STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235566	A. Building B. Wing	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Cheboygan	824 S Huron Cheboygan, MI 49721

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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41978 This citation pertains to intake MI00146968. Based on interview and record review, the facility failed to provide written notification for a facility-initiated discharge, including the reason, effective dates and right to appeal to the resident's representative and the Office of the State Long-Term Care (LTC) Ombudsman for one Resident (#1) of three residents reviewed for transfer or discharge, resulting in the resident and resident's representative being uninformed of their rights, an unnecessarily extended hospital stay and the potential for inappropriate discharge. Findings include: Resident #1 (R1) Review of the Minimum Data Set (MDS) assessment, dated 7/30/2024, revealed R1 was admitted to the facility on [DATE] with a primary diagnosis of schizophrenia (mental health disorder affecting the ability to think, feel and behave clearly). Review of R1's electronic medical record (EMR) revealed R1 was transferred to the emergency department (ED) for psychological evaluation on 7/30/2024 at 5:01 p.m. with no return as of 9/26/2024. Review of R1's Transfer Notice - Resident Expected to Return, dated 7/30/2024, revealed the following, in part: . It is anticipated that the Resident will return to the facility after the circumstances requiring transfer are resolved. Transfer Location: ED . The notice was signed as received by R1's court appointed guardian on 8/03/2024. Further review of R1's EMR revealed R1 did not return to the facility following transfer to the ED on 7/30/2024. Review of the R1's mental health Emergency Screening, dated 8/01/2024, provided by Social Services Director, Staff D, revealed following evaluation in the ED, R1 was admitted to a psychiatric facility for treatment. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/26/2024 at 11:56 a.m., hospital Case Manager, Registered Nurse (RN) I reported R1 was discharged , with no return expected, from the psychiatric hospital to the acute care for treatment of a urinary tract infection on 8/22/2024. RN I stated she was in contact with the facility to initiate discharge back as early as 8/26/2024. RN I reported she was informed the facility required further evaluation of R1's psychiatric condition prior to his return to the facility, specifically a Level II PASSAR (Preadmission Screening and Resident Review). RN I stated they initiated the assessment and were awaiting completion when R1's legal guardian, Family Member (FM) H called on 9/8/2024, stating the facility would not allow R1 to return. RN I stated no communication was received from the facility stating R1 was discharged . RN I reported R1's Level II PASSAR was completed on 9/11/2024 per the facility's request, but R1 remained hospitalized until 9/13/2024 awaiting placement in a new facility. During an interview on 9/26/2024 at 1:10 p.m., the Nursing Home Administrator (NHA) and Staff D reported when they did not hear from the hospital after the request for the Level II PASSAR, they considered R1 discharged from the facility. When asked if any further contact was initiated by the facility to determine the status of the Level II PASSAR, Staff D stated she did not reach out to the hospital to determine R1's status or anticipated return. When asked if R1 or his legal representative, FM H was provided a written notice of discharge, including information on how to appeal the facility-initiated discharge, the NHA reported no written notice was provided due to R1's extended leave from the facility. When asked if the Office of State Long-Term Care Ombudsman was notified of the discharge, the NHA and Staff D reported no notification was sent to the ombudsman as they considered R1 a resident-initiated discharge due to the length of his absence. Review of the email correspondence provided by the NHA revealed communication regarding R1's return to the facility began on 8/26/2024. It was noted that transfer back to the facility was initiated on 8/26/2024, less that 30 days after R1 was initially transferred to the emergency department on 7/30/2024. During an interview on 10/02/2024 at 11:34 a.m., FM H confirmed she did not receive written notification of R1's facility-initiated discharge, or information on how to appeal the decision. FM H stated she did not know the facility was not accepting R1 back until she received a phone call from a facility staff member on 9/08/2024 informing her of the need to pick up R1's belongings. FM H reported R1 was looking forward to being back at the facility and in the community where his family lived. Review of the facility policy titled, Transfer and Discharge, last reviewed 10/20/2023, revealed the following, in part: Discharge refers to the movement of a resident from a bed in one certified facility to a bed in another certified facility or location in the community, when return to the original facility in not expected . Non-Emergency Transfers or Discharges: At least 30 days before the resident id transferred or discharged , the Social Services Director will notify the resident and the resident's representative in writing in a language and manner they can understand (this time frame does not apply if the resident has not resided in the facility for 30 days) . A copy of the notice shall be provided to a representative of the Office of the State Long-Term Care Ombudsman . Emergency Transfers/Discharges: In case of discharge, notice requirements and procedures for facility-initiated discharge shall be followed.

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41978 This citation pertains to intakes MI00147076 and MI00147197. Based on observation, interview and record review, the facility failed to ensure appropriate assessments and communication for change in condition for one Resident (#2) of three residents reviewed for change in condition, resulting in harm when Resident #2 was transferred to the hospital for mental status changes, found to have a severe wound infection and underwent subsequent intravenous antibiotic administration and surgical intervention. Findings include: Resident #2 (R2) Review of R2's Minimum Data Set (MDS) admission assessment, dated 6/24/2024, revealed the Resident was admitted to the facility on [DATE] and had diagnoses including lumbar fracture, diabetes, anxiety and dementia. Further review of the MDS assessment revealed R2 scored six out of 15 on the Brief Interview for Mental Status, indicating severe cognitive impairment. Further review of R2's MDS data revealed R2 was discharged to a short-term stay, acute-care hospital on 9/03/2024. Review of R2's electronic medication record (EMR) revealed the following: 9/3/2024, 10:33 [a.m.] Nurses Notes . Resident confused and not making sense. Wife notified agree to transfer to the hospital. [Physician C] notified agree to transfer to hospital. Review of R2's hospital Discharge Summary, signed and dated 10/01/2024 at 12:08 p.m., revealed the following, in part: Hospital Course: . Prior to admission, he lived at [facility name] where he sustained a fall with a subsequent skin tear . Per the reports, it progressed into cellulitis, and he was started on Keflex [antibiotic]. Unfortunately, it did not improve. He started developing [acute mental status change] and was therefore sent to the ER [emergency room]. He was noted to have inflammatory markers . was started on empiric antibiotics . Impression: Extensive cellulitis. Further review of the hospital Discharge Summary, revealed, On 9/4/24, [R2] was taken to surgery for a left forearm volar [palmar side] and dorsal [back side] fasciotomy [incisions to relieve pressure from compressed blood vessels due to swelling]. Purulent fluid was found about the [back of] the forearm and [back of] the elbow . Repeat debridement [surgical procedure to remove dead tissue] was undertaken on 9/7/24 and a third on 9/10/24. He was continued on [antibiotics] for left arm cellulitis with necrotizing fasciitis [serious bacterial infection that destroys the tissue under the skin] . On 9/16 [2024] he returned to the [operating room] once again for debridement of left forearm including skin, subcutaneous tissue and some fascia [connective tissue] . plan for flap procedure [transfer of health tissue from one area of the body to another are of significant tissue loss] after allowing more healing with wound vac in place . (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Further review of the EMR revealed, 8/24/2024, 23:30 [11:30 p.m.] Pertinent Charting-Skin . left forearm . Description: Noted quarter size skin tear to left forearm . 8/30/2024, 09:03 [9:03 a.m.] resident is found to have skin tear on left forearm, mechanism of injury unknown. Resident was agitated and combative for a lot of the night, attempting repeatedly to stand on his own and climb out of bed. Area cleaned and non-adherent dressing applied with a silicone bandage. It was noted in review of R2's progress notes, the Resident was noted to have an increase in confusion on 8/29/24 and was placed on behavior monitoring. R2 was placed on one-to-one supervision on 8/30/2024 due to increased confusion and behavior. During an interview on 9/25/2024 at 7:52 a.m., Registered Nurse (RN) B reported she was working on when R2 was observed to have a second skin tear to his left forearm. RN B stated there was no evidence of infection at that time. RN B reported R2 had one small quarter-sized tear near left medial (closer to the body) elbow and a new larger, linear tear on his dorsal (back side) forearm. RN B stated she phoned the wound care nurse to obtain wound care orders. Review of R1's Nurses Note, dated 9/01/2024 at 4:44 p.m. revealed the following: Bandages on left arm are saturated. Bandages removed and non-adherent dressings placed over open areas, ABDs [large, highly absorbent dressing] placed for moisture management . It was noted in review of the EMR there were no assessments of R2's left forearm wounds, notification to the facility wound care nurse or physician, or wound cultures completed in response to the increased drainage from R2's wounds documented on 9/01/2024. Further review of R2's EMR, including progress notes, assessments/evaluation and skin/wound documentation, revealed no wound evaluations of the skin tears were observed on 8/24/2024 or 8/30/2024, to include a description of the wound, including the wound bed and peri-wound area until 9/03/2024. During an interview on 9/25/2025 at 3:25 p.m., Certified Wound Care Nurse, RN A reported she was unaware of the extent of R2's injury until 9/03/2024 when she was asked to assess the wound by nursing staff that day. RN A stated she did not remember being alerted of the need to use an ABD pad to contain the increased drainage from the wound on 8/30/2024. Upon assessment of the wound, RN A reported she found the wound to appear infected with severe swelling, so she phoned Physician C. RN A stated Physician C gave the order for R2 to begin Keflex (antibiotic) but was transferred to the ER for evaluation prior to beginning the medication. Review of R2's Wound Evaluation, dated 9/03/2024 at 10:30 a.m., revealed the following: Area: 154.73 [cubic centimeters]. Length: 29.83 cm [centimeters]. Width: 8/83 cm. Deepest Point: 0.1 cm. Location: Left Outer Forearm . Slough [dead tissue within the wound] 50% . Evidence of Infection: Redness/Inflammation . Exudate [drainage] . Moderate . Surrounding Tissue: Fragile . Crepitus [crackling sensation felt when palpating cause by gas pushed through the tissue] . pitting edema extends [greater than] 4 cm around wound . Resident delirious . Review of R2's August 2024 and September 2024 Medication Administration Record (MAR) and Treatment Administration Record (TAR) revealed the following orders: Keflex Oral Capsule 500 MG (milligram) . Give 2 capsules by mouth two times a day for cellulitis to left arm for 10 days. Start Date: 09/03/2024 [10:00 a.m.] . It was noted no doses of the medication were administered. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Left arm skin tear: cleanse, apply abx ointment, cover with silicone [daily] . Start Date: 8/28/2024. It was noted the wound care was performed daily from 8/28/2024 through 9/02/2024, with no corresponding wound assessments documented in the EMR. Apply oil emulsion to left posterior forearm wound, cover with ABD pad secure with [sleeve] change daily and [as needed] for soiled or removed dressing . Start Date: 9/01/2024. It was noted the wound care was performed on 9/01/2024 and 9/02/2024 with no corresponding wound assessments documented in the EMR. During an interview on 9/25/2024 at 3:43 p.m., the Director of Nursing (DON) reported she was notified of the R2's left forearm skin tears on 8/28/2024 when RN B phoned to inform her of R2's new injury and increased drainage from the injury noted as obtained from R2's fall on 8/24/2024. During an interview on 9/25/2024 at 4:20 p.m., Physician C confirmed he was not notified of R2's left forearm skin tears or the status of the wounds until phoned by RN A on 9/03/2024. Physician C reported necrotizing fasciitis can develop rapidly, within days or hours of injury. Review of the facility policy titled, Notification of Changes, last reviewed 8/29/2024, revealed the following, in part: 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 notification include . Accidents: resulting in injury, potential to require physician intervention . Circumstances that require a need to alter treatment. This may include: new treatment .