed soiled on the blue cushion padding with a dried crusted substance. The base of the lift, legs and remote were noted to be visibly soiled with dirt and grime.</p> <p>On 1/30/25 at 11:00 AM., the bay side day room was observed with 4 resident wheelchairs. All 4 wheelchairs were noted to be heavily soiled on the seat, arms, legs and overall components of the wheelchair. 1 motorized wheelchair was noted to be heavily soiled with food crumbs, dried spillage, the seat cushion was noted to have holes in it.</p> <p>On 1/30/25 at 11:05 AM., a resident wheelchair was observed in the hallway, heavily soiled on the seat. The left arm rest had medical tape around the end of it where it was noted to be torn. The medical tape was clear and covering what appeared to be white gauze. The tape and gauze were both noted to be soiled, tattered and worn in appearance.</p> <p>On 1/30/25 at 11:18 AM., a hooyer lift was observed outside of room [ROOM NUMBER]. The bag holding the sanitizing wipes was observed heavily soiled with dried crusted substances. The legs, and lift in general was noted to have a heavy accumulation of dust and debris on it.</p> <p>(continued on next page)</p>		

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 01/29/2025
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 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 1/30/25 at 11:25 AM., a hoier lift was observed outside of room [ROOM NUMBER]. There was a blue pad on the lift noted to be soiled. The bag holding the sanitizing wipes was soiled with dried crusted substances. The base, legs and lift itself was noted to be visibly soiled. A vital sign machine was observed next to room [ROOM NUMBER] and the base of the machine was observed soiled with dust and debris. The finger probe for the pulse oximetry (measures blood oxygen in the body) was noted to be soiled on the surface that comes into contact with residents. There was also an individual thermometer observed soiled with grime and felt sticky when picked up.</p> <p>On 1/30/25 at 11:44 AM., 7 wheelchairs all varying in styles and size were observed near the alcove by the Social Services office. Three of the seven wheelchairs were heavily soiled with food crumbs, dried spillage on the arms, sides, wheels and handles. A sit to stand lift was observed with the base of the lift (where residents plant their feet) observed soiled with food crumbs, dried crusted substances dust and debris. The knee pad (which stabilizes residents as they are lifted) was observed with a white substance, crusted and dried on it.</p> <p>In an interview on 1/30/25 at 2:00 PM., LPN K reported CNAs and nursing staff are suppose to wipe down/sanitize resident shared equipment before and after each use. LPN K reported resident wheelchairs should be wiped down if noticeably soiled, and thoroughly cleaned on 3rd shift by the CNA staff.</p> <p>Review of a facility Policy titled Cleaning and Disinfection of Resident-Care Equipment with a revision date of 11/12/2024 revealed: Policy: Resident-care equipment can be a source of indirect transmission of pathogens. Reusable resident-care equipment will be cleaned and disinfected in accordance with current CDC recommendations in order to break the chain of infection. Definitions: Cleaning is the removal of visible soil from objects and surfaces and normally is accomplished manually or mechanically using water with detergents or enzymatic products. Disinfection is a process of eliminating microorganisms, except spores, from inanimate objects, usually by chemical means Reusable single-resident items are items that may be used multiple times, but for one resident only. Examples include bedpans, urinals, and disposable blood pressure cuffs/stethoscopes. Reusable multiple-resident items are items that may be used multiple times for multiple residents. Examples include stethoscopes, blood pressure cuffs, feeding tube pumps, and oxygen concentrators 3. Staff shall follow established infection control principles for cleaning and disinfecting reusable, noncritical equipment. General guidelines include: a. Verify whether the equipment is single use or reusable. Discard single-use items after use. b. Direct care staff are responsible for cleaning single-resident equipment when visibly soiled, and according to routine schedule. c. non-critical multi resident use items will be cleaned and disinfected on a routine basis per facility schedule and if visibly soiled .</p>		