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	01/16/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49310 Based on observation, interview, and record review, the facility failed to ensure respectful treatment and a dignified dining experience for three Residents (#18, #20, and #58) of five residents reviewed for residents' rights. This deficient practice resulted in the potential for feelings of frustration, embarrassment, and humiliation. Findings include: Resident #18 (R18) R18 was admitted to the facility on hospice services on 9/9/24. The most recent Minimum Data Set (MDS) assessment dated [DATE] documented R18 was dependent on staff for eating. On 1/14/25 at 11:22 a.m., R18 was observed awaiting the lunch meal in the dining room in a high-back mobile reclining chair seated at a table next to the hospice Social Worker (SW). The SW was using a cell phone and laptop computer. The SW was not speaking with or interacting with R18. The SW was drinking from a Styrofoam cup. R18 was not provided or offered fluids while waiting for his meal. R18 sat and watched the SW drinking from the cup and using the cell phone and laptop computer. On 1/14/25 at 11:43 a.m., the SW remained typing on the cell phone and still had not interacted with R18. The lunch meal had not yet been provided nor were fluids offered to R18. At 11:48 a.m. on 1/14/25, a meal tray was placed in front of R18. The SW answered a phone call and started talking on the phone while the meal tray sat in front of R18. Nurse Aide (NA) B approached the table and turned R18 around in the high-back mobile reclining chair so R18's back was to the table where two other residents were awaiting their meals. NA B put on gloves and began feeding R18 with R18 facing away from the two other residents at the table. Resident #20 (R20) On 1/14/25 at approximately 11:45 a.m., an uncovered lunch meal was placed on a table in the dining room with no resident present at the table. The meal consisted of beef stew, mixed vegetables, and a dinner roll. At 11:56 a.m., R20 propelled his wheelchair into the dining room to the table and began eating the meal that had been sitting uncovered for approximately 11 minutes. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R20 was asked regarding temperature and palatability of the meal. R20 responded, it's cold - very cold. A staff member was told R20's meal was cold. The staff member left the original meal on the table and went to obtain another meal. R20 was provided with a fresh meal of beef stew and soup but not a new roll or vegetables. R20 started eating the vegetables from the original lunch meal and said, Now it's really cold. Resident #58 (R58) R58 was admitted [DATE]. A quarterly MDS completed 12/13/24 documented R58 was dependent on staff for all activities of daily living, including eating. On 1/14/25 at 12:02 p.m., R58 was observed in the dining room sitting at a table with a lunch meal in front of him without being assisted with eating. R58 watched two other residents at the table being fed by staff. At 12:07 p.m., the two residents at the table with R58 had finished eating. The staff members who had been feeding the residents left the table while R58 continued to wait to be fed. At 12:17 p.m., Regional Nurse K entered the dining room and began feeding R28 without reheating R58's meal or ensuring an appropriate temperature of the food. On 1/14/24 at 1:26 p.m., hospice CNA O was observed pulling R18 backward down the hall in his high-back mobile reclining chair. Registered Nurse (RN) A and NA B were in the hallway and did not stop or correct CNA O. When CNA O was stopped by the surveyor midway down the hall and asked the reason R18 was being propelled backward, CNA O responded, I only go backward to move these and indicated R18's high-back mobile reclining chair. CNA O continued to pull R18 backward in the high-back mobile reclining chair down the hallway to his room at the end of the hall. The Nursing Home Administrator (NHA) was interviewed on 1/16/25 at 10:10 a.m. The NHA agreed the expectation was for anyone in the facility, including contracted staff, to treat all residents with dignity and respect. The NHA said propelling residents in a chair backward down the hallway or being on the phone and not paying attention to residents are a big no-no. The policy Promoting/Maintaining Resident Dignity dated as reviewed/revised on 10/26/23 read, in part: .It is the practice of this facility to protect and promote resident rights and treat each resident with respect and dignity as well as care for each resident in a manner and in an environment, that maintains or enhances resident's quality of life by recognizing each resident's individuality . When interacting with a resident, pay attention to the resident as an individual . Conversation should be resident focused, and resident centered .

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 49310 Based on observation, interview, and record review, the facility failed to appropriately dispose of contaminated medications for three Residents (#61, #50, and #47) of eight residents reviewed for medication administration. Findings include: Resident #61 (R61) During medication preparation for R61 on 1/15/25 at 1:07 p.m., Registered Nurse (RN) H opened a bottle of acetaminophen and dispensed two tablets directly from the bottle into the palm of her hand. RN H said, Oh, I don't want to touch those. RN H disposed of the acetaminophen tablets into the garbage container on the side of the medication cart. Resident #50 (R50) During medication preparation for R50 on 1/16/25 at 7:31 a.m., RN D opened a bottle of vitamins and dropped one on top of the medication cart. RN D picked up the vitamin and disposed of it in the biohazard container on the side of the medication cart. Resident #47 (R47) R47 was prescribed 10 milliequivalents (mEq) of potassium daily. While preparing medication for R47 on 1/16/25 at 7:31 a.m., RN D placed 20 mEq of Potassium in a medication cup for administration to R47. The dosage discrepancy was pointed out after medication preparation was completed and RN D was ready to administer the medications to R47. RN D removed the 20 mEq tablet of potassium from the medication cup and disposed of it in the garbage container on the side of the medication cart. Nurse manager, Registered Nurse (RN) I, was interviewed on 1/16/25 at 1:42 p.m. RN I was asked the expectation and facility process for disposing of medications. RN I said medications were wasted by placing the medications in a drug destroyer (a medication solution intended to dissolve and deactivate medication). RN I confirmed the facility had drug destroyer solutions available for medication disposal. The policy Medication-Destruction of Unused Drugs dated 1/18/24 read, in part: . Drugs will be destroyed in a manner that renders the drugs unfit for human consumption . combine tablets, capsules, liquids, and contents of vials and ampules in container with Kitty Litter or other agent such as a drug destroyer .

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 49310 Based on observation, interview, and record review, the facility failed to ensure two Residents (#47, & #224) of eight residents reviewed for medication administration received the correct dosages of prescribed medications. This deficient practice resulted in a medication error rate of 9.38 % with 3 medication errors detected in 32 opportunities. Findings include: Resident #47 (R47) R47 was prescribed 10 milliequivalents (mEq) of potassium daily. While preparing medication for R47 on 1/16/25 at 7:31 a.m., Registered Nurse (RN) D placed 20 mEq of potassium in a medication cup for administration to R47. The dosage discrepancy was mentioned by the surveyor after medication preparation was completed but before RN D administered the medications to R47. Upon inspection of the blister pack (resident-specific card-type package containing a supply of medication), it was noted RN D had dispensed the 20 mEq of potassium from a blister pack of another resident whose blister pack had been placed in R47's section of the medication cart. RN D said, Someone put the card [blister pack] in the wrong place. I should have checked the name and dose before I popped the pill out. R47 was prescribed Ativan 1 milligram (mg) three times daily for Anxiety. On 1/16/25 at 7:31 a.m., RN D retrieved R47's blister pack of Ativan labeled lorazepam (generic for Ativan) 0.5 mg. The instructions on the blister pack read Take 2 tablets by mouth three times daily for Anxiety. RN D placed one tablet in the medication cup and signed out one tablet on the medication record titled Control Substance Record. RN D was directed to the dosage discrepancy between the physician's dosage order for Ativan and the dosage contained in the blister pack. RN D said, They were supposed to get new ones. I ordered those. The order changed months ago. The Nurse Manager, Registered Nurse (RN) I, was interviewed on 1/16/25 at 1:42 p.m. RN I confirmed nurses are expected to verify the correct resident and the correct dosages when administering medications. RN I said, Nurses absolutely need to adhere to the rights of medication administration. Resident #224 (R224) R224 was prescribed meloxicam 15 milligrams (mg) daily for pain. During medication administration observation on 1/15/25 at 1:07 p.m., the meloxicam order for R224 was read on the Medication Administration Record (MAR), indicating the medication was overdue to be administered. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/15/25 at 1:20 p.m., Registered Nurse (RN) H asked R224 if she was experiencing pain. R224 indicated she had pain in her back and neck. RN H asked R224 to rate the pain on a scale of one to ten with one being no pain and ten being excruciating pain. R224 said her pain was ten out of ten. When asked why the meloxicam had not been administered as scheduled at 8:00 a.m., RN H said the meloxicam was not in the facility emergency supply of medications, and pharmacy had not yet delivered the medication. RN H said the medication was ordered on 1/14/25 at 6:10 p.m. which was after the pharmacy cut-off time for faxing medications so it would not have been delivered when pharmacy delivered medications the morning of 1/15/25. RN H said the meloxicam for R224 would arrive in the evening delivery of medications from pharmacy on 1/15/25. RN H admitted the pharmacy should have been contacted via phone call on 1/14/25 instead of by fax. RN H confirmed the pharmacy delivered medications stat (immediately) when requested by the facility. On 1/16/25 at 9:15 a.m., the MAR of R224 revealed the dose of meloxicam was signed out by RN H as administered on 1/15/25 at 8:00 a.m. Regional Nurse K was asked to provide a record of medication administration times on 1/15/25 for R224 and pharmacy delivery time and receipt for the meloxicam. On 1/16/25 at 1:05 p.m., a report Medication Admin Audit Report was presented by Regional Nurse K. The report disclosed the meloxicam signed out by RN H as administered at 8:00 a.m. on 1/15/25 was administered at 2:37 p.m. on 1/15/25. There were no medication notes or progress notes found in R224's record documenting the late administration of the medication. There was no documentation in the record indicating R224's physician had been notified of the medication being unavailable or administered late on 1/15/25 at 8:00 a.m. A pharmacy delivery manifest provided by Regional Nurse K on 1/16/25 at 1:05 p.m. documented the meloxicam for R224 was delivered on 1/16/25 at 1:08 a.m. Regional Nurse K was asked how the meloxicam was signed out as administered on 1/15/24 if the medication was not in the facility. Regional Nurse K said R224's family brought in the medication from home and RN H used the home supply of meloxicam for medication administration. Regional Nurse K confirmed there were no medication notes or progress notes regarding the delayed administration of the meloxicam or notification of R224's physician regarding medication unavailability or delayed administration. On 1/16/25 at 1:22 p.m., nurse manager (RN J) was asked the process if a medication is withheld or not available for administration. RN J said the physician should be notified. On 1/16/25 at 1:42 p.m., nurse manager (RN I) was asked the expectation if a medication is withheld or not available for administration. RN I said the nurse would be expected to call the physician and inform him, and the nurse should document in progress notes and follow-up with any new or revised orders implemented by the physician. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The policy Medication Errors dated as reviewed/revised on 1/24/24 read, in part: .'Medication error' means the observed or identified preparation or administration of medications or biologicals which is not in accordance with the prescriber's order . The facility shall ensure medications will be administered as follows: a. According to physician's orders . Medication administered not in accordance with the prescriber's order. Examples include, but not limited to i. Incorrect dose .

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. 49310 Based on observation, interview, and record review, the facility failed to ensure medications were administered as prescribed for two Residents (R224 and R47) of eight residents reviewed for medication administration. This deficient practice resulted in R224 experiencing excruciating pain and the potential for R47 to experience increased anxiety. Findings include: Resident #224 (R224) R224 was prescribed meloxicam 15 milligrams (mg) daily for pain. During medication administration observation on 1/15/25 at 1:07 p.m., the meloxicam order for R224 was read on the Medication Administration Record (MAR), indicating the medication was overdue to be administered. On 1/15/25 at 1:20 p.m., Registered Nurse (RN) H asked R224 if she was experiencing pain. R224 indicated she had pain in her back and neck. RN H asked R224 to rate the pain on a scale of one to ten with one being no pain and ten being excruciating pain. R224 said her pain was ten out of ten. When asked why the meloxicam had not been administered as scheduled at 8:00 a.m., RN H said the meloxicam was not in the facility emergency supply of medications, and pharmacy had not yet delivered the medication. RN H said the medication was ordered on 1/14/25 at 6:10 p.m. which was after the pharmacy cut-off time for faxing medications so it would not have been delivered when pharmacy delivered medications the morning of 1/15/25. RN H said the meloxicam for R224 would arrive in the evening delivery of medications from pharmacy on 1/15/25. RN H admitted the pharmacy should have been contacted via phone call on 1/14/25 instead of by fax. RN H confirmed the pharmacy delivered medications stat (immediately) when requested by the facility. On 1/16/25 at 9:15 a.m., the MAR of R224 revealed the dose of meloxicam was signed out by RN H as administered on 1/15/25 at 8:00 a.m. Regional Nurse K was asked to provide a record of medication administration times on 1/15/25 for R224 and pharmacy delivery time and receipt for the meloxicam. On 1/16/25 at 1:05 p.m., a report Medication Admin Audit Report was presented by Regional Nurse K. The report disclosed the meloxicam signed out by RN H as administered at 8:00 a.m. on 1/15/25 was administered at 2:37 p.m. on 1/15/25. There were no medication notes or progress notes found in R224's record documenting the late administration of the medication. There was no documentation in the record indicating R224's physician had been notified of the medication being unavailable or administered late on 1/15/25 at 8:00 a.m. A pharmacy delivery manifest provided by Regional Nurse K on 1/16/25 at 1:05 p.m. documented the meloxicam for R224 was delivered on 1/16/25 at 1:08 a.m. Regional Nurse K was asked how the meloxicam was signed out as administered on 1/15/24 if the medication was not in the facility. Regional Nurse K said R224's family brought in the medication from home and RN H used the home supply of meloxicam for medication administration. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Regional Nurse K confirmed there were no medication notes or progress notes regarding the delayed administration of the meloxicam or notification of R224's physician regarding medication unavailability or delayed administration. On 1/16/25 at 1:22 p.m., nurse manager (RN J) was asked the process if a medication is withheld or not available for administration. RN J said the physician should be notified. On 1/16/25 at 1:42 p.m., nurse manager (RN I) was asked the expectation if a medication is withheld or not available for administration. RN I said the nurse would be expected to call the physician and inform him, and the nurse should document in progress notes and follow-up with any new or revised orders implemented by the physician. Resident #47 (R47) R47 was prescribed Ativan 1 mg three times daily for diagnosed anxiety. On 01/16/25 at 7:31 a.m., RN D retrieved R47's blister pack (resident-specific card-type package containing a supply of medication) of Ativan labeled lorazepam (generic for Ativan) 0.5 mg. The instructions on the blister pack read Take 2 tablets by mouth three times daily for Anxiety. RN D placed one tablet in the medication cup and signed out one tablet on the medication record titled Control Substance Record. RN D was directed to the dosage discrepancy between the physician's dosage order for Ativan and the dosage contained in the blister pack. RN D said, She was supposed to get new pills. I ordered those. The order changed months ago. It was verified there were no blister packs of Ativan 1mg tablets available for dispensing to R47. Only 0.5 mg tablets were verified present in the controlled substance locked drawer. R47's medical record identified Ativan 1 mg three times daily was originally ordered on 11/22/23. A review of R47's Control Substance Record for lorazepam for 12/21/24 through 12/26/24 revealed R47 received only one tablet of lorazepam 0.5 mg instead of the two required to meet the prescribed dosage order on 12/21/24 at 1:38 p.m., 12/21/24 at 7:15 p.m., 12/22/24 at 8:50 a.m., and 12/22/24 at 1:15 p.m. The lorazepam Control Substance Record for 12/27/24 through 1/5/25 revealed R47 received 1 mg of Ativan on 1/4/25 with no other Ativan documented as administered on 1/4/25. Ativan 1 mg was documented on the Control Substance Record on 1/5/25 as being removed from R47's Ativan inventory five times: 1/5/25 at 2:10 p.m., 1/5/25 at 7:49 p.m., 1/5/25 at 8:00 a.m., 1/5/25 at 1:46 p.m., and 1/5/25 at 7:00 p.m. There were no orders in the record amending the three times daily frequency of Ativan administration. The Control Substance Record for R47's lorazepam for 1/6/25 through 1/15/25 were requested but not provided by the end of survey. RN I was interviewed on 1/16/25 at 1:42 p.m. RN I said administering the correct dosages of medications is one of the rights of medication administration. RN I said, Nurses absolutely need to adhere to the rights of medication administration. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The policy Medication Errors dated as reviewed/revised on 1/24/24 read, in part: Policy: It is the policy of this facility to provide protection for the health, welfare, and rights of each resident by ensuring residents receive care and services safely in an environment free of significant medication errors .Significant medication error means one which causes the resident discomfort or jeopardizes his/her health and safety . The facility shall ensure medications will be administered as follows: a. According to physician's orders .c. In accordance with accepted standards and principles which apply to professionals providing services. 2. The facility will consider factors indicating errors in medication administration, including, but not limited to, the following: a. Medication administered not in accordance with the prescriber's order. Examples include, but not limited to: i. Incorrect dose, route of administration, dosage form, or time of administration .5. To prevent medication errors and ensure safe medication administration, nurses should verify the following information: a. Right resident, right medication, right dose, right route and right time of administration. 6. If a significant medication error occurs, the following procedure will be initiated: a. The nurse assesses and examines the resident's condition and notifies the prescriber of the medication as soon as possible. b. Monitor and document the resident's condition, including response to any provider orders. c. Document actions taken in the medical record .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 49310 Based on observation, interview, and record review, the facility failed to implement safe and effective infection prevention and control (IPC) practices for eight residents (#10, #30, #14, #59, #50, #67, #6, and #65) of ten residents reviewed for IPC to prevent the potential transmission of communicable diseases and infections as evidenced by failure to: 1. Maintain room doors closed for residents with COVID-19. 2. Appropriately sanitize and disinfect contaminated medical equipment. 3. Remove Personal Protective Equipment (PPE) prior to exiting the room of a resident with COVID-19 on Transmission-Based Precautions (TBP). 4. Prepare and handle medications in a manner to prevent contamination. 5. Ensure care plans were initiated for residents with COVID-19. 6. Ensure physicians' orders for were obtained before placing residents in TBP. This deficient practice resulted in the potential for the transmission of pathogens between residents and the spread of infectious organisms to all 67 residents in the facility. Findings include: Resident #10 (R10) R10, who was on hospice services, tested positive for COVID-19 on 1/6/25. On 1/14/25 the door to R10's room contained a posting indicating R10 was on TBP. There was no physician's order in R10's record to place R10 in TBP nor was there a care plan to provide staff with interventions for COVID-19 and TBP. The door to R10's room was open to the hallway on 1/14/25 at 1:22 PM, 1/14/25 at 1:34 PM, 1/14/25 at 2:41 PM, 1/14/25 at 3:45 PM, 1/15/25 at 8:14 AM, 1/15/25 at 10:19 AM, and 1/15/25 at 11:19 AM. On 1/15/25 at 10:19 AM, the hospice nurse, Registered Nurse (RN) N, was observed exiting R10's room wearing the face shield, N95 mask, gown, and gloves she was wearing in the room. RN N propelled a wheeled, portable vital sign device from the room. RN N obtained disinfectant wipes from an isolation cart down the hallway and began wiping down the vital sign device in the hallway wearing the PPE worn in R10's room. RN N was asked where disinfecting of contaminated medical equipment should occur. RN N responded, I usually do it right here (and indicted the hallway). No one has asked me to go anywhere else. After wiping down the vital sign device, RN N removed the face shield, N95 mask, gown, and gloves in the hallway and carried the PPE down the hall to dispose of in a refuse container. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	RN C was in the hallway when RN N exited R10's room wearing PPE and was wiping down the medical equipment from R10's room. RN C did not instruct RN N to remove PPE prior to exiting R10's room or to take potentially contaminated equipment to the soiled utility room for cleaning and disinfecting. Resident #30 (R30) R30 tested positive for COVID-19 on 1/10/25. On 1/14/24 at 11:18 AM, the door to R30's room was observed to have TBP signage posted. The door was open to the hallway. The door was observed to be open on the following dates and times: 1/14/25 at 1:22 PM, 1/14/25 at 1:34 PM, 1/14/25 at 2:41 PM, 1/14/25 at 3:45 PM, 1/15/25 at 8:14 AM, 1/15/25 at 10:19 AM, 1/15/25 at 11:19 AM, 1/15/25 at 11:50 AM, and 1/15/25 at 12:27 PM. On 1/15/25 at 11:50 AM, R30 was in a wheelchair in the hallway without a mask. RN C and Certified Nurse Aide (CNA) E were in the hallway but did not request R30 to return to his room or put on a mask. RN P approached and spoke with R10 about lunch but did not request he go to his room or wear a mask. R30's COVID-19 care plan contained an intervention that read, in part: .Redirect back to his room when opening door or sitting at doorway. If he insists, have him wear a mask . Resident #14 (R14) R14 tested positive for COVID-19 on 1/6/25. There was no physician's order in R14's record to place R14 in TBP nor was there a care plan to provide staff with interventions for COVID-19 and TBP. On 1/14/25 at 1:12 PM, the door to R14's room was observed with posted TBP signage. The door to the room was open. The door to the room was open on the following dates and times: 1/14/25 at 1:22 PM, 1/14/25 at 1:34 PM, 1/14/25 at 2:41 PM, 1/14/25 at 3:45 PM, 1/15/25 at 8:31 AM, 1/15/25 at 10:19 AM, and 01/15/25 at 11:19 AM. Resident #59 (R59) R59 tested positive for COVID-19 on 1/9/25. On 1/14/25 at 1:11 PM, the door to R59's room was observed with posted TBP signage. The door to the room was open. The door to the room was open on the following dates and times: 1/14/25 at 1:22 PM, 1/14/25 at 1:34 PM, 1/14/25 at 2:41 PM, 1/14/25 at 3:45 PM, 1/15/25 at 8:14 AM, 1/15/25 at 10:19 AM, and 1/15/25 at 11:19 AM. Resident #65 (R65) R65 was in TBP for COVID-19. A sanitized and disinfected face shield was hanging on a hook outside of R65's room for the next staff member who entered the room to apply as part of necessary PPE. (continued on next page)

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	01/16/2025

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/15/25 at 1:17 PM, CNA F was walking in the hallway and bumped into the face shield resulting in the face shield falling to the floor. CNA F picked up the face shield from the floor and placed it back on the hook without cleaning or disinfecting the face shield. RN H was present and observed CNA F pick up the face shield and place it back on the hook without properly disinfecting it. RN H did not instruct CNA F to sanitize or disinfect the face shield. The Infection Preventionist (IP) G was interviewed on 1/15/25 at 4:57 PM. IP G said the doors to the rooms for residents who have COVID-19 were to remain closed. IP G said if residents leave their rooms they should be redirected back to their rooms if possible or encouraged to wear a mask and remain away from others. IP G said staff were educated on these endeavors, especially keeping the doors to the rooms closed. IP G said physicians' orders are required to place residents in TBP, and residents with COVID-19 should have care plans for the infection. IP G said PPE is expected to be removed prior to exiting the room of a resident on TBP, and it is not permissible to clean resident care equipment in the hallway. IP G said face shields are expected to be disinfected after being exposed to potential contamination. The policy Transmission-Based (Isolation) Precautions dated as last reviewed/revised on 12/27/23 read, in part: .It is our policy to take appropriate precautions to prevent transmission of pathogens . Residents on transmission-based precautions should remain in their rooms . An order for transmission-based precautions/isolation will be obtained for residents who are known or suspected to be infected or colonized with infectious agents that require additional controls to prevent transmission effectively .Donning personal protective equipment (PPE) upon room entry and discarding before exiting the room is done to contain pathogens . Residents on Droplet Precautions who must be transported outside of the room should wear a facemask if tolerated . The policy COVID-19 Prevention, Response and Reporting dated as last reviewed/revised on 5/26/24 read, in part: .It is the policy of this facility to ensure that appropriate interventions are implemented to prevent the spread of COVID-19 .Residents with suspected or confirmed SARS-CoV-2 infection should be placed in a single-person room when possible and available with the door kept closed . All non-dedicated, non-disposable medical equipment used for that resident should be cleaned and disinfected . Resident #50 (R50) During medication preparation for R50 on 1/16/25 at 7:31 AM, RN D opened a bottle of vitamins and dropped one on top of the medication cart. After picking up the vitamin and disposing of it in the biohazard container on the side of the medication cart, RN D placed her ungloved finger in the medication cup and moved the medications around to count and identify the pills in the med cup. Resident #67 (R67) When preparing medications for R67 on 1/16/25 at 7:31 AM, RN D poured an incorrect amount of Vitamin D capsules into the medication cup. RN D used her ungloved finger to scoop out the extra capsules from the medication cup and place the extra capsules back into the bottle, contaminating the remainder of the capsules in the container. Resident #6 (R6) (continued on next page)

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	01/16/2025

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R6 was prescribed Vitamin C 1,000 milligrams (mg). On 1/16/25 at 7:31 AM, RN D opened a bottle of Vitamin C 500 mg and dispensed one tablet from the bottle into a medication cup. RN D reached into the bottle of Vitamin C with her ungloved finger to remove an additional tablet to add to the medication cup, contaminating the inside of the bottle and therefore the remainder of the tablets in the bottle. On 1/16/25 at 7:31 AM, RN D picked up a stack of blister packs (resident-specific card-type package containing a supply of medication) that were stacked atop the medication cart and held them against her uniform while she reviewed the Medication Administration Record (MAR). After reviewing the MAR, RN D placed the blister packs back into the medication cart. Nurse manager, RN I, was interviewed on 1/16/25 at 1:42 p.m. RN I was asked the process if a nurse places an incorrect amount of medication into a medication cup. RN I said the nurse should dispose of all the medications in the cup and start preparation over or perform hand hygiene and put on a glove to remove the incorrect amount. RN I was asked about holding blister packs of medications against a uniform. RN I answered, I saw [RN D] do that. That's not the way meds (medications) should be handled - they should be put in the drawer without touching the body. It's infection control. The policy Medication Administration dated as reviewed/revised on 1/17/23 read, in part: . Medications are administered . in accordance with professional standards of practice, in a manner to prevent contamination or infection . 13. Remove medication from source, taking care not to touch medication with bare hand .