STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235630	A. Building B. Wing	07/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Wyoming	2786 56 Street, SW Wyoming, MI 49418

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to obtain informed consent and offer information about formulating an Advanced Directive for 1 resident (R82) out of 5 residents reviewed for Advanced Directives. Findings include: Review of an admission Record reflected R82 admitted to the facility on [DATE] with diagnoses that included encephalopathy (a brain disease that can appear as confusion, memory loss, personality changes and/or coma), cognitive communication deficit, mild cognitive impairment, major depression, and generalized anxiety disorder. Review of a form Advanced Directives Acknowledgements/CPR (Cardiopulmonary Resuscitation) Consent reflected what CPR is; Acknowledgments, including spaces after each statement for initials to indicate understanding,I have been informed of my rights and all rules and regulations regarding decisions regarding medical care; I have been fully informed of my options when choosing CPR or Do Not Resuscitate (DNR) services; I understand I have the right to alter my decisions concerning CPR or DNR services and that any change must be communicated., a CPR Decision for resuscitation, no resuscitation or I do not wish to make a choice at this time and a section that pertained to requesting additional information about how to formulate an Advanced Directive (Medical POA, (power of attorney)) with boxes giving the signer of the form the option to check a box indicating Yes or No. Review of the Advanced Directives Acknowledgements/CPR Consent form signed by R82 on [DATE] (the date R82 admitted to the facility) reflected R82 specified their CPR decision but was incomplete pertaining to areas of informed consent and interest in additional information about formulating an Advanced Directive or establishing a Medical Power of Attorney. A facility representative (the Director of Nursing, DON) also signed the form on [DATE]. During an interview on [DATE] 9:42 AM, Social Services Director (SSD) F reported the Advanced Directives/CPR Consent form is new to the admission process in the last 6 months. According to SSD F the priority is to get the form signed by the resident in order to establish that resident's code status. Upon reviewing R82's form that was signed on [DATE], she could not tell if any follow-up had occurred to determine if R82 had a medical POA and/or was fully informed of their rights related to CPR. During an interview on [DATE] at 10:52 AM the DON reported she assisted with the admission of R82 and only got the signature R82's CPR decision. The DON reported the resident would stay a full code until the physician gets the two witnesses and order on the chart. The DON said that any additional information pertaining to the Advanced Directives Acknowledgements/CPR Consent may be available with SSD E who is assigned to R82 at the facility. The DON acknowledged that there is pertinent information missing from the form. Review of a Discharge Planning Evaluation form dated [DATE] indicated an admission Care Conference took place and did NOT include R82 and did not reflect a discussion about Advanced Directives or CPR Decisions had taken place. During an interview on [DATE] at 11:30 AM, SSD F reported that R82's Advanced Directives/CPR Consent form was incomplete and had been signed by the R82 and the DON. SSD F said that R82 had family involved with care conferences but did not have any documentation indicating they would have any authority to act on R82's behalf if her circumstances changed and she was no longer able to make medical decisions for herself. Review of a facility policy Residents' Rights Regarding Treatment and (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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Advanced Directives dated [DATE] reflected, It is the policy of this facility to support and facilitate a resident's right to request, refuse and/or discontinue medical or surgical treatment and to formulate an advanced directive. The policy specified 1. On admission, the facility will determine if the resident has executed an advanced directive, and if not, determine whether the resident would like to formulate an advanced directive. 2. The facility will provide the resident or resident representative information, in a manner that is easy to understand, about the right to refuse medical or surgical treatment and formulate an advanced directive.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the physician reviewed monthly drug regimen review recommendations for 1 resident (R70) of 5 residents reviewed for unnecessary medication. Findings include:Review of an admission Record revealed R70 admitted to the facility on [DATE] with pertinent diagnoses which included hypertension and gastro-esophageal reflux disease (GERD).Review of R70's drug regimen review Physician Recommendations dated 6/14/2025 revealed .This resident is receiving famotidine 20mg BID (twice daily) for GERD since 03/2023. Please evaluate for continued need/reduction. There was no indication that the physician had reviewed this recommendation.Review of R70's Physician's Orders on 7/14/2025 at 11:14 AM revealed an active order for famotidine 20mg to be taken by mouth twice a day. Further review of the electronic medical record revealed no documentation that the physician had reviewed the drug regimen review Physician Recommendations dated 6/14/2025.In an interview on 7/24/2025 at 12:42 PM, the Director of Nursing (DON) reported R70's drug regimen review Physician Recommendations dated 6/14/2025 had not been reviewed by the physician. The DON reported she was not sure how this was missed.Review of facility policy/procedure Addressing Medication Regimen Review Irregularities, reviewed 12/28/2023, revealed .Any irregularities noted by the pharmacist during this review must be documented on a separate, written report. The report will be sent to the attending physician. The attending physician must document in the resident medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. The report should be submitted to the DON within 10 working days of the review.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation and interview, the facility failed to maintain proper infection control practices for one of two Residents (R69) observed during clinical care activities. Findings include:Resident #69 (R69)On 7/23/25 at approximately 9:41 AM, RN C administered a prescribed nasal spray to R69. RN C prepared to give R69 their insulin injection via pen in the abdomen by cleansing the area with alcohol swab. RN C then waved her hand back and forth over the area swabbed by alcohol to get it dried prior to administering the insulin injection. According to the World Health Organization (WHO) 2020, injections are unsafe when administered with unsterile or improper techniques. The WHO recommends swabbing the injection site for 30 seconds and allowing the area to dry for 30 seconds. RN C waving their hand over the alcohol causes it to evaporate too quickly, disrupting the alcohol's action, while potentially introducing new microorganisms. RN C's actions can increase the risk for infection at the injection site. Upon return to the medication cart, RN C did not cleanse the nasal applicator that had visible residue on the tip prior to placing it back into the medication cart. RN C did not cleanse insulin pen prior to placing it in a plastic bag without sealing the bag and put it back in the medication cart. Not cleansing the nasal tip or the insulin pen increased the risk for cross contamination to other residents' medications.On 7/24/25 at 8:32 AM, during interview with Infection Prevention (IP) nurse, the IP nurse stated that all staff were expected to perform their duties including medication administration, hand washing, and environmental services per standards of care. The IP nurse stated that any education given to staff, regarding these duties was provided by the education department. The IP nurse could not state the standards regarding medication administration for insulin or nasal sprays.