STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	694020	A. BUILDING _____ B. WING _____	2/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDILODGE OF GAYLORD	508 RANDOM LANE GAYLORD, MI 49735

(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 Gaylord was surveyed for a re-visit survey on 2/14/23. Census= 71	F0000		
F0755 SS= D	Pharmacy Srvcs/Procedures/Pharmacist/Records §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to properly store and label medications for	F0755	Resident medication will be stored and reconciled per regulatory requirements. No residents were affected. Residents who receive medication have the potential to be affected. The carts were promptly cleaned to ensure loose pills were removed and medications that expire when opened were labeled appropriately. Immediate education was completed with nurses on proper medication storage. Regional Clinical Consultant will provide re-education with licensed staff regarding proper medication storage, including how to identify medications that require additional labeling if they have a shortened expiration date once opened. The medication storage policy was reviewed by the NHA and DON and deemed appropriate. DON or designee will conduct 5 medication cart audits 3 x weekly for 4 weeks and then monthly thereafter or until substantial compliance has been achieved regarding proper medication storage. Audit findings will be brought to the QAPI meeting monthly for 3 months to ensure substantial compliance has been achieved. The DON is responsible for sustaining	1/17/2023

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

Electronically Signed | 03/06/2023

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	two of two medication carts inspected. This deficient practice resulted in the potential for medication diversion, administration of expired medications, and inaccurate medication administration. Findings include: The C Hall medication cart was inspected on 2/9/23 11:45 a.m. with Licensed Practical Nurse (LPN) "1-FF". Findings were as follows: A bottle of bimaprost was observed to be unlabeled when it was opened. Six tablets were observed to be loose in one medication drawer. Four inhalers were unlabeled with the date in which they were opened. Miscellaneous items including remote controls for a television, jewelry, a lighter, a plug in for a phone charger, and a razor were present in the medication cart. During the inspection of the medication cart, LPN "1-FF", reported inhalers and eye drops were to be labeled with a date in which they were opened. LPN "1-FF" was unable to clarify when the inhalers or eye drops would expire. LPN "1-FF' said all nurses were responsible for maintaining the medication carts and was unable to determine when the cart had been inspected for loose pills and unnecessary items. When asked about the miscellaneous items being present in the cart, LPN "1-FF" said there were no other places to store those items. On 2/9/23 at 12:57 p.m., LPN "1-Y" and this Surveyor inspected the B hall medication cart. Findings were as follows: A total of 26 pills and two half pills were loose in		substantial compliance.	

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	one medication drawer. Six inhalers were present without a date indicating when they had been opened. Miscellaneous items including money and jewelry were also present in the medication cart. LPN "1-Y" could not offer an explanation as to why there were so many loose pills present in the medication cart and confirmed the medication cart should only be used for medication storage and not other items. LPN "1-Y" gave the loose medications to the Director of Nursing (DON) to determine what the loose medications were. On 2/9/23 at 1:58 p.m., the DON reported the loose medications which had been present in the B hall medication cart had been identified. The DON reported the loose medications were a concern due to the potential for residents not receiving medications and drug diversion. Nurses were expected to frequently inspect the carts and remove any loose pills and items which did not belong in them. All inhalers and eyedrops were expected to be labeled with resident names and the date in which they were opened. The DON said there was not a policy in place to pertaining to medication storage and maintaining medication carts. The DON said the medication carts should only be used for medication storage and not other items.			
F0759 SS= D	Free of Medication Error Rts 5 Prcnt or More §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by:	F0759	Resident #1-10, 1-401 were assessed for any negative outcomes r/t med error and none found. Residents who receive medications have the potential to be affected ty the deficient practice	1/17/2023

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	Based on observation, interview, and record review, the facility failed to maintain a medication error administration rate of less than 5%. This deficient practice resulted in a 7.5% medication administration error rate and the potential for residents receiving inaccurate or unsafe doses of medications. Findings include: Resident #1-10 Resident #1-10's Electronic Medical Record (EMR) contained a most recent admission date of 11/28/22 and medical diagnoses which included respiratory failure, brain damage, dysphasia (difficulty swallowing) requiring a feeding tube, and persistent vegetative state. Resident #1-10's physician orders contained an order written on 2/2/23 with the following information, "morphine sulfate concentrated solution 20 mg [milligram]/ml [milliliter], give 20 mg per peg tube four times a day for pain 1 ml = 20 mg and give 20 mg via peg tube every 12 hours as needed for pain 1 ml = 20 mg." During an interview on 2/9/23 at 12:14 p.m., Licensed Practical Nurse (LPN) "1-BB" said Resident #1-10 had appeared to be very restless earlier in the morning and reported the morphine order included the option to give Resident #1-10 her morphine orally. LPN "1-BB" said she had given Resident #1-10 her morphine sublingually because it was absorbed quicker orally than when given via peg tube. Further review of Resident #1-10's medical record did not contain an order to administer morphine orally. During an interview with the Director of Nursing (DON) on 2/14/23 at approximately 10:00 a.m., the DON said medications should only administered by the route in which they were		Regional Director of Clinical will provide re-education to all licensed staff regarding proper medication administration with emphasis on inhalers, insulin pens, route order. Medication observations will be completed with Licensed staff to ensure proper technique The medication storage policy was reviewed by the NHA and DON and deemed appropriate. DON or designee will complete audits of 10 medication pass observation per week time 4 weeks and then monthly thereafter or until substantial compliance has been achieved. Audit will be brought to the QAPI meeting monthly for 3 months to ensure substantial compliance has been achieved The DON is responsible for sustaining compliance	

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ordered. The DON confirmed that administering Resident #1-10's morphine sublingually instead of via the peg tube would be considered a medication error.

Resident #1-401

Resident's EMR revealed an admission date of 6/9/22 and medical diagnoses which included diabetes, chronic respiratory failure, and Chronic Obstructive Pulmonary Disease (COPD). Resident #1-401's medication orders contained an order dated 2/16/23 for insulin glargline solution 100 units/ml (milliliter), inject 15 units subcutaneous every morning for diabetes. An additional order dated 9/3/22 for albuteral sulfate HFA aerosol solutions...2 puffs inhale orally three times daily for COPD.

On 2/14/23 at approximately 8:35 a.m., Registered Nurse (RN) "1-EE" was observed preparing to administer insulin glargline solution 100 units/ml for Resident #1-401. RN "1-EE" positioned the insulin pen horizontally to prime the pen. A small air bubble remained present in the insulin pen. RN "1-EE" administered the insulin into Resident #1-401's abdomen. RN "1-EE" then gave Resident #1-401 the albuteral sulfate inhaler for self administration. RN "1-EE" did not instruct Resident #1-401 to exhale prior to using the inhaler or to hold his breath after administering the medication. Resident #1-401 continued to speak throughout the self administration of this inhaler.

During a follow up interview with RN "1-EE" on 2/14/23 at approximately 8:45 am, RN "1-EE" was asked how an insulin pen should be primed. RN "1-EE" demonstrated by holding the insulin pen horizontally and priming it with two units of insulin.

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	On 2/14/23 at approximately 10:00 a.m., the Director of Nursing (DON) was asked how insulin pens should be primed. The DON said two units of insulin should be used to prime the pen, but did not specify how the pen should be held. When asked how the pen should be held, the DON said, "I don't know, does it matter?" The following information was retrieved from the Association of Diabetes Care and Education Specialists website, in part, "Preparing a pen for injection, Check the pen: ensure that it contains the proper type of insulin and contains enough to cover your full dose. Also check to make sure that the expiration date has not passed. Gently stir intermediate or premixed insulin, turn the pen on its side to roll it between the palms of your hands...attach a fresh pen needle screw or click the needle securely in place according to the manufacturer's instructions. Remove the cap(s) from the pen needle to expose the needle. Prime the pen: pointing the needle up in the air, dial one or two units on the pen and press the plunger with your thumb. Repeat until a drop appears. Dial your dose: turn the dial on the pen to your prescribed dose." (retrieved from https://www.diabeteseducator.org on 2/23/23). On 2/14/23 at approximately 12:53 P.M., The DON was asked what expectation was concerning administering inhalers. The DON said nurses should instruct resident to exhale prior to administration, do a puff of the inhaler and then hold their breath to ensure the medication was absorbed. On 2/14/23 at 1:05 pm RN "1-EE" was asked what should be done when giving inhalers. RN "1 -EE" said residents should exhale and then puff and hold breath. RN "1-EE said she normally would remind residents to do this but had not reminded Resident #1-401 to exhale and hold his			

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	breath when he had used his inhaler earlier. The facility's "Medication-Inhaler" policy with the most recent revision date of 1/1/22 contained the following information, in part, "Policy: medications are administered as prescribed in accordance with current nursing principles and practices and only by persons legally authorized to do so...Policy Explanation and Compliance Guidelines: ...Instruct resident to exhale away from device. 8. Instruct resident to seal lips around the mouthpiece. 9. Instruct resident to press down on canister while breathing in slowly and deeply. 10. Instruct to hold breath for as long as possible to ensure deep instillation of medication. 11. Remove inhaler from mouth, and instruct resident to breath out gently..." The facility's "Medication Administration" policy with the most recent revision date of 1/1/22 contained the following information, in part, "Policy: Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection...11. Compare medication source with MAR [Medication Administration Record] to verify resident name, medication name, form, dose, route, and time of administration...c. If other than PO [Oral] route, administer in accordance with facility policy for the relevant route of administration (i.e. injection, eye, ear, rectal, etc.). There were a total of 3 medication errors out of a total of 40 observed opportunities which resulted in a 7.5% medication error rate.			