| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CL IDENTIFICATION NUMBER: | | |) MULTIPLE CONSTRUCTION (X3) DATI COMPLE | | | ATE SURVEY LETED | |
|---|---|---|--|--|--|--|----------------------------|
| | | 694020 | B. WING | | | 7/7/20 | 23 |
| NAME OF PRO | VIDER OR SUPPLIE | R | <u>l</u> | | STREET ADDRESS, CITY, | STATE, ZIP CO | DE |
| MEDILODGE | OF GAYLORD | | | | 508 RANDOM LANE GAYLORD, MI 49735 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN FULL REGULA | TEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FORY OR LSC IDENTIFYING NFORMATION) | ID PREFIX TAG | COR | VIDER'S PLAN OF CORRECT RECTIVE ACTION SHOULD FERENCED TO THE APPRO DEFICIENCY) | BE CROSS- | (X5) COMPLETION DATE |
| F0000 SS= | Abbreviated surv | ylord was surveyed for an rey on 07/07/23. 38092, MI00136559, | F0000 | | | | |
| F0602 SS= D | §483.12 The res from abuse, neg resident property in this subpart. T limited to freedor involuntary secluchemical restrain resident's medic. This REQUIREM evidenced by: This citations rel MI00138092. Based on interview facility failed to proper misappropriation of seven Resident deficient practice ongoing stress three perpetrator attemp Findings include: Review of Resider (MDS) assessmen Resident #1 was a 11/24/20, with diadisease, peripheral | IENT is not met as | F0602 | and pin borrow and did manner until Re month a investig \$800 ev The em withdra started were not they fel the mon Elemen All residen cards in potentia Resider residen audited Resider box for educate for any they no | nt #1 gave an employee he number so the employee with number so the employee with not pay resident back in a r. Facility staff were unaway esident #1 notified a staff nafter it occurred. During the patient, the employee admiven though they knew it was ployee repaid all money the wn. A resident trust account in Resident #1 □s name. To tified who did not further it this was not criminal in they had been returned in the property of the staff of | could thdrew \$800 a timely are of this nember one e ttted to taking as wrong, hat was ant was The police prosecute as ature and full. debit/credit acility have and/or those es were of the fered a lock etc., and ioney/cards imediately if | 8/7/2023 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Electronically Signed

07/28/2023

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.

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLI/AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | | | (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE S COMPLETE | | | | ATE SURVEY LETED | |
|--|---|--|---|---|--|---|-------------------------|----------------------------|--|
| | | 694020 | E | B. WING _ | | | 7/7/20 | 23 | |
| NAME OF PRO | /IDER OR SUPPLIE | R | | | STREET ADDRESS, CITY, STATE, ZIP CODE | | | | |
| MEDILODGE | OF GAYLORD | | | | | 508 RANDOM LANE GAYLORD, MI 49735 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN FULL REGULAT | TEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY ORY OR LSC IDENTIFYING IFORMATION) | | ID REFIX TAG | COR | PIDER'S PLAN OF CORRECTION (E RECTIVE ACTION SHOULD BE CR FERENCED TO THE APPROPRIAT DEFICIENCY) | OSS- | (X5) COMPLETION DATE | |
| | required extensive, mobility, transfers, assessment reveale and the behavior as behaviors. The Bri (BIMS) assessmen which showed Res The sensory assess impairment, and R himself understood others. Review of Residen dated 6/22/23, proyadministrator (NH reported he gave C \$600.00 to Certifice Resident #1 stated before CNA "N" w facility (in May 20 summary indicated to the NHA. Durin the NHA, Resident CNA "N" money; I clarified he did not "N" the money. Re expectation was to "N". The investigation s Resident #1 was hid local law enforcer due to the suspicio investigation by the had loaned CNA "indicated he gave the PIN (personal if the interview of Re NHA was shown a Resident #1 and C Media platform). It | and depression. Resident #1 , two-person assistance for bed and toileting. The mood d no symptoms of depression, sessment revealed no ef Interview of Mental Status t revealed a score of 15/15, ident #1 was cognitively intact. ment revealed no sensory esident #1 was able to make l, and was able to understand at #1's investigation summary, vided by the Nursing Home (A), revealed Resident #1 ertified Nurse Aide (CNA) "N" d Nurse Aide (CNA) "I" to CNA "I", this occurred vorked her last shift at the 23). The investigation I CNA "I" reported the incident g the follow-up interview by the follow-up interview by the follow-up interview by the state of the money has sident #1 confirmed he "loaned" however, it was \$400.00 and the feel pressured to loan CNA sident #1 conveyed the get the money back from CNA summary further clarified s own responsible party, and tent was contacted on 6/22/23 n of a possible crime. Further e NHA revealed Resident #1 N" the money. Resident #1 CNA "N" his debit card with dentification number). During esident #1 by the NHA, the message exchange between NA "N" on [Name of Social in the message exchange, CNA "N" when they would be | | | admitte Elemen Misappi deemed All staff focus oi prior to Elemen Audits v and mo complia Results substan The Adi | ropriation policy was reviewed and appropriate by QAPI. were re-educated on abuse, wire misappropriation and exploitate working their next shift. It #4: will be completed weekly for 4 weekly for 3 months or until substance is maintained. will be brought to QAPI monthly trial compliance is maintained. | nd th a ion eeks antial | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLI. IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION (X3) A. BUILDING | | | | |
|---|---|--|---------------------|---|--|------------|----------------------------|--|
| | | 694020 | B. WING _ | B. WING | | | 7/7/2023 | |
| NAME OF PRO | VIDER OR SUPPLIE | R | | | STREET ADDRESS, CITY, STA | TE, ZIP CC | DDE | |
| MEDILODGE | OF GAYLORD | | | | 508 RANDOM LANE GAYLORD, MI 49735 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN FULL REGULAT | TEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FORY OR LSC IDENTIFYING NFORMATION) | ID PREFIX TAG | COR | /IDER'S PLAN OF CORRECTION RECTIVE ACTION SHOULD BE (FERENCED TO THE APPROPR DEFICIENCY) | CROSS- | (X5) COMPLETION DATE | |
| | did not know wher #1 reported to the did not plan to premade with local lat involved reported to the did not plan to premade with local lat involved reported to the event Resident number was provided. Review of Resident report, requested 7 7/6/23, revealed, "determined that the was double what [I contacted [local latinformed him of the camera footage was stated he would ne Detective Sergeant forward" Review of the last provided by the NI worked at the facil CNA "N" worked During an interviet NHA confirmed the incident, and discos \$400.00 charges do not he same day, us 13th, 2023. The NI charges debited frow was reapproached reported they " to pressing charges to stated the facility's NHA indicated the said at this point was reapported they " to pressing charges to stated the facility's NHA indicated the said at this point was reapproached. | and CNA "N" responded they they were available. Resident NHA, during this interview, he see charges. A police report was we enforcement, and the officer they would follow-up with ervices (APS), and the facility by of the report if requested in #1 pressed charges. The report ded in the investigation report. It #1's accident and incident /5/23 from the NHA, received 06/30/2023: After it was a mount allegedly borrowed Resident #1] reported, NHA we enforcement officer] and the new information. ATM is requestedand [the officer] and the new information. ATM is requestedand [the officer] and the new information of the ton the process moving timecard for CNA "N", HA, revealed the last day ity was 5/21/23, and showed from 6:38 a.m. to 6:44 p.m. In wood of 22/23 at 2:13 p.m., the me facility investigated the overed Resident #1 had two bebited from his bank account sing his debit card, on May HA stated, given the two om his account, Resident #1 about pressing charges and would like to think about" In words CNA "N". The NHA legal team was contacted. The bir legal team advised, "They we would press charges for him defined the facility also contacted. | | | | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER: | | | (X2) MULTIPLE CONSTRUCTION (X3 A. BUILDING | | | | |
|---|---|--|---|-----|--|---------------|----------------------------|
| | | 694020 | B. WING _ | | | 7/7/20 | 023 |
| NAME OF PRO | VIDER OR SUPPLIE | R | <u>'</u> | | STREET ADDRESS, CITY, | STATE, ZIP CO | DE |
| MEDILODGE | OF GAYLORD | | | | 508 RANDOM LANE GAYLORD, MI 49735 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN FULL REGULA) | TEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FORY OR LSC IDENTIFYING NFORMATION) | ID PREFIX TAG | COR | VIDER'S PLAN OF CORREC RECTIVE ACTION SHOULD FERENCED TO THE APPR DEFICIENCY) | BE CROSS- | (X5) COMPLETION DATE |
| | statement. The NE a reliable reporter reported CNA "N" 5/21/23 and was sterminated after di misappropriation. had received their Elder Abuse. Whe training and perfor CNA "N" had no perfor consider the facility. Ton the report. The were obtained with to the survey. Review of a witne Aide (CNA) "I", d "I"] came to NHA [Resident #1] had [CNA "N"] lately. [Resident #1] told owed [Resident #1] borrowed for rent During an interviee "I" was asked abou "I" confirmed Resitaken \$600.00 from personal rent (living they were not surp demonstrated unput explained they had resident care responsable to many the survey of the survey of they were resident care responsable to many the survey of the s | The NHA indicated CNA "N" abuse training including in n asked about CNA "N"'s job mance, the NHA reported prior disciplinary action. In #1's debit card transactions, HA, revealed two \$400.00 from a local gas station ATM the debits were not timestamped facility indicated these reports in Resident #1's permission prior sess statement by Certified Nurse ated 6/22/23, revealed, "[CNA on 6/22/23 and reported that asked if [CNA "I"] heard from [CNA "I"] said she hadn't and [CNA "I"] that [CNA "N"] | | | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | | (X2) MULTIPLE CONSTRUCTION (X3) DAT A. BUILDING COMPLE | | | ATE SURVEY LETED | | |
|---|--|---|--|-----|--|---------------------|----------------------------|--|
| | | 694020 | B. WING _ | | | 7/7/20 | 7/7/2023 | |
| | | | | | | | | |
| NAME OF PROVIDE | R OR SUPPLIE | R | - | | STREET ADDRESS, CITY, STAT | E, ZIP CO | DE | |
| MEDILODGE OF | GAYLORD | | | | 508 RANDOM LANE GAYLORD, MI 49735 | | | |
| PRÉFIX (E. | ACH DEFICIEN FULL REGULAT | TEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY ORY OR LSC IDENTIFYING IFORMATION) | ID PREFIX TAG | COR | VIDER'S PLAN OF CORRECTION RECTIVE ACTION SHOULD BE C EFERENCED TO THE APPROPRI DEFICIENCY) | ROSS- | (X5) COMPLETION DATE | |
| the work the had con "[C" "." Dur 5:0: Ress NH Ress (pri mor involves was inte stat nurr [del [wir" CN accon NH \$40 \$80 con pres gett per be a into Ress retu saic ope Sur fror (6/2 | same hall. CNA uld speak disres resident care ha told facility nu neerns, as well a 2NA "N"] neglectring an interview 5 p.m., the NHA dident #1 regard IdA, per request, sident #1 regard IdA, per request, sident #1 earlier ior to survey staney, and local la estigating the ins interviewed breview lasted ab ted, "There was se aide] I lear bit] card. She w withdrew] \$400.00 Resident #1 clad (A "N" to withdrew] \$400.00 from Resident #1 clad (A "N" to withdrew] \$400.00 from Resident #1 (A, CNA "N" has 100.00 from Resident #1 (A) (CNA "N" has 100.00 from Resident #1 (A) | ently covering residents care on a "I" also reported CNA "N" pectfully to staff and swore in illways. CNA "I" reported they rese [unnamed] of the ongoing is Staff "M". CNA "I" stated, eted the needs of her residents of her residents. I w on 7/7/23 at approximately a with Surveyor present, askeding any missing money. The led the interview, due to reporting feeling stressed rt) regarding the missing awenforcement was reportedly cident further. Resident #1 iselfy per NHA request; the fout 15 minutes. Resident #1 a CF [clarified as certified at her money from my ATM ent to the ATM and got b. I'm not sure what I told her rified they had only agreed for raw \$400.00 from their that had also learned from the add withdrawn an additional dent #1's account, totaling stated this bothered him but to decided on whether or not to dent #1 stated his priority was back. Resident #1 confirmed to CNA "N". The NHA asked a pected the money was intended to N" and did not feel pressured to CNA "N". The NHA asked a pected the money to be sident #1 replied, "[CNA "N"] to pay the police," and then one screen to the NHA and phone showed text messages CNA "N", on "Tuesday ongoing text communication A "N" and Resident #1. CNA | | | | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER: | | | (X2) MULTIPLE CONSTRUCTION (X3) E A. BUILDING COM | | | | |
|---|---|---|--|-----|--|---------------|----------------------------|
| | | 694020 | B. WING _ | | | 7/7/20 |)23 |
| NAME OF PRO | VIDER OR SUPPLIE | R | L | | STREET ADDRESS, CITY, | STATE, ZIP CO | DE |
| MEDILODGE | OF GAYLORD | | | | 508 RANDOM LANE GAYLORD, MI 49735 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN FULL REGULA | TEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FORY OR LSC IDENTIFYING NFORMATION) | ID PREFIX TAG | COR | /IDER'S PLAN OF CORREC RECTIVE ACTION SHOULD FERENCED TO THE APPR DEFICIENCY) | BE CROSS- | (X5) COMPLETION DATE |
| | the money to Resitrying to figure ou money. Resident # acknowledging reconot appear to common assaked how this text messages from "Stressed." The im NHA and Surveyor feelings of stress, provided by NHA not re-interviewed suggestion by the psychosocial impaimpedance of the consider cutting uplow amounts from already lost a large "N". Resident # lie this was an option misappropriation to During a follow-up approximately 5:2 how they were good the ongoing exploit continued contact and Resident #1. Found the strength of the protect Residen psychosocial distribution to protect Residen which included nu entrance, and not a facility. The NHA enforcement despire. | ext, they were going to return dent #1; however, they were to the best way to return the el's text responses were brief, ceipts of the texts, and he did ment otherwise. Resident #1 s made him feel [receipt of the n CNA "N"], and he responded, terview was stopped here by rr, due to Resident #1's reported and emotional support was and Surveyor. Resident #1 was during the survey at the strong NHA to minimize any ct to Resident #1 and avoid ongoing law enforcement ing the interview, the NHA 1 use of a facility trust fund for nt #1 reported he would to his bank card, and use cash in the facility, given they had expressed not being made aware, although they had reported the of facility staff on 06/22/23. In interview on 7/05/23 at 0 p.m., the NHA was asked ng to protect Resident #1 from tation by CNA "N" given was evident between CNA "N" tesident #1 also still had his his person. Surveyor also the treported feelings of the sess from these communications the terminal terminal the survey with the NHA. The year coming up with a plan to the facility staff watching the facility allowing CNA "N" to enter the did not mention contacting law te the implications of this iminal matter, given the text | | | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER: | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | ISTRUCTION | (X3) DATE SURVEY COMPLETED | | |
|---|---|--|---------------------|-----|--|----------------------------|----------------------------|--|
| | | 694020 | B. WING _ | | | _ 7/7/20 |)23 | |
| NAME OF PRO | VIDER OR SUPPLIE | ER . | | | STREET ADDRESS, CITY, S | STATE, ZIP CO | DDE | |
| MEDILODGE | OF GAYLORD | | | | 508 RANDOM LANE GAYLORD, MI 49735 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENT FULL REGULA | ATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION) | ID PREFIX TAG | COR | /IDER'S PLAN OF CORRECT RECTIVE ACTION SHOULD I FERENCED TO THE APPRO DEFICIENCY) | BE CROSS- | (X5) COMPLETION DATE | |
| | money from Resic possessed their ba remained for addit misappropriation. had offered Reside fund prior, given I in using a facility. The NHA explain the incident occur verbalized it was a what he chose wit verbalized they we Resident #1 post to the summary of the NHA reported was safe in the facility of the newly report Resident #1 and C. Review of the Eleincluding Residen 07/05/23) revealed documentation of or social services a psychosocial affect misappropriation of Review of the EM care plan goals or Resident #1 from continued contact #1. During an intervies Social Services (Sif they were aware Resident #1's more resident #1's | ew on 7/6/23 at approximately A was asked for any follow-up. d they made sure Resident #1 cility. The NHA however I not notified law enforcement red communications between ENA "N". ctronic Medical Record (EMR) t #1's Care Plan (accessed d no progress notes or any the incident, including nursing notes, to ascertain any et related to Resident #1's | | | | | | |

| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING COMPL | | | ATE SURVEY PLETED | |
|--------------------------|--|---|---------------------|--|--|---------------|----------------------------|--|
| | | 694020 | B. WING _ | | | 7/7/20 | 023 | |
| NAME OF PRO | VIDER OR SUPPLIE | R | | | STREET ADDRESS, CITY, S | STATE, ZIP CC | DE | |
| MEDILODGE | OF GAYLORD | | | | 508 RANDOM LANE GAYLORD, MI 49735 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN FULL REGULA | TEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION) | ID PREFIX TAG | COR | VIDER'S PLAN OF CORRECT RECTIVE ACTION SHOULD FERENCED TO THE APPRO DEFICIENCY) | BE CROSS- | (X5) COMPLETION DATE | |
| | followed up with 1 "F" reported any in potential for abuse would typically be the medical record have provided psy ascertain any psyc an abuse allegation and their Social Softhey and the other note the incident of "F" reported the S was on vacation, at the survey they we they had traveled was unable to conthe incident, per N During an intervien NHA reported the "N", and said they the facility on 7/10 Resident #1. As st only aware of CN, belonging to Resident #1. As st only aware of the money had not planned on time of this intervithey were going to show to the NHA text messages betw "N", with Residen reported they wou for clarification. T with Surveyor, and Resident #1 for so The NHA explain by the police, and this being an ongo want to cause Resident Reside | le aware, and they would have Resident #1 had they known. SS neident and follow-up with the eincluding misappropriation e documented and included in l. SS "F" clarified they would chosocial affect, given this was in. SS "F" reviewed the EMR ervices records, and confirmed facility social worker did not or provide any follow-up. SS ocial Services Director (SSD) and the NHA reported earlier in ere unavailable for interview, as out of the country. Surveyor firm if the SSD was aware of the SSD was aware of the report. We won 7/6/23 at 3:07 p.m., the y had heard back from CNA were planning on coming to 0)/23 to return the \$800.00 to ated, prior, Resident #1 was A "N" having \$400.00 dent #1. The NHA clarified they CNA "N" in the parking lot to with another staff member and in notifying the police at the lew. The NHA was also asked if the consider obtaining screenshots and Surveyor, of Resident #1's ween Resident #1 and CNA the thing primise the police with their legal team. The NHA soon after followed up the stated they would not ask reenshots, per their legal team. The had concerns regarding ing investigation and did not ident #1 more stress. The NHA enterouse in the police | | | | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CIDENTIFICATION NUMBER: | | | | (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE COMPLETED | | | | |
|---|--|--|---------------------|--|--|---------------|----------------------------|--|
| | | 694020 | B. WING | 3 | | 7/7/2 | 023 | |
| | VIDER OR SUPPLIE | R | | | STREET ADDRESS, CITY, 5 508 RANDOM LANE GAYLORD, MI 49735 | STATE, ZIP CO | DDE | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN FULL REGULAT | TEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION) | ID PREFIX TAG | COR | // JUDER'S PLAN OF CORRECT RECTIVE ACTION SHOULD EFERENCED TO THE APPRODEFICIENCY) | BE CROSS- | (X5) COMPLETION DATE | |
| | to two weeks to be Review of an emain NHA, showed conthe NHA. The emain acknowledged with a contract, but I had thought I could just back" During an interviee "M" confirmed CN demeaning, had an towards staff. The unprofessional won NHA, who reporte action. Review of CNA "I with the NHA afte disciplinary action. Review of the policy it is the pfor the health, well by developing and and procedures than englect, exploitation; review of the policy: It is the pfor the health, well by developing and and procedures than englect, exploitation; means taking advagain through the usintimidation, threa "Misappropriation the deliberate misy wrongful, tempora resident's belonging endiand procedures than the contract of the contract | al thread, received from the munication from CNA "N" to ail, dated 7/5/23, revealed CNA I misappropriation of Resident m, and stated, "I have mey and planned to bring it up been busyI know I signed a a moment of weakness and at turn around and give it right won 7/7/23 at 3:28 p.m., Staff IA "N" was at times a titude, and was very rude by reported the concerns regraphered the concerns regraphered disciplinary "S" semployee personnel file interview revealed no or write up in the file. cy, "Abuse, Neglect, and sed 10/24/2022, revealed, policy of this facility to provide fare, and rights of each resident implementing written policies at prohibit and prevent abuse, on, and misappropriation of Definitions:"Exploitation" intage of a resident for personal se of manipulation, | | | | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 8/1/2023 FORM APPROVED OMB NO. 0938-0391

| | | (X1) PROVIDER/SUPPLIER/CLI. IDENTIFICATION NUMBER: | A | (X2) MULTIPLE CONS A. BUILDING | | | (X3) DATE SURVEY COMPLETED | | |
|---|---|--|---|-----------------------------------|-----|--|-------------------------------|---------|--|
| | | 694020 | | B. WING _ | | | 7/7/20 | /7/2023 | |
| NAME OF PROVIDER OR SUPPLIER MEDILODGE OF GAYLORD (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY | | | | | | STREET ADDRESS, CITY, STATE, 508 RANDOM LANE GAYLORD, MI 49735 | | | |
| | | | | ID PREFIX TAG | COR | DER'S PLAN OF CORRECTION (EACH LECTIVE ACTION SHOULD BE CROSS- FERENCED TO THE APPROPRIATE DEFICIENCY) (X5) | | | |
| | make efforts to ens from physical and additional abuse, d Examples include Increased supervis residentsE. Prot Providing emotion the resident during | on of Resident. The facility will sure all residents are protected psychosocial harm, as well as luring and after investigation. but are not limited to:C. ion of the alleged victim and ection from retaliation. F. al support and counseling to and after the investigation he resident's care plan" | | | | | | | |