STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	134110	A. BUILDING _____ B. WING _____	4/3/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDILODGE OF MARSHALL	879 EAST MICHIGAN AVE MARSHALL, MI 49068

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000 SS=	INITIAL COMMENTS Medilodge of Marshall was surveyed for a Recertification survey on 4/3/25. Intakes: MI00151639 Census: 91	F0000		
F0585 SS= D	Grievances §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or	F0585	Element 1 Resident #52 no longer resides in the facility. Resident #52 concerns were addressed with Assistant Administrator. A white noise machine was purchased to assist with the noise level in the hall. Follow up visit was completed, and resident states the machine has helped. Concern form signed and completed by the Administrator. Element 2 The Administrator/Designee will complete an audit of residents to ensure concerns have been documented on grievance forms. Any new concerns will be documented per the QA policy and addressed. Element 3 The QAPI Committee will review the Quality Assistance Procedure policy and deem it appropriate. The Administrator and Director of Nursing have been educated by Regional Director of Operations on the QA Policy. Staff will be educated on the QA policy/grievance policy to ensure concerns are addressed appropriately. Staff to turn concern forms to the administrator daily. Administrator will follow up with appropriate departments to ensure concerns are addressed. Element 4 Administrator/Designee will complete random weekly audit for 4 weeks and then monthly until substantial compliance is achieved, ensuring concern forms and follow up are	4/21/2025

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

Electronically Signed | 04/23/2025

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.

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	her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to		completed. Audit findings will be presented to the facility QAPI Committee and will only be discontinued with substantial compliance and with approval of the facility QAPI Committee. The Administrator is responsible for achieving and maintaining compliance.	

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	whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that grievances were promptly documented, investigated, tracked and resolved for one resident of one resident reviewed for grievances (Resident #52), resulting in anger, frustration and unresolved grievances. Findings include: Review of the Face Sheet and Minimum Data Set (MDS) dated 3/20/25, reflected R52 was a 42 year old female admitted to the facility on 5/6/23, with diagnoses that included hypertension(high blood pressure), Guillain-Barre Syndrome with paraplegia, major depression and anxiety disorder. The MDS reflected R52 had a BIM (assessment tool)			

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	score of 15 which indicated her ability to make daily decisions was cognitively intact. During an observation on 3/31/25 at 2:55 PM, resident in Hall C, room 9 could be heard yelling out repeatedly, "help me, help me, help me." with door closed. Observed resident in bed through small crack in closed door. Continued to observe with no staff response for greater than thirty minutes. During an observation and interview on 3/31/25 at 4:46 PM, R52 door was closed, this surveyor was granted permission to enter room. R52 was laying in bed, appeared calm and able to answer questions without difficulty. R52 reported they (herself along with roommate) preferred to have door closed because of three residents all around them that yell out constantly through the day and night and reported difficult to sleep (Room C9 directly across the hall). R52 stated, "I know one of the residents that yells out has dementia but is so annoying and frustrating." R52 and roommate both reported had told staff on several occasions about frustration with no changes. During an interview on 4/01/25 at 2:22 PM, R52 was in bed, appeared slightly anxious and reported continued frustration related to three residents who yell out at all hours of the day and seem to be in sequence. R52 reported keeps door closed, music on via ear buds with continued frustration and stated, "on her last nerve."			

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	During an interview on 4/03/25 at 9:15 AM, Certified Nurse Aid(CNA) "Z" reported working at facility for almost one year and CNA "AA" reported about four years. CNA "Z" and CNA "AA" reported routinely worked on C hall and was familiar with residents and reported daily complaints from residents on hall about residents yelling out. CNA "Z" and CNA "AA" reported alert and oriented residents on Hall C, including R52, often report frustration and then yell back to shut up, and stated was not like R52 at all. CNA staff reported they both reported to Unit Manager "BB". During interview one of three residents on Hall C started to yell out. During an interview on 4/03/25 at 12:15 PM, R52 reported again continued frustration about yelling residents constantly every day. R52 reported recently even yelled back and that is not like her. R52 reported another resident on the hall who often keeps to self, quiet and self propels up and down halls raised his voice at one of yelling residents which was very unlike him. R52 reported both CNA "Z" and CNA "AA" aware of frustration and reported was not familiar with grievance processes at facility. During an interview on 4/3/25 at 12:25 p.m., reported would expect staff to reported resident concerns to herself or unit managers and grievances should be completed and verified.			

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F0641 SS= D	Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to complete accurate Minimum Data Set (MDS) assessments for one resident (#8) of 19 residents reviewed for MDS accuracy, resulting in inaccurate MDS assessments. Findings Included: Resident #8 (R8) Review of the medical record demonstrated R8 was admitted to the facility 02/23/2025 with diagnoses that included type 2 diabetes, hypertension, stage 3 kidney disease, vascular dementia, cognitive communication deficit, dysphagia (difficulty swallowing), cataract right eye, mood disorder, hallucinations, delusional disorder, anxiety, depression, chronic pain, gastro-esophageal reflux, and hyperlipidemia (high fat content in blood). Review of R8's Minimum Data set (MDS), with an Assessment Reference (ARD) of 02/28/2025, revealed R8 had a Brief Interview for Mental Status (BIMS) of 05 (severe cognitive impairment) out of 10. Review of section H-Medications of the MDS, with the same ARD, demonstrated that R8 had received one injection of insulin during the	F0641	Element 1 Resident #8 MDS assessment was modified to insure correct coding of section N of the MDS. Element 2 All current residents with insulin coded on the most recent MDS were reviewed to verify accurate drug class coded and modifications made as necessary. Element 3 Regional MDS Coordinator to provide facility MDS coordinator and MDS nurse education on RAI manual Chapter 3, pages N1-N28 for accurate coding of Section N. Facility MDS staff provided with pharmacy reference material to identify proper drug classes of medications. MDS will verify MDS coding of section N to ensure appropriate coding of insulin medication class prior to completion. Element 4 MDS coordinator or designee will audit Section N for accurate insulin coding for 5 residents weekly x4 weeks, and then 5 residents monthly x 3 months. Audit findings will be presented to the facility QAPI Committee and will only be discontinued with substantial compliance and with approval of the facility QAPI Committee. Administrator is responsible for overall compliance	4/21/2025

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	seven day look back period. Review of section H- Medications of the MDS, with an ARD of 12/24/2024, demonstrated that R8 had received seven injections of insulin during the seven day look back period. Review of R8's physician orders did not demonstrate that R8 had ever received insulin injections during her entire stay at the facility. In an interview on 04/01/2025 at 03:57 p.m. Minimum Data Set (MDS) Coordinator "E" explained that she was responsible for the completion of the MDS in the facility. MDS Coordinator "E" confirmed that R8's MDS, with an ARD of 02/28/2025, revealed that she had received one injection of insulin. MDS Coordinator "E" also confirmed that R8's MDS, with an ARD of 12/24/2024, revealed that she had received seven injections of insulin. MDS Coordinator "E" then reviewed R8's physician orders and verified that R8 did not have an order for insulin her entire stay at the facility. MDS Coordinator "E" could not explained why R8's MDS, with an ARD of 12/24/2024 and 02/28/2025, had been coded with incorrect information.			
F0656 SS= D	Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with	F0656	Element 1 Resident 7 no longer resides in facility. Element 2 Residents in facility were reviewed to ensure their care plans were implemented	4/21/2025

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	the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by:		appropriately to reflect activities interests and preferences. If missing, interests and preferences were added to care plans. Element 3 Education was provided to Activity Director and staff to ensure care plans are implemented timely to include interests. Activities staff will ensure comprehensive care plans are updated upon completing the activities assessment. Element 4 Act dir/designee will audit 10 random residents weekly to ensure activity comprehensive care plan is completed and individualized. Audit findings will be presented to the facility QAPI Committee and will only be discontinued with substantial compliance and with approval of the facility QAPI Committee. Any instances of noncompliance that are identified will be addressed per company policy concerning education and disciplinary action when necessary. The Administrator is responsible for achieving and sustaining compliance.	

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	Based on observation, interview, and record review the facility failed to implement comprehensive resident-centered care plans for one out of 19 residents (R7), resulting in unmet care needs and constant yelling out for help and increase frustration for all residents on hall C. Findings include: Review of the Face Sheet and Minimum Data Set (MDS) dated 2/16/25, reflected R7 was a 84 year old female admitted to the facility on 2/10/25, with diagnoses that included hypertension(high blood pressure), heart failure, kidney failure, lung cancer, depression and anxiety disorder. The MDS reflected R7 had a BIM (assessment tool) score of 15 which indicated her ability to make daily decisions was cognitively intact. During an observation on 3/31/25 at 2:55 PM, R7 was laying in bed with door open small crack yelling, "help me, help me, help me." R7 refused to speak with surveyor. R7 continued to yell out for over half an hour and no staff observed to enter room. Review of R7 care plans, dated 2/25/25, reflected, "[named R7] is at risk for altered activity patterns/pursuits related to anxiety, continuous oxygen, decline in health status,			

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	disinterest...1:1 visits from staff and volunteers as [named R7] will allow...Provide [named R7] with activity calendar...Respect wishes to decline invitations into structured activity programs...[named R7] preferred activities are:(SPECIFY)Keeping up with the news, watching TV, coloring or word searches, reading if she is in the mood..." Review of R7 tasks, dated 3/1/25 through 4/3/25, reflected no evidence of 1:1 activity visits. During an observation on 4/01/25 at 11:00 AM, R7 observed sleeping in bed. R7 observed in bed on several occasions between 8:30 a.m. and 5:30 p.m. with no observed 1:1 staff activity or independent activity. During an observation on 4/2/25 at 2:45 p.m., R7 observed sleeping in bed. R7 observed in bed on several occasions between 8:30 am and 5:00 p.m. with no observed 1:1 staff activity or independent activity. During an interview on 4/03/25 at 9:15 AM, Certified Nurse Aid(CNA) "Z" reported working at facility for almost one year and CNA "AA" reported about four years. CNA "Z" and CNA "AA" reported routinely worked on C hall and was familiar with residents and reported daily complaints from residents on hall about residents yelling out. CNA "Z" and CNA "AA" reported alert and oriented residents on Hall C often report frustration.			

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	CNA "Z" and CNA "AA" reported R7 does not get out of bed and had never observed staff doing activities with R7 including 1:1 activities in room. Review of R7 Nurse Progress notes, dated 3/1/25 through 4/3/25, reflected almost daily mentions of R7 yelling out from room, including causing frustration and sleep disruption to other residents on hall C. During an interview and Record review of 1:1 activity staff documentation, provided by NHA "A", date for February through March 2025, reflected R7 was offered 1:1 activity on five occasions in 60 days according to list of highlighted names.(unable to located documentation in R7 medical record). NHA "A" reported would expect staff to document in medical record and follow resident care plans. There was no evidence that R7 had been invited to and refused any group, music programs, or taken outside.			
F0679 SS= D	Activities Meet Interest/Needs Each Resident §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each	F0679	Element 1 Resident 7 no longer resides in facility. Element 2 Residents in facility were reviewed to ensure their care plans were updated appropriately to reflect interests and preferences. If missing interests and preferences were added to care plans. Element 3 Education was provided to Activity Director and staff to ensure likes/dislikes are followed	4/21/2025

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	resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide meaningful, individualized, and engaging activities to one resident (#7) of one reviewed for activities. Findings include: Review of the Face Sheet and Minimum Data Set (MDS) dated 2/16/25, reflected R7 was a 84 year old female admitted to the facility on 2/10/25, with diagnoses that included hypertension(high blood pressure), heart failure, kidney failure, depression and anxiety disorder. The MDS reflected R7 had a BIM (assessment tool) score of 15 which indicated her ability to make daily decisions was cognitively intact. During an observation on 3/31/25 at 2:55 PM, R7 was laying in bed with door open small crack yelling, "help me, help me, help me." R7 refused to speak with surveyor. R7 continued to yell out for over half an hour and no staff observed to enter room. Review of R7 care plans, dated 2/25/25, reflected, "[named R7] is at risk for altered activity patterns/pursuits related to anxiety,		and care plan updated and a meaningful and diverse calendar was offered. Activities staff will ensure residents get equal opportunity to participate in activities each week. Element 4 Act dir/designee will audit 10 random residents weekly to ensure activity likes and dislikes are in place and care planned. Audit findings will be presented to the facility QAPI Committee and will only be discontinued with substantial compliance and with approval of the facility QAPI Committee. Any instances of noncompliance that are identified will be addressed per company policy concerning education and disciplinary action when necessary. The Administrator is responsible for achieving and sustaining compliance.	

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	continuous oxygen, decline in health status, disinterest...1:1 visits from staff and volunteers as [named R7] will allow...Provide [named R7] with activity calendar...Respect wishes to decline invitations into structured activity programs...[named R7] preferred activities are:(SPECIFY)Keeping up with the news, watching tv, coloring or word searches, reading if she is in the mood..." Review of R7 tasks, dated 3/1/25 through 4/3/25, reflected no evidence of 1:1 activity visits. During an observation on 4/01/25 at 11:00 AM, R7 observed sleeping in bed. R7 observed in bed on several occasions between 8:30 a.m. and 5:30 p.m. with no observed 1:1 staff activity or independent activity. During an interview on 4/03/25 at 9:15 AM, Certified Nurse Aid(CNA) "Z" reported working at facility for almost one year and CNA "AA" reported about four years. CNA "Z" and CNA "AA" reported routinely worked on C hall and was familiar with residents and reported daily complaints from residents on hall about residents yelling out. CNA "Z" and CNA "AA" reported alert and oriented residents on Hall C often report frustration. CNA "Z" and CNA "AA" reported R7 does not get out of bed and had never observed staff doing activities with R7 including 1:1 activities in room.			

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	Review of R7 Nurse Progress notes, dated 3/1/25 through 4/3/25, reflected almost daily mentions of R7 yelling out from room, including causing frustration and sleep disruption to other residents on hall C. During an interview and Record review of 1:1 activity staff documentation, provided by NHA "A", date for February through March 2025, reflected R7 was offered 1:1 activity on five occasions in 60 days according to list of highlighted names.(unable to located documentation in R7 medical record). NHA "A" reported would expect staff to document in medical record and follow resident care plans. There was no evidence that R7 had been invited to and refused any group, music programs, or taken outside.			
F0686 SS= D	Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as	F0686	Element 1 Resident #81 was assessed by a licensed nurse to ensure wound assessment was completed to include measurements and correct staging. The APM was assessed to ensure proper function. And resident has been turned and repositioned per care plan. Element 2 Residents in facility with impaired skin integrity are considered at risk. Residents in facility have had a full skin assessment completed. If any new skin areas found, they were measured, and assessed, with appropriate interventions in place. Braden assessments were completed to identify the residents at risk for skin	4/21/2025

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	evidenced by: Based on observation, interview, and record review the facility failed to prevent the development of a pressure ulcer for one resident (#81) of one residents reviewed for the development of pressure ulcers. Findings Included: Resident #81 (R81) Review of the medical record revealed R81 was admitted to the facility 12/23/2024 with diagnoses that included fracture of left femur, repeated falls, dementia, nutritional deficiency, protein calorie malnutrition, urinary incontinence, and bilateral (right and left) hearing loss. The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/29/2025, demonstrated a Brief Interview for Mental Status (BIMS) of 2 (severe cognitive impairment) out of 15. Review of section M-Skin Conditions, of the MDS with the same ARD, demonstrated that R81 did not have any pressure ulcers. During a telephone interview on 03/31/2025 R81's family member "F" explained that R81 had a pressure ulcer, that he had obtained at the hospital prior to his admission at the nursing facility. R81's family member "F" could not explain if the R81's currently had a pressure ulcer.		breakdown. The DON/designee to ensure accurate staging of the wound was documented and measurements completed. Any identified concerns were addressed. Care plans were reviewed by IDT for Residents with pressure ulcer or at risk for developing to ensure interventions were in place including turning and repositioning to promote healing. Element 3 The Administrator and DON have reviewed using the NPUAP Guidelines for Pressure Injury Staging, Pressure injury prevention and management and Pressure Injury Prevention Guidelines Policies and deemed them appropriate. Wound Nurse will receive education from the DON/Designee on staging and the documentation required for a pressure ulcer using the NPUAP Guidelines for Pressure Injury Staging. This education also includes who to contact if assistance is needed. Licensed nurses will receive education on Pressure Ulcer/Skin Breakdown Clinical Protocol including who to notify if a new area is observed or a change in injury is noted, also educated on documenting nutritional supplement intake. Clinical staff including Nurses Aides will be educated on Pressure Ulcer Prevention and Management including where to find the turn and reposition schedule in the kardex for each resident. As well as ensuring interventions are in place. Daily (Monday-Friday) during the morning clinical meeting all new admissions and clinical alerts will be reviewed to identify any new skin conditions. New admissions and residents with pressure ulcers will be observed weekly during wound rounds to ensure that the staging of the wound remains accurate. Changes in the	

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	Review of R81's medical record demonstrated an Admission assessment, dated 12/23/24, demonstrated surgical wound to left lateral thigh but did not demonstrate a pressure wound. Progress notes dated 3/20/2025 at 01:56 p.m. "IDT-Interdisciplinary Progress Note Note Text: IDT team met to discuss resident changes. Resident has new stage 3 pressure and has had a weight decrease of 6.3% in 30 days. Due to cognition IDT team agrees resolution of these declines will not be met within 14 days". Review of R81's plan of care revealed entry on 12/27/2024 "Resident has impaired skin integrity as evidenced by: admitted with left lateral thigh surgical incision, left leg bruising related to displaced intertrochanteric fracture of left femur with surgical repair Resident is at further risk for impaired skin integrity related to repeated falls, dementia, urinary incontinence". Review of R81's medical demonstrated a documents entitled "Skin & Wound Evaluation V7.0", dated 03/19/2025, revealed documentation that revealed R81 had a pressure ulcer, stage 3 to left gluteal fold. The document also was marked that the pressure wound was present on admission, however no other assessment was available in R81's medical record. Review of the wound measurements on the "Skin & Wound Evaluation V7.0",dated 03/19/2025, revealed a wound of with a surface area of 6.3cm (centimeters) squared, a length of 4.4ccm, a width of 1.9cm, and a depth was documented		pressure ulcer will be reported to the provider for further recommendations as needed. Element 4 DON/Designee will audit 10 residents with pressure ulcers or with a decreased Braden score per week ensuring care plan is appropriate and being implemented, wound notes, and provider notes accurately reflect the status of the pressure injury weekly x4 weeks and then monthly to ensure that interventions are in place and appropriate for resident. Results will be reviewed monthly by the QAPI Committee. The Administrator is responsible to maintain compliance.	

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	as none applicable. The document as revealed that 50% of the wound had "slough" present in the wound bed. Review of R81's medical record demonstrated a document entitled "Skin & Wound Evaluation V7.0" dated 03/31/2025 revealed documentation that R81 had a pressure ulcer, stage 3 to left gluteal fold. The same document revealed wound measurements of 1.8cm(centimeters) squared surface area, 2.0cm in length, 1.3cm in width, and less than 0.1cm in depth. The documents also revealed the wound was covered with 90% of slough. Review of R81's medical record revealed a document entitled "Skin Assessment -V4", completed 03/17/2025 that revealed "right gluteal fold - open area". No other wounds record on the document. The document entitled "Skin Assessment-V4", completed 3/24/2025, revealed "left gluteal fold-pressure, right gluteal fold pressure, other - left elbow scab, and other left lateral foot/abrasion. In an interview of 04/02/2025 at 09:06 a.m. Wound Nurse (WN) "G" explained that she was responsible for the oversight of all pressure ulcers at the facility and also explained she was wound certified. WN "G" explained that it was the facility policy that skin assessments are completed weekly on every resident at the facility. WN "G" explained that it is facility policy that the skin assessments would be recorded weekly on a			

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	document entitled "Skin Assessment V4". WN "G" explained that if a resident had a pressure ulcer, it was the facility policy weekly measurements were completed and a picture of those wounds would be recorded. After Review of R81's "Skin Assessment -V4", dated 03/17/2025, WN "G" explained that she had completed that documentation. WN "G" was asked to review R81's document entitled "Skin & Wound Evaluation V7.0", dated 03/19/2025. She explained that the pressure ulcer to his left gluteal fold was first identified as a stage 3 on 03/19/2025. WN "G" was asked why "Skin Assessment -V4", dated 03/17/2025 did not demonstrate the wound to the left gluteal fold that was recorded as a pressure ulcer. WN "G" explained that she must have missed it. WN "G" was asked to review the pictures of the left gluteal wound, that were taken 03/19/2025 and 03/31/2025. WN "G" was asked how she could stage the pressure wound with "slough tissue" covering the wound bed. WN "G" explained that the documentation of a stage 3 wound was not correct and R81's pressure ulcer to his left gluteal fold should be documented as an "unstageable wound". WN "G" could not explain why a R81 wound assessment was not completed weekly. Review of R81's medical record revealed a plan of care, with a revision date of 03/20/2024, which stated "Resident has impaired skin integrity as evidenced by: Stage 3 pressures to left gluteal fold". The same			

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	plan of care demonstrated Interventions which stated: 1. "Pressure redistribution mattress to bed", written 12/23/2024. 2. "Air pressure redistribution mattress to bed", written 01/02/2025. 3. "Alternating pressure redistribution mattress" written 03/20/2025. 4. "Assist resident with turning and repositioning as needed" written12/23/2024. On 04/02/2025 at 10:00 a.m. during observation and attempted interview R81 was observed lying down in bed. R81 was observed lying on his left side, facing the wall, and his lower extremities appeared contracted. R81 was unable to answer questions. A wings alternating mattress was observed on R81's bed and the pump was observed not to be plugged in. The alternating mattress was observed totally deflated. During an interview on 04/02/2025 at 10:17 a.m. Certified Nursing Aide (CNA) "H" explained that it was the facility expectation that residents are turned every two hours. CNA "H" explained that it was documented in the task section of R81's POC (Plan of Care Documentation- used by the CNA's to document the completion of task).			

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	During an interview on 04/02/2025 at 10:19 a.m. Certified Nursing Aide (CNA) "I" explained that it was the facility expectation that residents are turned every two hours. CNA "I" explained that it would be documented every two hours in the residents POC. During an interview on 04/02/2025 at 10:21 Certified Nursing Aide (CNA) "J". explained that it was the facility expectation that residents are turned every two hours. CNA "J" explained that it would be documented every two hours in the residents POC. During an interview on 04/02/2025 at 10:24 Certified Nursing Aide (CNA) "K". explained that it was the facility expectation that residents are turned every two hours. CNA "K" explained that it would be documented every two hours in the residents POC. CNA "K" explained that she also checks the "air pumps" if a resident has one. CNA "K" explained that she was providing care to R81 today and was asked to demonstrate R81's mattress pump. When CNA "K" entered R81's room and viewed that the alternating air mattress was deflated she identified the "air pump" was not plugged into the electrical outlet. CNA "K" then proceed to plug the "air pump" into the electrical outlet and R81's alternating air mattress was observed to inflate. On 04/02/2025 at 11:20 a.m. Wound Nurse (WN) "G" was explained that R81 had wound			

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	dressing completed earlier in the morning but was willing to re complete the wounds. R81 was observed lying in bed. R81 was rolled further to the left side of his bed with the assistance of Registered Nurse (RN) "L" and Licensed Practical Nurse "M". Observed left gluteal fold dressing, dated 04/02/2025, was removed. Minor blood drainage noted on dressing. Area observed with eschar in wound bed. Wound bed was cleaned with wound cleanser. A Picture was taken by wound nurse and wound was measured. Wound measurements were observed to be 2.5cm (centimeters)squared in surface area, x 2.3 cm in length, 1.4cm in width, and 0.1cm in depth. WN "G" explained that the wound still was classified as unstageable as slough tissue was covering the wound bed. WN "G" then applied calcium alginate, and reapplied foam dressing. It was then observed that R81 was rolled to his right side, and his left sock was removed from his foot. A foam dressing was observed present on his left outer foot. The foam dressing was dated 04/02/2025. The foam dressing was removed and observed to have bloody slough present on the dressing. The wound was observed with slough tissue covering the bed of the wound. The wound was cleansed with wound cleanser. Wound measurements were taken by WN "G" and observed to be 1.3cm squared in surface area, 1.5cm in length, 1.2cm in width, and 0.2cm in depth. When asked WN "G" how she would classify the wound she stated that it was unstageable but explained that she would need assistance of the physician to			

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	classify the wound as pressure wound or a vascular wound. Review of documentation provided by the facility demonstrated a "Skin & Wound Evaluation V7.0", dated 04/02/2025, that described the left lateral foot wound as pressure - unstageable." Review of R81's turning and reposition task, since 01/29/2025 did not demonstrate that he had been turned every 2 hours has reported. The documentation demonstrated that R81 was turned only once per shift. The documentation also demonstrated that R81 was only turned and repositioned twice per day, on the days before the pressure wound to R81s left gluteal fold for the dates of: 01/30/2025, 01/31/2025, 02/03/2025, 02/04/2025, 02/05/2025, 02/08/2025, 02/14/2025, 02/15/2025, 02/26/2025, 03/03/2025, 03/05/2025, 03/07/2025, 03/10/2025, 03/11/2025, and 03/13/2025. The documentation demonstrated that R81 was turned only once per shift. The documentation also demonstrated that R81 was only turned and repositioned once per day, on the days before the pressure wound to R81s left gluteal fold for the dates of: 02/07/2025, 02/11/2025, and 02/13/2025.			
F0695 SS= D	Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care,	F0695	Element 1 Resident #38 and 87 physician orders reviewed and updated to reflect correct trach orders including sizing. Element 2	4/21/2025

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	including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure professional standards for tracheostomy care including physician orders with the size of the tracheostomy for two Residents (#38, #87) of three residents review for respiratory care. Findings Included: Resident #87 (R87) Review of the medical record revealed R87 was admitted was admitted 03/14/2025 with diagnoses that included stroke, respiratory failure, tracheostomy, dysphagia (difficulty swallowing), nutritional deficiency, cardiomyopathy (heart muscle disease), atrial fibrillation, ischemic cardiomyopathy (damaged heart muscle and heart can not pump effectively), asthma, hyperlipidemia (high fat content in blood), tricuspid (heart valve) insufficiency, and hypertension. The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 03/20/2025, revealed R87 had a Brief Interview of Mental Status (BIMS) of 13 (intact cognition) out of 15.		Residents with Trachs are like residents. No other residents in facility with a trach. Element 3 The Trach Policy has been reviewed by the NHA and DON and deemed appropriate. The facility licensed nursing staff have been re-educated on the Trach care policy, and appropriate orders required During daily clinical stand up nurse managers will ensure orders are in place for Trach Element 4 Residents who have a Trach will have their orders reviewed weekly x4 weeks to ensure the orders are correct and match the trach currently being used for each resident. Audits will then be completed monthly for 3 months, or until substantial compliance is obtained or discontinued by the QAPI team. Results will be reviewed monthly by the QAPI Committee. The Administrator is responsible to maintain compliance	

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	On 04/03/2025 at 10:19 a.m. during observation and interview, R87 was observed lying down in bed. She was observed to have oxygen connected to her tracheostomy and was breaking easily. R87 explained that she only had her tracheostomy for a few months. A 7.0 was observed on the inner cannula of her tracheostomy and it appeared to be clean and tracheostomy ties were observed intact. Review of R87 medical record demonstrated the orders "Trach care every shift and as needed three times a day for trach care" and "suction tracheostomy as needed" and "Suction tracheostomy as needed as needed." No orders were present that explained the current size of the inner cannula or outer cannula of the tracheostomy. No place in the medical record did it identify what was the current size of the inner or outer cannula of the tracheostomy. In an interview on 04/03/2025 at 10:38 a.m., Unit Manager (UM) "N" explained that residents that have a tracheostomy should have orders that define the size of the inner and outer cannula of the tracheostomy. UM "N" was asked to verify if R87 had physician orders defining the size of the inner and outer cannula of the tracheostomy. UN "M" confirmed that no orders were present. UM "N" could not explain why orders were orders were not present of the size of R87's inner and outer cannula of her tracheostomy.			

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	In an interview on 04/03/2025 at 01:27p.m. Regional Respiratory Therapist (RRT) "Q" explained that it was a professional standard of practice that all resident with a tracheostomy would include physician orders that identified the size of the inner and outer cannula of the tracheostomy and should include the manufacture of the cannula as the sizes may be different. Resident #38(R38) Review of the Face Sheet and Minimum Data Set (MDS) dated 3/19/25, reflected R38 was a 70 year old male admitted to the facility on 11/26/24, with diagnoses that included hypertension(high blood pressure), heart failure, respiratory failure with tracheostomy, pulmonary fibrosis, depression and anxiety disorder. The MDS reflected R38 had a BIM (assessment tool) score of 14 which indicated he ability to make daily decisions was cognitively intact. During an observation and interview on 3/31/25 at 3:35 PM, R38 was sitting in wheelchair with tracheostomy in place and able to answer questions without difficulty. R38 reported staff do not perform tracheostomy care on regular basis and depends on staff working. Review of R38 Physician orders, dated 1/7/25, reflected, "Trach Care PRN every morning and at			

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	bedtime related to TRACHEOSTOMY STATUS." The order did not mention size of R38 tracheostomy. Review of R38 Medication Administration Record, dated 3/1/25 through 3/31/25, reflected tracheostomy care two times daily. During an observation on 4/03/25 at 10:26 AM, observed Licensed Practical Nurse (LPN) "P" replace R38 inner-cannula with a size 6 Shiley. During an interview on 4/03/25 at 11:15 AM, LPN "P" verified use 6 shiley to replace R38 inner cannula on tracheostomy. LPN "P" reported knows what size to use because was familiar with R38 and reported size of inner cannula should be on R38 Physician order. During an interview on 4/03/25 at 1:24 PM, Clinical Regional Consultant "U" reported would expect inner cannula size to be part of R38 Physician order and verified changes had been made to make R38 more clear and include size needed.			
F0743 SS= D	No Behavior Difficulties Unless Unavoidable §483.40(b)(2) A resident whose assessment did not reveal or who does not have a diagnosis of a mental or psychosocial adjustment difficulty or a documented history of trauma and/or post- traumatic stress disorder does not display a pattern of decreased social interaction and/or increased withdrawn, angry, or depressive behaviors, unless the resident's clinical	F0743	Element 1 Resident 52 no longer resides in facility. Element 2 Residents on C hall with a Brief Interview of Mental Status of 9 or greater had a Patient Health Questionaire-9 completed to ensure residents have had no expressions of distress, developed decreased social interaction, increased withdrawn, anger, and depressive behaviors.	4/21/2025

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	condition demonstrates that development of such a pattern was unavoidable; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to assess a resident's expressions of distress, developed decreased social interaction, increased withdrawn, anger, and depressive behaviors, and reported possible cause of frustration for one residents (Residents #52) of two residents reviewed for psychosocial distress. Findings include: Review of the Face Sheet and Minimum Data Set (MDS) dated 3/20/25, reflected R52 was a 42 year old female admitted to the facility on 5/6/23, with diagnoses that included hypertension(high blood pressure), Guillain-Barre Syndrome with paraplegia, major depression and anxiety disorder. The MDS reflected R52 had a BIM (assessment tool) score of 15 which indicated her ability to make daily decisions was cognitively intact. During an observation on 3/31/25 at 2:55 PM, Resident 7, who resided in Hall C could be heard yelling out repeatedly, "help me, help me, help me." with door closed. R7 was observed in bed through small crack in closed door. Continued to observe with no staff response for greater than thirty minutes to assist R7.		Any changes in Patient Health Questionaire-9 have had referrrals made to psychology services. Element 3 CNAs and Nurses were re-educated on proper documentation of behaviors including depression, agitation, withdrawal, distress, anger etc. Interdisciplinary Team will review clinical documentation M-F to ensure any changes in behaviors are followed up on. Element 4 Administrator will complete an audit reviewing 6 residents per week to evaluate Patient Health Questionaire-9 scores and ensure appropriate interventions are in place if eligible. Audit findings will be presented to the facility QAPI Committee and will only be discontinued with substantial compliance and with approval of the facility QAPI Committee. Any instances of noncompliance that are identified will be addressed per company policy concerning education and disciplinary action when necessary. The Administrator is responsible for achieving and sustaining compliance.	

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	During an observation and interview on 3/31/25 at 4:46 PM, R52 door was closed, this surveyor was granted permission to enter room. Upon discussion with R52, R52 immediately began to discuss R7's yelling. During the interview with R52, resident was laying in bed, appeared calm and able to answer questions without difficulty. R52 reported they (herself along with roommate) preferred to have door closed because of three residents all around them that yell out constantly through the day and night and reported this made it difficult to sleep. R52 stated, "I know one of the residents that yells out has dementia but is so annoying and frustrating." R52 and roommate both reported they had told staff on several occasions about frustration with no changes. During an observation on 4/01/25 at 9:42 AM, another resident from room 15 in Hall C was heard yelling out with noises every time someone walked by doorway. Review of R52 Psychiatric Consult, dated 9/18/24, reflected R52 was frustrated related to unable to fall asleep or stay sleeping even with use of fan, relaxation music and white noise. The Consult reflected plan that included, "Promote regular sleep schedule, consistent exercise and minimizing stress...Continue to document any changes in patient's mood or behavior. Encourage non-pharmaceutical techniques including increasing sunlight exposure, regular human contact and reducing stimulants..."			

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	Review of R52's Psychiatric Consult, dated 12/26/24, reflected, "Chief Complaint***Medication review; depression/anxiety management...OBRA (assessment) evaluation was reviewed with diagnosis of major depressive disorder...Facility made diagnosis of bipolar disorder...PHQ-9(depression assessment) 18...Patient reports history of "bipolar tendencies" most of her life, however, review of previous notes make me suspicious for depression as a more likely diagnosis versus true bipolar disorder. Consider removing this diagnosis from the chart..." During a separate interview on 4/01/25 at 2:22 PM, R52 was in bed, appeared slightly anxious and reported continued frustration related to three residents who yell out at all hours of the day and seem to be in sequence. R52 reported keeps door closed, music on via ear buds with continued frustration and stated, "on her last nerve." Review of R52 Quarterly MDS assessments, dated 2/5/25, 2/25/25 and 3/20/25, reflected incomplete mood assessments. During an interview on 4/03/25 at 9:15 AM, Certified Nurse Aid(CNA) "Z" reported working at facility for almost one year and CNA "AA" reported about four years. CNA "Z" and CNA "AA" reported routinely worked on C hall and was familiar with residents and reported daily complaints from residents on			

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	hall about more than one resident yelling out. CNA "Z" and CNA "AA" reported alert and oriented residents on Hall C, including R52, often report frustration and then yell back to shut up, and stated was not like R52 at all. CNA staff reported they both reported to Unit Manager "BB" and reported they did not think about completing grievance form. During interview one of the residents on Hall C started to yell out. During an interview on 4/03/25 at 12:15 PM, R52 reported again continued frustration about yelling residents constantly every day. R52 confirmed she recently even yelled back and that is not like her. R52 reported another resident on the hall who often keeps to self, quiet and self propels up and down halls raised his voice at one of yelling residents which was very unlike him. R52 reported both CNA "Z" and CNA "AA" aware of frustration. Review of one of the yelling residents, Resident R7, nursing notes reflected for time dated 3/1/25 through 4/3/25, reflected R7 mostly daily documented episodes of yelling out including note on 3/17/25 at 2:02 a.m. that reflected, "Resident was heard screaming from her room help. She was screaming so loud that nursing staff could hear from the nurses station. As i approached i could hear other residents on the hall yelling shut up. When i walked in the room and asked resident what was wrong, resident said she wanted crackers. Writer tried to explain to her about using her call light, that her screaming			

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	makes people think she is hurt. She said " I dont f*cking care, now open those crackers and make yourself useful". Residents roommate was heard crying, writer asked [named] what was wrong, resident stated she cant sleep with all the screaming, all she wants to do is sleep. Resident was heard screaming even louder a few minutes later, when resident was approached and asked what was wrong she said " Open these muffins NOW" i explained i would open them but she has a call light for these situations, reminding her why screaming wasn't the best choice. i kneeled down to open the muffins up, she then gripped my hand squeezing pushed it away then aggressively grabbed the muffins out of my hand, i said Ouch, this is when the resident grabbed my hair and said " your a whore liar its not open then let go" i told the CNAs not to go in there for awhile until resident calmed down. resident was given her medication and resident seemed to be calm until the CNA went in to give her care, she started becoming verbally abusive, calling the CNAs unacceptable names. I told the CNAs not to go into the room alone for hers and there safety. DON messaged in regards to the situation." During an interview on 4/3/25 at 12:25 p.m., NHA "A" reported decision was made to place several residents in same area of facility that often yelled out instead of spreading them throughout the facility that could potentially effect more residents.			

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	During an interview on 4/03/25 at 1:29 PM, Social Service Director(SSD) "V" reported was hired in at facility as the Social Worker Director (SSD "V" was not a certified social worker) in November 2024. SSD "V" reported was familiar with R52 and was recently made aware of R52 increased frustration related to a few residents on Hall C that yell out a lot. SSD "V" reported R52 was usually nice with minimal complaints with recent incidents of yelling back at residents that yell out and reported that was very unlike R52. SSD "V" verified R52 had adjusted to long term care facility until recent outbursts.			
F0921 SS= F	Safe/Functional/Sanitary/Comfortable Environ §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to effectively clean and maintain the physical plant effecting 91 residents, resulting in the increased likelihood for cross-contamination, bacterial harborage, and potential cross-connections between the potable (drinking) and non-potable (non-drinking) water supplies. Findings include: On 03/31/25 at 02:15 P.M., An environmental	F0921	Element #1 Clean Laundry Room: Hand wash sink leak was fixed. Overhead light assembly clear plastic protective lens covers cleaned. Soiled Laundry: 6 new laundry transport carts were ordered. Nurses station: 6 new chairs were ordered. Staff Restroom: return-air-exhaust cleaned Shower Room (A): wand assembly corrected, light assemblies functioning, hand sink basin re-secured. Call light system corrected. Nursing Supply Closets ALL now have painted, sealed shelves. Stained ceiling tiles replaced. Womens Locker Room: sink drain repaired, cove base reinstalled, Emergency Water Supply area cleaned with new shelving purchased. Staff Breakroom was cleaned including the toaster and refrigerator freezer unit. A11 - The restroom overhead light assembly Was fixed. The restroom Commode base perimeter was also cleaned and caulked. B1 - The restroom over sink light assembly	4/21/2025

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	tour of the facility Laundry Service was conducted with Environmental Services Manager "D". The following items were noted: Clean Laundry Room: The hand wash sink cold water supply valve was observed leaking water. Environmental Services Manager "D" indicated he would contact maintenance for necessary repairs as soon as possible. 3 of 3 overhead light assembly clear plastic protective lens covers were observed soiled with accumulated and encrusted dust/dirt deposits. Environmental Services Manager "D" indicated he would have maintenance thoroughly clean and sanitize the clear plastic protective lens covers as soon as possible. Soiled Laundry Room: 6 of 6 soiled laundry transport carts were observed (etched, scored, particulate), creating a non-cleanable and non-sanitizable surface. Environmental Services Manager "D" indicated he would contact administration for cart replacement as soon as possible. On 03/31/25 at 02:59 P.M., A common area environmental tour was conducted with Maintenance Director "C". The following items were noted: Nurses Station: 6 of 6 chairs were observed		was fixed. The restroom Commode base perimeter caulking was redone. The Interior and exterior commode base surfaces Were cleaned. The window ledge drywall surface was repaired. The floor mounted heating grill assembly was replaced. B7 The commode base caulking was redone. B9 - The floor mounted heating grill plate was replaced. C2- Commode base caulking was repaired. The restroom sink was unclogged and is draining normally. C3 - The Bed 1 over bed light assembly pull String was replaced. The Bed 2 floor mounted anti-skid strips were replaced. The restroom over sink Light assembly corrected and is functioning. The restroom commode base Caulking was replaced. The restroom bathtub Interior surface and perimeter surround was cleaned. The Bed 1 over bed light Assembly pull string was added. C6- The Bed 2 over bed light assembly pull String extension was replaced. The Restroom overhead light assembly was also fixed. The restroom Commode base caulking was redone. The Restroom commode base seat was replaced. C-7 The restroom commode base caulking was repaired. The Restroom over sink light assembly was also corrected. The restroom Overhead light assembly protective lens cover Was cleaned and replaced. The Bed 2 drywall surface was Further observed (etched, scored, particulate), Adjacent to the footboard. The damaged drywall Surface measured approximately 4-feet-wide by 4-feet-long. C9 - The restroom commode base caulking was redone. The Restroom overhead light assembly was also corrected. C-10 The restroom commode base caulking redone. The Restroom hand sink basin was unclogged and is draining normally. The	

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	soiled with accumulated and encrusted dust/dirt deposits. Maintenance Director "C" indicated he would contact housekeeping for routine cleaning as soon as possible. A-Unit Staff Restroom B: The return-air-exhaust ventilation grill was observed soiled with accumulated dust and dirt deposits. Shower Room: The shower wand assembly was observed missing an atmospheric vacuum breaker. 1 of 3 overhead light assemblies were also observed non-functional. The hand sink basin was additionally observed loose-to-mount. 1 of 2 resident call system actuation stations were further observed non-functional. Maintenance Director "C" indicated he would have staff perform necessary repairs as soon as possible. Nursing Supply Closet: 1 of 4 shelving units were observed bare and unsealed. The bare shelving plywood surface was also observed without any protective sealant. Maintenance Director "C" indicated he would have staff seal the bare plywood surface as soon as possible. B-Unit Two acoustical ceiling tiles were observed stained from previous moisture exposure. The stained ceiling tiles measured approximately		restroom perimeter Wall/flooring coving strip was reinstalled and is no longer loose. D2- The restroom commode base caulking was redone. The Restroom over sink light assembly was also corrected. The restroom Commode support was additionally tightened. D-3: The restroom commode base caulking was replaced. The Restroom overhead light assembly was also corrected. The Bed 2 drywall Surface was repaired. D7 - The commode base caulking was replaced. The restroom and Sink basin caulking was also replaced. The drywall surface was repaired. D-9: The restroom commode base caulking was replaced. The Restroom commode base was also tightened. The restroom commode support was Additionally tightened. The restroom Over sink light assembly was repaired. The restroom overhead light Assembly lens cover was also cleaned. The Bed 1 Over bed light assembly pull string extension was replaced. D-11: The restroom commode base caulking Was repaired. The Restroom commode base was also tightened. The restroom commode support was Additionally tightened. The restroom Over sink light assembly was fixed. The restroom overhead light Assembly lens cover cleaned. The Bed 1 over bed light assembly pull string extension was added D-13: The Bed 1 over bed light assembly pull String extension was added. The Restroom commode base caulking was also replaced. D-17: The restroom commode base caulking was redone. The Restroom overhead light assembly lens cover Was cleaned. Element 2 Residents who reside in facility are considered at risk. Facility wide audit was completed to ensure safe and sanitary environment is possible for	

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	2-feet-wide by 4-feet-long. Maintenance Director "C" indicated he would replace the stained ceiling tiles as soon as possible. C-Unit Shower Room: 2 of 5 overhead light assemblies were observed non-functional. The commode support was also observed loose-to-mount. Maintenance Director "C" indicated he would have staff perform necessary repairs as soon as possible. Women's Locker Room: 1 of 2 hand sink basins were observed draining slowly. The vinyl wall/floor coving base was also observed loose-to-mount. The loose-to-mount coving base measured approximately 4-feet-long. The emergency water supply closet was additionally observed in disarray. The five-gallon plastic containers of water were further observed soiled with accumulated and encrusted dust/dirt deposits. Maintenance Director "C" indicated he would have staff perform necessary repairs as soon as possible. Maintenance Director "C" also indicated he would have housekeeping thoroughly clean and sanitize the plastic five-gallon containers of emergency water as soon as possible. Staff Breakroom: The food counters (3) were observed soiled with accumulated and encrusted food residue. The toaster interior was also observed soiled with accumulated and encrusted breadcrumbs. The hand wash		all residents. Findings were entered into TELS and corrected by facility maintenance. Element 3 The Administrator has reviewed the Preventative maintenance policy and cleaning schedules policy and deemed them appropriate. Staff have been educated on the use of the TELS work order system. Staff will utilize TELS daily to submit needed work orders. Element 4 NHA or designee will audit 10 areas each week x4 weeks, then monthly to ensure proper maintenance needs have been met, and surfaces are cleanable. Results will be reviewed monthly by QAPI until substantial compliance achieved. Administrator is responsible for overall compliance.	

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	sink basin was additionally observed soiled with accumulated and encrusted food residue. The refrigerator freezer unit was further observed soiled with accumulated and encrusted food residue." Nursing Supply Closet: 1 of 3 shelving units were observed bare and unsealed. The particle board shelving unit was also observed completely bare and unsealed. Maintenance Director "C" indicated he would have staff perform necessary repairs as soon as possible. On 03/31/25 at 04:40 P.M., An interview was conducted with Maintenance Director "C" regarding the facility work order system. Maintenance Director "C" stated: "We have the TELS program." On 04/02/25 at 10:10 A.M., An environmental tour of sampled resident rooms was conducted with Environmental Services Manager "D". The following items were noted: A-11: The restroom overhead light assembly was observed non-functional. The restroom commode base perimeter was also observed soiled with accumulated dirt/grime deposits. The restroom commode base caulking was additionally observed missing. B-1: The restroom over sink light assembly was observed non-functional. The restroom commode base perimeter caulking was also			

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	observed (etched, scored, particulate). The interior and exterior commode base surfaces were additionally observed soiled with accumulated and encrusted dirt/grime deposits. The window ledge drywall surface was further observed (etched, scored, particulate). The damaged drywall surface measured approximately 4-inches-wide by 60 -inches-long. The floor mounted heating grill assembly was also observed severely bent inward. B-7: The restroom commode base caulking was observed (etched, scored, particulate). B-9: The floor mounted heating grill plate was observed missing from the grill assembly. The grill face plate was also observed resting in the corner, adjacent to Bed 1. The grill face plate measured approximately 4-inches-wide by 12-inches-long. C-2: The commode base caulking was observed (etched, scored, particulate). The restroom hand sink basin was also observed draining very slow. C-3: The Bed 1 overbed light assembly pull string extension was observed missing. The Bed 2 floor mounted anti-skid strips (2) were also observed (etched, scored, worn), creating a cleanability concern. The restroom over sink light assembly was also observed non-functional. The restroom commode base caulking was additionally observed (etched, scored, particulate). The restroom bathtub			

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	interior surface and perimeter surround was further observed soiled with accumulated (dust, dirt, grime) deposits. The Bed 1 overbed light assembly pull string extension was further observed missing. C-6: The Bed 2 overbed light assembly pull string extension was observed missing. The restroom overhead light assembly was also observed non-functional. The restroom commode base caulking was additionally observed (etched, scored, particulate). The restroom commode base seat was further observed discolored and porous. Environmental Services Manager "D" indicated he would contact maintenance for necessary repairs as soon as possible. C-7: The restroom commode base caulking was observed (etched, scored, particulate). The restroom over sink light assembly was also observed non-functional. The restroom overhead light assembly protective lens cover was additionally observed with numerous dead insect carcasses. The Bed 2 drywall surface was further observed (etched, scored, particulate), adjacent to the footboard. The damaged drywall surface measured approximately 4-feet-wide by 4-feet-long. C-9: The restroom commode base caulking was observed (etched, scored, particulate). The restroom overhead light assembly was also observed non-functional. C-10: The restroom commode base caulking			

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	134110	A. BUILDING _____ B. WING _____	4/3/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDILODGE OF MARSHALL	879 EAST MICHIGAN AVE MARSHALL, MI 49068

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	was observed (etched, scored, particulate). The restroom hand sink basin was also observed draining very slow. The restroom perimeter wall/flooring coving strip was additionally observed loose-to-mount. The damaged perimeter wall/floor coving strip measured approximately 12-inches-long. On 04/02/25 at 01:20 P.M., An environmental tour of sampled resident rooms was continued with Environmental Services Manager "D". The following items were noted: D-2: The restroom commode base caulking was observed (etched, scored, particulate). The restroom over sink light assembly was also observed non-functional. The restroom commode support was additionally observed loose-to-mount. The commode support could be moved from side to side approximately 2-4 inches. D-3: The restroom commode base caulking was observed (etched, scored, particulate). The restroom overhead light assembly was also observed non-functional. The Bed 2 drywall surface was additionally observed (etched, scored, particulate), adjacent to the 4 -drawer dresser. The damaged drywall surface measured approximately 4-feet-wide by 4-feet-long. D-7: The commode base caulking was observed (etched, scored, particulate). The restroom hand sink basin caulking was also			

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	134110	A. BUILDING _____ B. WING _____	4/3/2025

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	observed (etched, scored, particulate). The drywall surface was additionally observed (etched, scored, particulate), adjacent to the Bed 2 footboard. The damaged drywall surface measured approximately 4-feet-wide by 4-feet-long. D-9: The restroom commode base caulking was observed (etched, scored, particulate). The restroom commode base was also observed loose-to-mount. The commode base could be moved from side to side approximately 4-6 inches. The restroom commode support was additionally observed loose-to-mount. The commode support could be moved from side to side approximately 2-4 inches. The restroom over sink light assembly was further observed non-functional. The restroom overhead light assembly lens cover was also observed with numerous dead insect carcasses. The Bed 1 overbed light assembly pull string extension was additionally observed missing. Environmental Services Manager "D" indicated he would contact maintenance for necessary repairs as soon as possible. D-11: The restroom commode base caulking was observed (etched, scored, particulate). The restroom commode base was also observed loose-to-mount. The commode base could be moved from side to side approximately 4-6 inches. The restroom commode support was additionally observed loose-to-mount. The commode support could be moved from side to side			

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	134110	A. BUILDING _____ B. WING _____	4/3/2025

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	approximately 2-4 inches. The restroom over sink light assembly was further observed non-functional. The restroom overhead light assembly lens cover was also observed with numerous dead insect carcasses. The Bed 1 overbed light assembly pull string extension was additionally observed missing. Environmental Services Manager "D" indicated he would contact maintenance for necessary repairs as soon as possible. D-13: The Bed 1 overbed light assembly pull string extension was observed missing. The restroom commode base caulking was also observed (etched, scored, particulate). Environmental Services Manager "D" indicated he would contact maintenance for necessary repairs as soon as possible. D-17: The restroom commode base caulking was observed (etched, scored, particulate). The restroom overhead light assembly lens cover was also observed with numerous dead insect carcasses. Environmental Services Manager "D" indicated he would contact maintenance for necessary repairs as soon as possible. On 04/03/25 at 10:00 A.M., Record review of the Policy/Procedure entitled: "Cleaning Schedules" dated 2/1/2022 revealed under Policy: "It is the policy of this facility to identify the functional areas in the facility that require cleaning and to use cycle cleaning schedules to outline the frequencies			

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	134110	A. BUILDING _____ B. WING _____	**4/3/2025**

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	and maintain regularly scheduled environmental service tasks. Record review of the Policy/Procedure entitled: "Cleaning Schedules" dated 2/1/2022 further revealed under Policy Explanation and Compliance Guidelines: "(1) Routine cleaning of environmental surfaces and non-critical resident care items shall be performed according to a predetermined schedule and shall be sufficient enough to keep surfaces clean and dust free." On 04/03/25 at 10:15 A.M., Record review of the Policy/Procedure entitled: "Preventative Maintenance Program" dated 3/12/2022 revealed under Policy: "A Preventative Maintenance Program shall be developed and implemented to ensure the provision of a safe, functional, sanitary, and comfortable environment for residents, staff, and the public." On 04/03/25 at 10:30 A.M., Record review of the "Direct Supply TELS Work Orders" for the last 60 days revealed no specific entries related to the aforementioned maintenance concerns.			