STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235553	A. Building B. Wing	05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Rogers City	555 N Bradley Hwy Rogers City, MI 49779

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49310 This deficiency pertains to intake MI00152410 Based on interview and record review, the facility failed to notify the resident representative of a change in condition requiring testing and treatment for one Resident (R2) of one resident reviewed for notifications of change. Findings include: Resident #2 (R2) Review of Intake #MI00152410 filed with the state agency revealed an allegation that read, in part: .[R2] has never been tested for UTI before . [R2's Durable Power of Attorney (DPOA)] was not notified that [R2] was being tested for a UTI or that [R2] was receiving the [medication] . During an interview on 4/30/25 at 8:09 AM, R2 confirmed a recent urinary tract infection (UTI) with subsequent administration of an antibiotic. Review of the Electronic Medical Record (EMR) indicated R2 was readmitted to the facility on [DATE] with a primary diagnosis of bipolar disorder. A quarterly Minimum Data Set (MDS) assessment dated [DATE] documented R2 was dependent on staff for toileting/hygiene. A physician's order dated 4/8/25 indicated a urinalysis (UA) with culture and sensitivity (C&S) needed to be obtained due to behaviors. The EMR documented the laboratory specimen was obtained as ordered with resultant proliferation of two different bacteria measuring greater than 100,000 CFU/ml (colony-forming units per milliliter). A physician's order dated 4/12/25 revealed R2 was to receive an antibiotic to be administered through intramuscular injection. The order read: ceftriaxone sodium injection solution reconstituted 1 GM [gram] Inject 1 GM intramuscularly one time a date for UTI for 7 days. No documentation was in the EMR indicating the DPOA was made aware R2 had symptoms of an infection or that a UA/C&S was obtained. Documentation was not located in the EMR indicating R2's DPOA was notified of the specimen results or the need for an antibiotic ordered to treat the UTI. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Registered Nurse (RN) B was interviewed on 4/30/25 at 9:52 AM and confirmed she was the facility's Infection Preventionist. RN B said UA/C&S testing was obtained on R2 due to displaying symptoms of a UTI. RN S said R2 had a change in behaviors, a cloudy appearance to the urine, and verbalized a burning sensation when urinating. RN S said R2 was also experiencing urinary urgency, frequency, and dysuria (painful urination). When asked the expectation for DPOA notification, RN B said the expectation was for the Resident Representative (RR) of a resident to be notified with any change in a resident's condition, including a need for testing such as UA/C&S, the outcome of any testing, and any follow-up such as the implementation of antibiotic therapy. RN B said the nurses are expected to document RR notifications of testing in the progress notes in the EMR. RN B reviewed the EMR of R2 and confirmed there was no documentation the DPOA for R2 had been notified of symptoms, change in behavior, urine testing, or the antibiotic. The DPOA of R2 was interviewed on 5/1/25 at 7:57 AM. The DPOA confirmed they were not notified by staff of R2 was exhibiting a change of condition and was experiencing symptoms of a UTI. The DPOA said staff did not make them aware R2 had a UA/C&S completed and was placed on an antibiotic. The DPOA said they were informed by R2 of the testing, infection, and antibiotic when R2 went to the hospital on 4/14/25 for an unrelated matter. The Director of Nursing (DON) was interviewed on 5/1/25 at 9:23 AM. The DON agreed there was no documentation of R2's DPOA being contacted with R2's symptoms of infection, change in behaviors, need for UA/C&S testing, or placement of R2 on an antibiotic. The DON was asked the expectation for DPOA notification, and responded, I expect immediate notification of RR with multiple attempts to re-call them [RR] if needed, and the documentation should be in progress notes. The policy titled Notification of Changes dated as revised 8/29/24 read, in part: .The purpose of this policy is to ensure the facility promptly informs the resident, consults the resident's physician; and notified, consistent with his or her authority, resident's representative when there is a change requiring notification. The facility must inform the resident, consult with the resident's physician and/or notify the resident's family member or legal representative when there is a change requiring such notification .Circumstances requiring notifications include: . 3. Circumstances that require a need to alter treatment. This may include: a. New treatment . Additional considerations: 1. Competent individuals: a. The facility must still contact the resident's physician and notify resident's representative .

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49310 Based on interview, and record review, the facility failed to limit the duration of a PRN (as needed) psychotropic medication to 14 days and/or ensure the physician documented rationale to extend the duration of use, and failed to document the behavioral symptoms and non-pharmacological interventions prior to administering a PRN psychotropic medication for one Resident (#74) of five residents reviewed for unnecessary medications. Findings include: Resident #74 (R74) R74 was admitted to the facility on [DATE] with a primary diagnosis of unspecified dementia. R74 had a court-appointed guardian for medical, legal, and mental health decisions. An admission Minimum Data Set (MDS) assessment dated [DATE] assessed R74 with a Brief Interview for Mental Status (BIMS) score of seven, indicating severe cognitive impairment. Further review of the MDS revealed R74 displayed no behavioral symptoms. Review of R74's physician's orders revealed an active order dated 3/23/25 for Xanax (a psychotropic medication for anxiety) dosed at 2.5 mg (milligrams) every six hours PRN. The order did not contain a stop or end date and no documentation was found indicating R2 was re-evaluated for continued use. The Medication Administration Records (MAR) for March 2025 and April 2025 were reviewed on 5/1/25. The MAR for March 2025 documented R74 was administered Xanax on 3/29/25 and 3/30/25. The April 2025 MAR documented the Xanax was administered to R74 on 4/11/25, 4/12/25, twice on 4/13/25, 4/18/25, 4/19/25, 4/20/25, 4/23/25, 4/24/25, 4/25/25, 4/26/25, 4/27/25, and twice on 4/30/25. Review of the Electronic Medical Record (EMR) did not reveal physician documentation documenting the rationale for extending the PRN Xanax beyond 14 days. Documentation regarding the behavioral symptoms leading to the PRN Xanax administration in March 2025 and April 2025 was not located in the EMR. Documentation of non-pharmacological interventions attempted before administering the Xanax was not located in the EMR. Medication Regimen Reviews (MRR) by the licensed pharmacist were not found in the EMR. When the MRR was requested, the Director of Nursing (DON) provided the pharmacist's documented recommendations to nursing dated 4/9/25 and said there were no other recommendations by the pharmacist. The recommendation did not note or propose recommendations for the PRN Xanax. The DON was interviewed on 5/1/25 at 10:57 AM. The DON said PRN Xanax was limited to a 14-day duration. The DON said the physician should assess and document in the medical record if the Xanax was indicated beyond 14 days. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Registered Nurse (RN) O was interviewed on 5/1/25 at 12:47 PM and confirmed she was the nurse manager for the unit where R74 resided. RN O said psychotropic medications were limited to 14 days, then the order was reviewed with the provider to determine if the medication needed to be continued or discontinued. RN O was asked if the Xanax for R74 was reviewed with the provider. RN O said the facility process was to enter an order for nurses to review PRN psychotropic medications with the physician after 14 days, but said the order to review the Xanax with R74's physician was not entered. RN O reviewed R74's EMR and said there was no documentation the medication was reviewed with the physician. RN O confirmed there was no documentation by the physician indicating rationale for continuing the PRN Xanax. RN O said behaviors warranting the administration of psychotropic medications were documented in the EMR in progress notes or under the tasks tab. RN O added that behavioral information and interventions were also found as medication administration notes with the MAR. The progress notes, tasks tab, and medication administration notes were reviewed by RN O who acknowledged there was no documentation of behaviors or non-pharmacological interventions leading to the administration of PRN Xanax to R74. The policy Use of Psychotropic Drugs and Gradual Dose Reductions dated as revised 10/30/23 read, in part: . The indications for use of any psychotropic drug will be documented in the medical record . Non-pharmacological interventions that have been attempted, and the target symptoms for monitoring shall be included in the documentation . Residents who use psychotropic drugs shall also receive non-pharmacological interventions to facilitate reduction or discontinuation of the psychotropic drugs . PRN orders for psychotropic drugs shall be used only when the medication is necessary to treat a diagnosed specific condition that is documented in the clinical record, and for a limited duration (i.e. 14 days). a. If the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she shall document their rationale in the resident's medical record and indicate the duration for the PRN order . The policy Behavior Management Program dated as revised 10/27/23 read, in part: . a. Resident documentation of observed behaviors will be maintained and monitored using our electronic medical records (EMR) system . Documentation may include but not limited to the following . A description of the behavior or symptom observed and or reported behavior may include the following: Reason, Place, Intervention, and outcome .

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F 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41978 Based on observation, interview and record review the facility failed to assess, monitor and treat changes in respiratory, skin and bowel patterns for four Residents (#55, #10, #22 and #44). This deficient practice resulted in a decline in transfer ability, eating, and alertness and ultimately delayed response including hospitalization for treatment of pneumonia for Resident #55, delayed assessment, diagnosis and treatment of a potentially cancerous skin lesion for R10, and the potential for bowel complications from delayed treatment for Resident #55, #22 and #44. Findings include: Respiratory Care Resident #55 (R55) Review of the Minimum Data Set (MDS) assessment, dated 1/22/2025, revealed R55 was admitted to the facility on [DATE] and had diagnoses including Parkinson's Disease, dementia, and dysphagia (difficulty swallowing). R55 scored 6/15 on the Brief Interview for Mental Status (BIMS), indicating severe cognitive impairment. The MDS assessment revealed R55 was transferred to an acute care hospital on 1/30/2025 and returned to the facility on [DATE]. On 4/29/2025 at 10:35 a.m., R55 was observed being transferred from a wheelchair to his bed by Certified Nursing Assistant (CNA) N and CNA P. R55 appeared weak, with his head hung down toward his chest with his eyes closed as CNA P placed a gait belt around his torso in preparation for a stand and pivot transfer. CNA P stated to CNA N, He's awfully tired, is he going to be able to transfer? CNA N replied, He [R55] gets like this sometimes. CNA P then left the room and returned with a mechanical sit-to-stand lift and sling. CNAs N and P proceeded to transfer R55 to the bed with minimal participation from R55. R55's eyes remained closed, and his head hung toward his chest during the transfer. Review of R55's electronic medical record (EMR) revealed a physician progress note, dated 2/10/2025 at 9:40 a.m., that read in part, . He is reported to have increased difficulty swallowing. [Speech Therapy] is working with him on this. He has been hospitalized and treated for pneumonia repeatedly . Further review of the EMR revealed a nurse's note, dated 1/30/2025 at 3:10 a.m., that read in part, Resident was complaining of back pain to CNA. Nurse went to see if resident could have anything for pain. When nurse came in resident was grunting and having difficulty breathing. O2 [oxygen level] was at 69% and resident was taking quick shallow breaths . Resident was complaining of chest pain and was holding his left hand over the right side of his chest. [Physician] called and ordered resident to be sent to ER for evaluation . EMS [emergency medical services] arrived and resident was breathing faster, grunting louder and O2 was 81% on 4 L [4 liters per of oxygen per minute] . Review of the hospital H&P [History and Physical], dated 1/30/2025 at 5:24 a.m., revealed the following: (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	. [R55] with Parkinson's disease and recurrent pneumonia felt to be secondary to aspiration . sent from [facility] after complaining of right-sided chest pain and having a pulse ox of 80% on room air . He was seen by speech therapy last time and was discharged on a modified diet . SpO2 100% on 6 L/min supplemental oxygen via BiPAP [a non-invasive ventilator to assist in breathing] . He has rhonchi [abnormal lung sound indicative of fluid in the lung] in the right middle field and right lower field . Further review of the H&P revealed, Imaging Study Results . XR Chest . Impression: Interval development of a moderate to large area of airspace disease/pneumonia of the right lung. Recommend follow-up upon completion of any anticipated therapy . Assessment & Plan: Acute hypoxic respiratory failure . Sepsis secondary to pneumonia . Right lower lobe pneumonia, fairly dense consolidation, suspect aspiration . Review of the assessments section of R55's EMR revealed an SBAR (Situation, Background, Assessment, Response) Communication Form, dated 12/25/2025 at 9:42 p.m. that read in part: Situation: increased audible bronchial secretions, refusal to get out of bed, increased lethargy . Mental Status Changes . decreased consciousness . Functional Status Changed (compared to baseline) . needs more assistance with ADLs, decreased mobility, weakness . Respiratory . abnormal lung sounds . possible aspiration, wet vocals and increased [sic] in dysphagia that could lead to infection . Further review of the SBAR Communication Form, revealed, RN spoke with Resident's [daughter] via phone call. Discussed decline in condition, resident receiving food from family in bed, current wet rattle/gurgle during insp [inspiration] and expirations . [daughter] decided to monitor resident in facility and to follow up with necessary testing tomorrow . It was noted physician notification of the concerns was documented as 12/26/2025 at 9:00 a.m., nearly 12 hours after the change in condition was identified. Review of the physician note for R55, dated 12/27/2024 at 8:20 a.m., revealed the following: Patient is seen for therapies, however he has missed several treatments due to sleepy/lethargy per nursing . given patients continued decline and repeated hospitalization s a discussion with family regarding hospice/palliative care is warranted. It was noted R55 maintained the status of Full Resuscitation, as of the survey date of 5/1/2025. Further review of R55's EMR, including progress notes, assessments, scanned documents, vital signs and the Medication and Treatment Administration records, for the period of 12/25/2024 through the date of R55's most recent hospitalization on [DATE], revealed no follow-up testing, including a chest x-ray, was ordered for R55 in response to the suspected aspiration, increased lethargy and abnormal lung sounds documented on 12/25/2024. Review of the EMR revealed no pertinent charting for change in condition was initiated in response to the SBAR documentation of R55's change in condition on 12/25/2024. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Continued review of the EMR revealed R55's condition continued to decline after 12/25/2024. Review of a nurse's note, dated 12/28/2024 at 3:54 p.m., read in part: Notified daughter of resident refusing meals and meds (medications). Resident preferring to sleep and minimal responses. Review of a Skilled Daily, nursing note, dated 12/30/2024 at 11:52 a.m., read in part: Resident has had increased lethargy . decreased po (oral) intake per staff report. Review of the Skilled Daily, nursing note, dated 12/31/2024 at 11:51 a.m., read in part: He did not eat or drink today. Refused his meds. Would not open mouth. [Physician] informed of how his condition is been declining. He just sleeps most of the time. Physician documentation for the period of 12/28/2024 through R55's hospitalization on [DATE], revealed the resident was evaluated as follows: 12/31/2024 at 11:01 a.m., Patient is seen for continued decline. Staff state patient has not been eating or drinking for the last week and spends most of this time in bed . Assessment: weakness, AMS [altered mental status]. 1/16/2025 4:26 p.m., Assessment: weakness. 1/22/2025 10:49 a.m., Assessment: weakness. It was noted in review of the EMR, the required skilled nursing care charting ended on 12/31/2024. No further respiratory assessments were documented by nursing until 1/30/2025 when R55 was found with right sided chest pain and an oxygen saturation level of 69% on room air, as documented in the nursing note previously referenced and dated 1/30/2025 at 3:10 a.m. Further review of R55's EMR revealed he was previous hospitalized on [DATE] and returned to the facility on [DATE] after being treated for pneumonia and acute encephalopathy (decreased brain function). Review of EMR for the period of 12/1/2024 through 12/9/2024, prior to the resident's transfer to the hospital, revealed the following: 12/4/2024 at 10:30, Change identified . Would not respond to me verbally when trying to find out what was wrong . combative with care . he has been this way before when he is not getting enough sleep or when he had aspiration pneumonia . Assessment: His vss [vital signs stable]. Lung sounds CTA [clear to auscultation]. His moaning stopped when he was put back to bed and he went to sleep . 12/09/2024 at 10:43, Transcribed Physician Progress Note: Patient is seen for report of general decline. He is obtunded upon exam. He has been refusing medications and [has] mental status changes . Assessment: weakness, AMS . Orders given to transfer to ED for AMS. It was noted in review of the physician note, R55's pulmonary exam was negative for cough, dyspnea, and congestion. During an interview on 5/01/2025 at approximately 10:45 a.m., the B-Hall Unit Manager, Registered Nurse (RN) O reviewed R55's EMR and confirmed there were no comprehensive nursing assessments after the skilled daily nurse charting ended on 12/31/2024 until R55 was transferred to the hospital on 1/30/2025. RN O reported the documentation in the skilled nursing and physician notes indicated a change in condition but the pertinent charting for monitoring for infection or change in condition was not initiated. RN O was asked why R55 did not have a follow-up chest x-ray to assess response to treatment following his return from hospitalization for pneumonia on 12/16/2024, to which she reported a repeat x-ray was only ordered if abnormal findings were identified on assessment. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	During an interview on 5/1/2025 at 1:25 p.m., the Director of Nursing (DON) was queried regarding the process staff were expected to follow when assessment revealed abnormal findings. The DON reported staff were to complete an SBAR note and notify the physician. The DON reported completion of an SBAR note indicated the need to initiate the pertinent charting for change in condition to ensure completion of comprehensive assessments each shift for monitoring. The DON reported she was aware of the concern related to R55's change in condition remaining undiagnosed prior to his hospitalization on [DATE]. The DON reviewed R55's EMR during the interview and when asked if a chest x-ray should have been completed after the identification of abnormal lung sounds, increased lethargy and suspicion of aspiration on 12/25/2024, the DON responded, yes and chest x-ray was warranted at that time. The DON confirmed changes in condition do not always present clearly in the elderly and staff should be documenting resident condition consistently and clearly to ensure continuity of care and recognition of acute changes. Skin/Wound Care Resident #10 (R10) Review of the MDS assessment, dated 3/18/2025, revealed R10 was admitted to facility on 12/9/2020 and had diagnoses including diabetes and dementia. Further review of the MDS assessment revealed R10 required partial/moderate assistance with most ADLs (activities of daily living) and scored 9/15 on the BIMS, indicating she had moderate cognitive impairment. Section M - Skin Conditions, revealed R55 was assessed as having no Other Ulcers, Wounds and Skin Problems. On 4/29/2025 at 9:52 a.m., R10 was observed seated in a wheelchair in the doorway of her room. R10 had a black scab noted on the left side tip of her nose. When asked what caused the wound, R10 reported I just have a small sore, it bleeds sometimes. Review of R10's EMR for the period of 1/2/2025 through 5/1/2025, revealed no treatment ordered or wound evaluations documented in relation to the wound on R10's nose. During an interview on 4/30/2025 at 8:11 a.m., RN L reported the wound on R10's nose was not being treated. RN L reported the wound was not caused by an injury and at times was only a small scaly patch of skin that opens when R10 picks at it. On 4/30/2025 at 8:24 p.m., R10 was observed self-propelling from the main dining room toward her room. The wound on the right side of the tip of R10's nose was devoid of the scab. Closer observation revealed an open lesion with slightly raised edges and a marbled appearance to the wound bed. During an interview on 5/1/2025 at 8:04 a.m., the DON was asked about the open lesion on R10's nose. The DON reported the wound appeared to be chronic and had been present for at least six months. The DON stated she would check with the B-Hall Unit Manager, RN O for information related to the wound. The DON reported she checked the EMR for documentation related to the wound but was unable to find any. When asked if the non-healing wound should initiate a concern of skin cancer or an infection with a multi drug-resistant organism (MDRO), the DON reported staff should always be aware of non-healing wounds and report to the physician for further assessment. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	On 5/1/2025 at 10:17 a.m., RN O was interviewed and reported the condition of the wound on R10's nose was discussed at a care conference on 1/9/2025. Review of the, Care Plan Conference Summary, dated 1/9/2025 at 3:04 p.m., revealed, Nursing concerns with scab on her nose that [R10] continues to pick at out of habit . The Summary included no further information related to R10's wound. When asked if the wound had been reported to the physician for evaluation, RN O was unable to provide an answer. RN O stated she thought she remembered a provider looking at the wound but was unable to find documentation of the event or any orders provided, therefore, R10 was placed on the list for the provider to assess during the next provider rounds. RN O reported she phoned R10's patient advocate who reported the wound was present prior to admission. R10's patient advocate agreed a referral to dermatology was warranted for evaluation for skin cancer. Bowel Care Resident #55 (R55) Review of the MDS dated [DATE], revealed R55 was admitted to the facility on [DATE] and had diagnoses including Parkinson's Disease, dementia, and dysphagia (difficulty swallowing). Further review of the MDS revealed R55 scored 6/15 on the BIMS, indicating severe cognitive impairment. Further review revealed R55 required substantial/maximal assistance with toilet transfers and toileting hygiene. Review of R55's point of care documentation for Bowel Elimination for the period of 4/3/2025 through 4/30/2025 revealed documentation of No bowel movement, as follows: 4/3/2025 at 1:59 p.m. through 4/8/2025 at 9:59 p.m., a total of more than five days with no bowel movement. Review of R55's April 2025 Medication Administration Record (MAR) revealed the following active physician orders and administration documentation: Milk of Magnesia Suspension [MOM] 400 MG [milligrams]/5 ML [milliliters] . Give 30 ML by mouth as needed for constipation if no BM [bowel movement] in 3 days. Start Date: 2/01/2025. Documented as administered on 4/8/2024 at 9:19 p.m., the fifth day of no bowel movement for R55. Bisacodyl Suppository 10 MG. Insert 1 suppository rectally as needed for constipation daily if no results for MOM. Start Dated: 4/07/2025 . Documented as administered on 4/7/2025 at 6:33 a.m. the fourth day of no bowel movement for R55. It was noted no administration of the ordered MOM was administered prior to administration of the bisacodyl suppository per physician order. During an interview on 5/1/2025 at 1:25 p.m., the DON reported it was a standard of practice for nursing staff to review bowel elimination patterns for residents daily to allow for the identification abnormalities and to allow for initiation of appropriate interventions for constipation. The DON confirmed prolonged constipation can cause severe discomfort and serious adverse consequences such as bowel obstruction, especially in residents with decreased mobility. When asked when treatment for constipation should be initiated, the DON reported treatment should be initiated after three days without a bowel movement. 40383 (continued on next page)

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	235553	A. Building B. Wing	05/01/2025

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Medilodge of Rogers City	555 N Bradley Hwy Rogers City, MI 49779

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Resident #22 (R22) R22 was first admitted to the facility on [DATE] and had diagnoses including dementia, anxiety disorder, depression and cognitive communication deficit. A review of the most recent MDS assessment, dated 3/21/2025, revealed R22 was coded as always incontinent and was dependent for toileting hygiene (helper does ALL of the effort. Resident does none). The routine medication regimen included Senna (herbal bowel supplement) Plus (containing colace-additional bowel laxative) Oral Tablet 8.6-50 MG (milligrams) . Give 1 tablet by mouth two times a day for Constipation which was ordered 2/2/25. The MAR indicated R22 regularly accepted this constipation medication twice per day for the month of April 2025. The EMR task list was reviewed on 4/29/25 and revealed R22 had not had a bowel movement (BM) on 4/17/25, 4/18/25, 4/19/25, 4/20/25, and not until 11:43 PM on 4/21/25. The EMR physician's orders and administration of these orders for R22 included: - Milk of Magnesia Oral Suspension (Magnesium Hydroxide) Give 30 ml (milliliters) by mouth as needed for Constipation. Start date 10/12/24. - MiraLax (Powdered Bowel Laxative) Oral Powder 17 GM (gram)/SCOOP Give 1 scoop by mouth every 24 hours as needed for Constipation. Start Date 2/28/2025. - Bisacodyl Rectal Suppository 10 MG (Bisacodyl) Insert 1 suppository rectally every 96 hours as needed for constipation Start (ordered on) Date 07/02/2024. The April 2025 MAR indicated these medications were not given when the resident had not had a bowel movement for 5 days from 4/17/25 until the end of day 4/21/25. - Bisacodyl EC (enteric coated) Oral Tablet Delayed Release 5 MG Give 5 mg by mouth every 72 hours as needed for constipation Start Date 07/02/2024. The April 2025 MAR indicated this medication was not given for the entire month. Resident #44 (R44) R44 was admitted on [DATE] and had diagnoses including dementia, chronic kidney disease, cognitive communication deficit and constipation. The routine medication regime included Senna Plus Oral Tablet 8. 6-50 MG (milligrams) . Give 2 tablets by mouth at bedtime related to CONSTIPATION which was ordered 10/13/24. The Medication Administration Record (MAR) indicated R44 regularly accepted the constipation medication every day for the month of April. A review of the EMR revealed the care plan included a focus of (R44) has an impaired gastrointestinal status related to history of constipation. Date Initiated: 10/01/2024. The interventions for this focus included in part: - Medications as ordered Date Initiated: 10/01/2024 - Observe for abdominal pain, abdominal cramping, increase in abdominal girth, hyperactive/hypoactive bowel sounds, frequency, urgency and loose stools Date Initiated: 10/01/2024 (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	- Observe for no BM in 3 days Date Initiated: 10/01/2024 . A review of the EMR task list on 4/29/25 revealed R44 had not had a bowel movement for four days from 4/17/25 at 1:59 PM and then not until 1:59 PM on 4/21/25. The EMR physician's orders for R44 included: - Milk of Magnesia Oral Suspension (Magnesium Hydroxide) Give 30 ml by mouth every 64 hours as needed for Constipation. Start date 04/12/2022. The April 2025 MAR indicated this medication was not given for the entire month. During an interview on 4/30/25 at 8:21 AM, the DON stated the facility did not have a policy/protocol or standing orders to treat constipation. The DON said their EMR dashboard included an alert after three days without a BM. The nurses and DON receive the alerts and should follow up by checking individual orders and if none are written they should contact the physician for actions to be taken. When asked about the order for R44 which included Milk of Magnesia (MOM) to be given every 64 hours as needed for Constipation, the DON did not know why the order was written for that time frame. She stated MOM orders were usually given every 24 hours.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 45123 Based on observation, interview, and record review, the facility failed to ensure a physician's order was obtained for independent urinary catheterization, and failed to ensure safe and sanitary practices were assessed prior to self-catheterization for one Resident (#329) of three residents reviewed for bowel and bladder. Findings include: On 4/29/25 at 10:49 AM, an observation was made of R329 lying in their bed resting. The bathroom had an empty 14 french (size)/4.7 mm (millimeters) 38 cm (centimeters)/14.9 in. (inch) brand name straight catheter kit. On 4/29/25 at 3:31 PM, an interview was conducted with the Director of Nursing (DON) who was asked what the process was for resident self-catheterization. The DON replied, Nursing needs to ensure that the resident is safe to perform and that they are doing it in a sanitary manner. The DON was asked if R329 was assessed to be able to safely and sanitarily self-catheterize and had a physician order to perform. The DON replied, No, there was not an order for the resident to self-catheterize and no documentation for assessment or progress note. On 4/30/25 at 9:35 AM, a record review of R329's electronic medical record, dated 4/24/25 through 4/30/25, revealed a lack of any documentation of a progress note, an evaluation for safe and sanitary self-catheterization or a physician order. R329 did not have any nursing assessment that they were physically able to safe and sanitary for self-catheterization. Review of R329's progress note, dated 4/24/2025 at 9:40 PM, read in part, Resident arrived with daughter . via private vehicle, and was admitted .is alert to person at this time .is unable to void, however is able to self cath (catheterize) .does have some slight urine leakage .does wear a pull up for moisture .can be very unsteady .at times and should use a walker, but needs frequent encouragement to use. Review of R329's care plan, dated 4/25/25, read in part, .Focus: (R329) has a need for self-catheter use related to inability to urinate .Goal: (R329) will have reduced catheter-related complications through the next review. Interventions: Assist resident with self-catheter care as needed. Observe for signs and symptoms of UTI and report to the Physician: blood in urine, cloudiness, foul smell, fever, change in mental status. Review of R329's nursing admission assessment, dated 4/18/25, read in part, .section II: Activities of Daily Living - Section A: Number 2 Most support needed for toileting marked supervision/cueing needed. Section C: ADL (Activities of Daily Living) Care Plan - Focus: Resident has an ADL self-care performance deficit related to: Goal: Resident's Activities of Daily Living (ADL) needs will be met through next review. Intervention: Toileting: Supervision - offer setup help as needed . (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of facility document titled, Self-intermittent catheterization (IC), not dated, Guidelines should prioritize resident safety, comfort, and adherence to facility protocols. Focus should be on preventing UTI's (urinary tract infections), maintaining bladder function, and promoting independence while respecting individual needs and preferences .

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45123 Based on interview and record review, the facility failed to accurately transcribe medication orders for one Resident (#330) out of three new admissions reviewed for competent nursing staff. Findings include: Resident #330 (R330) Review of R330's census section of the Electronic Medical Record (EMR) revealed admission to the facility on [DATE] from a local hospital for rehabilitation. R330's progress note, dated 4/18/25 at 6:18 PM, read in part, Resident is alert, confused, mostly non verbal (sic) per his wife he rarely talks to anyone. He is very stiff, no skin issues noted on assessment . Admission note entered by Registered Nurse (RN) E. On 4/29/25 at 12:35 PM, a record review of R330's progress notes were conducted. R330's progress note, dated 4/22/25 at 4:39 PM, revealed the following: Resident is new admit from hospital. His Metoprolol was entered in (EMR) incorrectly. It was entered at Metoprolol 25 mg (milligrams) bid (twice daily), it should have been Metoprolol 25 mg daily. He received 3 extra doses of the medication. Progress note entered by RN J Unit Manger. Review of R330's hospital discharge instructions, dated 4/18/25, revealed the following medication order, metoprolol Metoprolol Succinate ER [extended release] 25 mg, oral tablet, one tab oral every day. Review of R330's medication administration record, dated April 2025, revealed an order dated 4/18/25 for metoprolol succinate ER oral tablet extended release 24-hour 25 mg, give 1 tablet by mouth two times a day for HTN (hypertension - elevated blood pressure) at 8:00 AM and 4:00 PM. Review of R330's drug regimen review, dated 4/18/25, originally transcribed by RN E had scribble marks on it and had not been verified where the information was obtained. On 4/30/25 at 10:45 AM, an interview was conducted with RN J who was asked if the physician was made aware of the medication transcription error and if the nurse's error in transcribing the medication orders from the local hospital discharge paperwork was addressed. RN J replied, Yes, the Director of Nursing (DON) has the performance improvement form. RN J stated this was the second time RN E had made a medication transcription error. On 4/30/25 at 10:50 AM, the DON provided a copy of RN E's performance improvement form for the medication error. Review of RN E's performance improvement form, dated 4/23/25, revealed this was not the first time RN E had made a medication error, and RN E had made other medication errors on 2/4/25, 7/29/24, and 12/27/24. A request was made for the other medication error performance improvement forms for RN E. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of RN E's performance improvement form and re-education revealed the following: a.) On 12/27/23 - No performance improvement form was provided. b.) On 7/29/24 - Topic: Entering medications for new admits medications were entered the page was not flipped over to see additional medications. c.) On 2/4/25 - Reason for counseling/corrective action: Failure to report medication error immediately following knowledge of error. Failure to contact the Dr (doctor) immediately following knowledge of medication error. Administration of medications to the wrong resident. Failure to complete assessment of res (resident) involved in the medication error. Has this concern been previously discussed with the employee: Yes. Staff has had previous history of corrective actions in regard to medication errors. d.) On 4/23/25 - Reason for counseling/corrective action: Failure to transcribe medication properly on admission. Has this concern been previously discussed with the employee: Yes. e.) RN E had the same education, Prevention of Medical Errors on 2/4/25 and 4/30/25. f.) RN E work on 4/28/25 and 4/29/25 prior to completing their medication error education. On 4/30/25 at 10:52 AM, an interview was conducted with the DON who was asked the process for transcribing medication orders for a new admission. The DON replied, The nurses are supposed to have a second nurse double check the orders with the original medication list and not with the drug regimen review list. The DON was asked if education and competencies were provided for RN E. The DON replied, Yes, competencies and education were provided. The DON was asked if RN E had completed her education that was due on 4/30/25. The DON replied, I asked for them to complete it yesterday before they left. Let me check. Upon review by the DON, RN E had not completed their education. Review of R330's progress note, dated 4/23/25 at 8:49 AM, entered by Nurse Practitioner (NP) M, read in part, Patient .recently admitted for therapy services, he is confused and not able to make his needs known. Patient did recently receive 3 extra doses of Metoprolol due to a transcription error which has since been corrected. VS (vital signs) are reviewed and per nursing no ill effects noted . Review of the policy titled, Medication Reconciliation, dated 1/30/24, read in part, Policy: This facility reconciles medication upon admission and as needed .Policy Explanation and Compliance Guidelines: 1. Medication reconciliation involves collaboration with the resident/representative and multiple disciplines, including admission liaisons, licensed nurses, physicians, and pharmacy staff .3. Pre-Admission Processes: a. Obtain current medication list from referral source (i.e. hospital, home health, hospice, or primary care provider). b. Obtain current medication/admission orders. 4. Admission Processes: a. Verify resident information received. b. Compare orders to hospital records .e. Verify medications received match the medication orders. f. Licensed staff to verify that all medications are accounted for, and that medications on hand match physician orders .