STATEMENT C AND PLAN OF	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CON	ISTRUCTION		ATE SURVEY LETED
		694020	B. WING			12/16/	2024
NAME OF PRO	VIDER OR SUPPLIE	R			STREET ADDRESS, CITY, STA	TE, 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 TORY 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
E0000	Initial Comments	,	E0000				
SS=	Preparedness So Michigan Depart Regulatory Affair Certification. At t Gaylord was four compliance with participation in M	5, 2024, an Emergency urvey was conducted by the ment of Licensing and rs, Bureau of Survey and he survey, Medilodge of nd not in substantial the requirements for ledicare/Medicaid at 42 CFR ncy Preparedness.					
E0025	Arrangement wit	h Other Facilities	E0025	ELEME	ENT #1		2/5/2025
SS= F	(7), §460.84(b)(8 (7), §483.475(b)) §485.920(b)(6), § [(b) Policies and must develop an preparedness pol based on the em paragraph (a) of assessment at p section, and the paragraph (c) of and procedures i updated at least LTC facilities]. At and procedures i "[For Hospices as §441.184,(b) Hos LTC Facilities at procedures. (7) [arrangements wi other providers t event of limitatio to maintain the c facility patients. "[For PACE at §4 §483.475(b), CA	procedures. The [facilities] d implement emergency licies and procedures, ergency plan set forth in		deficier The fac with oth signed transfe ELEME All occu to be a Annual Transfe ensure receivin ELEME The Re educat and NH related	upants in the facility have the ffected by this deficient practi- review of the facility's Evacua er Agreement will be complete they are signed and dated by ng and transferring facilities.	potential ce. ation d to both ce rector g Policy ed/dated	
LABORATORY	DIRECTOR'S OR PI	ROVIDER/SUPPLIER REPRESENT	ATIVE'S SIGNA	TURE	TITLE	(X6) DA	TE
Electronical	ly Signed					01/10	/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.

AND PLAN OF CORRECTION IDENTIFICATION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING				(X3) DATE SURVEY COMPLETED	
		694020	B. WING _			12/16/2024		
IAME OF PRO	VIDER OR SUPPLIE	R			STREET ADDRESS, CITY, ST	ATE, ZIP CC	DDE	
IEDILODGE	OF GAYLORD			508 RANDOM LANE GAYLORD, MI 49735				
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULA	NTEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	IDER'S PLAN OF CORRECTIC RECTIVE ACTION SHOULD BE FERENCED TO THE APPROP DEFICIENCY)	CROSS-	(X5) COMPLETIO DATE	
	 (6), (8)] The deview with other [facilitize receive patients cessation of ope continuity of services for RNHCIs at procedures. (7) arrangements with providers to receive providers to receive the services to RNH This REQUIREMevidenced by: Based on record refailed to develop a facilities that were receiving and transpractice could affe an emergency required by 42 CF had written transfer facilities for any facilities for any facilities for any facilities for any facilities of the service of the s	AENT is not met as eview and interview, the facility irrangements with other LTC e signed and dated by both sferring facility. This deficient cct all occupants in the event of airing resident evacuation. 2024, during review of cy preparedness plan at 0 PM, revealed the facility's r agreement with other tions were not in compliance as R 483.73(b)(7). The facility er agreements that were lated by both receiving and y. re confirmed through interview nce Director, Renovation gional Maintenance Director at		Evacua comple ELEME The NH Emerge annuall The NH Disaste address	IA will ensure annual review tion Transfer Agreements a ted.	the I review it irrent. mergency ittee to		

TATEMENT OF I ND PLAN OF CC		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 694020	À. ÉUILDI	2) MULTIPLE CONSTRUCTION BUILDING		COMP	(X3) DATE SURVEY COMPLETED 12/16/2024	
IAME OF PROVID	DER OR SUPPLIE F GAYLORD	R			STREET ADDRESS, CITY, ST 508 RANDOM LANE GAYLORD, MI 49735	ATE, ZIP CO	DE	
(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	VIDER'S PLAN OF CORRECTIC RECTIVE ACTION SHOULD BE FERENCED TO THE APPROP DEFICIENCY)	E CROSS-	(X5) COMPLETION DATE	
SS= F ((\$\$ () pri a pri s pa u L a () () [f S o tt b F P a a pri c o T F P a u L a f () V V v v c ir i T	4403.748(b)(8), § 6)(C)(iv), §441.1 (482.15(b)(8), § 4485.542(b)(7), § 7), §494.62(b)(7) rocedures. The mplement emerged and procedures, plan set forth in p isk assessment ection, and the paragraph (c) of and procedures in plated at least TC facilities]. At and procedures in 8) [(6), (6)(C)(iv) facility] under a becretary, in acc of the Act, in the reatment at an ar by emergency in RNHCIs at §403 procedures. (8) To waiver declared by emergency mergency in waiver declared incordance with provision of care dentified by emergency widenced by: Based on record re ailed to establish Vaiver declared by with section 1135 are and treatment dentified by emergency in waiver declared by in a section in the rest of the act, in the rest of the act of the act of the act of the a	Aiver Declared by Secretary §416.54(b)(6), §418.113(b) 184(b)(8), §460.84(b)(9), 483.73(b)(8), §483.475(b)(8), §485.625(b)(8), §485.920(b)). [(b) Policies and [facilities] must develop and gency preparedness policies based on the emergency baragraph (a) of this section, at paragraph (a)(1) of this communication plan at this section. The policies must be reviewed and every 2 years [annually for t a minimum, the policies must address the following:]), (7), or (9)] The role of the waiver declared by the cordance with section 1135 provision of care and alternate care site identified anagement officials. *[For .748(b):] Policies and The role of the RNHCI under d by the Secretary, in section 1135 of Act, in the at an alternative care site ergency management IENT is not met as	E0026	deficier The 11: placed Binder. ELEME All occu to be af The fac and upo ELEME The Re educate and NH for revie The NH the 113 the Em ELEME The NH Waiver The NH with the issues/o	dents have been affected by it practice. 35 Waiver has been comple- in the Emergency Disaster F NT #2 upants in the facility have the fected by this deficient pract ility's 1135 Waiver will be re dated annually. NT #3 gional Director of Maintenar ed the facility Maintenance D A on the Roles Under a 113 wing and updating the 1135 Waiver is completed and a ergency Disaster Plan Binde	ted and Plan e potential tice. viewed Director 35 Policy 5 Waiver. /updates of added to er. the 1135 mually. 135 Waiver ss any	2/5/2025	

STATEMENT O AND PLAN OF (F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLI IDENTIFICATION NUMBER: 694020	À. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 12/16/2024	
	VIDER OR SUPPLIE	R	•	508	REET ADDRESS, CITY, STATE, ZI RANDOM LANE YLORD, MI 49735	ATE, ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULAT	TEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY ORY OR LSC IDENTIFYING IFORMATION)	ID PREFIX TAG	CORRECT	R'S PLAN OF CORRECTION (EAC TIVE ACTION SHOULD BE CROS ENCED TO THE APPROPRIATE DEFICIENCY)		
E0029 SS= F	facility's emergenci approximately 3:3 could not produce knowledge of 1133 how to obtain 1133 emergency. This con- facility to be without during a declared of provided by exit of These findings were with the Maintenar Employee and Reg the time of record of \$403.748(c), §441 §441.184(c), §46 §483.73(c), §483 §485.68(c), §485 §485.727(c), §483 §485.68(c), §485 §485.727(c), §484 §491.12(c), §494 develop and main preparedness co complies with Fe and must be revi every 2 years [ar This REQUIREM evidenced by: Based on record re facility failed deve communication pla agencies officials s	re confirmed through interview nee Director, Renovation gional Maintenance Director at review. Communication Plan 6.54(c), §418.113(c), 50.84(c), §482.15(c), 4.475(c), §485.102(c), 5.542(c), §485.625(c), 5.920(c), §485.625(c), 6.62(c). (c) The [facility] must ntain an emergency mmunication plan that deral, State and local laws ewed and updated at least nually for LTC facilities]. IENT is not met as	E0029	deficient pra The Emerge been update Plan. ELEMENT # All occupant to be affecte The Commu updated and ELEMENT # The Region	ts have been affected by this actice. ency Disaster Plan Binder has ed to include a Communication #2 ts in the facility have the poten ed by this deficient practice. unication Plan will be reviewed nually.	tial and	

STATEMENT OF	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLI/ IDENTIFICATION NUMBER:	A (X2) MULT A. BUILDIN	PLE CON	STRUCTION		ATE SURVEY LETED
		694020	B. WING			12/16/	/2024
NAME OF PROV	/IDER OR SUPPLIE	R			STREET ADDRESS, CITY, STAT	=, ZIP CO	DE
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 TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	IDER'S PLAN OF CORRECTION RECTIVE ACTION SHOULD BE CI FERENCED TO THE APPROPRIA DEFICIENCY)	ROSS-	(X5) COMPLETION DATE
	facility's emergency approximately 3:3: emergency prepare contain a written c directed how the a with emergency pr documentation wa These findings we with the Maintenau	2024, during review of cy preparedness plan at 3 PM, revealed the facility's edness documentation did not ommunication plan that gency was to communicate reparedness officials. No s provided by exit of survey. re confirmed through interview nee Director, Renovation gional Maintenance Director at review.		Proced reviewi Plan ar The NH of the C to the E ELEME The NH Commu annual The NH Commu Commu	A will ensure annual reviews/u communication Plan have been mergency Disaster Plan Binde NT #4 A will ensure completion of the unication Plan and review and u y. A will review the updated unication Plan with the QAPI ttee to address any issues/com	for cation pdates added r. update it cerns.	
E0030 SS= F	(1), §416.54(c)(1 §441.184(c)(1), § §483.73(c)(1), § (1), §485.68(c)(1 §485.625(c)(1), § (1), §486.360(c)(§494.62(c)(1). [(d and maintain an communication p Federal, State ar reviewed and up [annually for LTC communication p following:] (1) Na for the following: providing service Patients' physicia Volunteers. *[For CAHs at §485.62	act Information §403.748(c)), §418.113(c)(1), §460.84(c)(1), §482.15(c)(1), §483.475(c)(1), §484.102(c)), §485.542(c)(1), §485.727(c)(1), §485.920(c) 1), §491.12(c)(1), c) The [facility must develop emergency preparedness blan that complies with nd local laws and must be dated at least every 2 years c facilities]. The blan must include all of the imes and contact information (i) Staff. (ii) Entities is under arrangement. (iii) ans (iv) Other [facilities]. (v) Hospitals at §482.15(c) and 25(c)] The communication e all of the following: (1)	E0030	ELEME No resi deficier The En been u informa staff ph ELEME All occu to be al The En Contac updated	dents have been affected by th tt practice. Detergency Disaster Plan Binder odated to include names and co tion of administrative staff, emo one tree, and employee directo	is has ontact ergency yry. otential e. & nd	2/5/2025

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CON	STRUCTION		ATE SURVEY LETED
		694020	B. WING			12/16/2024	
NAME OF PRO	VIDER OR SUPPLIE	R			STREET ADDRESS, CITY, ST	ATE, 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 TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	IDER'S PLAN OF CORRECTIC RECTIVE ACTION SHOULD BE FERENCED TO THE APPROP DEFICIENCY)	CROSS-	(X5) COMPLETIO DATE
	following: (i) Star services under a physicians (iv) C (v) Volunteers. * §403.748(C):] Th include all of the contact informati (ii) Entities provi- arrangement. (iii custodian. (iv) O *[For ASCs at §4 communication p following: (1) Na for the following: providing service Patients' physici. Hospices at §41 communication p following: (1) Na for the following: Entities providing arrangement. (iii Other hospices. The communication p following: (1) information for th Entities providing arrangement. (iii Volunteers. *[Fo communication p following: (2) Na for the following: providing service Volunteers. (iv) C and donor hospi Service Area (D This REQUIREN evidenced by:	e communication plan must following: (1) Names and on for the following: (i) Staff. ding services under) Next of kin, guardian, or ther RNHCIs. (v) Volunteers. 116.45(c):] The blan must include all of the mes and contact information (i) Staff. (ii) Entities se under arrangement. (iii) ans. (iv) Volunteers. *[For 8.113(c):] The blan must include all of the mes and contact information (i) Hospice employees. (ii) g services under) Patients' physicians. (iv) *[For HHAs at §484.102(c):] tion plan must include all of Names and contact ne following: (i) Staff. (ii) g services under) Patients' physicians. (iv) r OPOs at §486.360(c):] The blan must include all of the mes and contact information (i) Staff. (ii) Entities se under arrangement. (iii) Dther OPOs. (v) Transplant tals in the OPO's Donation		educate and NH Proced Names annuall adminis The NH Informa Emerge and/or n ELEME The NH Contact Emerge added t The NH Contact to addre	gional Director of Maintenar ed the facility Maintenance D IA on the Emergency Comm ures Policy related to updatii & Contact Information at lea y and/or when there is a cha strative staff. IA will ensure Names & Con tion has been updated to the ency Disaster Plan Binder ar with changes in administrativ	Director unication ng the sst unge in tact e nually ve staff. es & d to the nnual ges will be ames & Committee	

-	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 694020	À. BUILDIN	IG	ISTRUCTION	(X3) DATI COMPLE	
		004020	D. WING			12/10/20	
NAME OF PRO	OVIDER 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 REGULA	TEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	IDER'S PLAN OF CORRECTION (E/ RECTIVE ACTION SHOULD BE CRC FERENCED TO THE APPROPRIATI DEFICIENCY)	oss- c	(X5) COMPLETION DATE
	all of the followin information of adr staff phone tree, as	a communication plan including g: up to date names and contact ninistrative staff, emergency nd employee directory. This could affect all occupants in the ency.					
	Findings Include:						
	facility's emergence approximately 2:2 telephone director interviewed at the maintenance direct	6, 2024, during review of cy preparedness plan at 1 PM, revealed the facility y was dated 09/13/19. When time of record review, the tor said, "there are staff on the work here anymore."					
	facility's emergend approximately 2:2	6, 2024, during review of cy preparedness plan at 3 PM, revealed the facility hone tree listed staff no longer icility.					
	facility's emergend approximately 2:2 titled, Medilodge	6, 2024, during review of cy preparedness plan at 5 PM, revealed the document of Gaylord Emergency mbers contained staff no longer icility.					
	with the Maintena	re confirmed through interview nce Director, Renovation gional Maintenance Director at review.					
E0036 SS= F	§416.54(d), §418 §460.84(d), §482 §483.475(d), §482 §485.542(d), §48 §485.920(d), §48	Testing §403.748(d), 8.113(d), §441.184(d), 2.15(d), §483.73(d), 84.102(d), §485.68(d), 35.625(d), §485.727(d), 36.360(d), §491.12(d), r RNCHIs at §403.748,	E0036	deficier The fac	ENT #1 dents have been affected by this nt practice. sility has established a Training an Program and it has been added	nd	2/5/2025

FORM CMS-2567(02-99) Previous Versions Obsolete

STATEMENT OF DEFIC		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI	TIPLE CON	STRUCTION	(X3) DATE SURVEY COMPLETED 12/16/2024		
		694020	B. WING					
NAME OF PROVIDER O	R SUPPLIE	R			STREET ADDRESS, CITY, ST	TATE, ZIP CO	DE	
MEDILODGE OF GA	YLORD		508 RANDOM LANE GAYLORD, MI 49735					
PRÉFIX (EACI	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			COR	IDER'S PLAN OF CORRECTION RECTIVE ACTION SHOULD B FERENCED TO THE APPROF DEFICIENCY)	E CROSS-	(X5) COMPLETION DATE	
PRTFs Hospit CORF CAHs 485.72 §486.3 Trainir develo prepar that is in para assess section paragr comm section must b 2 year (d) Tra musto 2 year (d) Tra musto 2 year that is in para assess section paragr comm section must b 2 year that is in para assess section paragr comm	s at §441.1 als at §445. als at §485. at §486.62 27, CMHC 360, and R ag and tesi p and mai redness tra based on agraph (a) sment at p n, policies aph (b) of unication p n. The train based on agraph (a) sment at p n, policies aph (b) of unication p n. The train based on agraph (a) sment at p n, policies aph (b) of unication p n. The train based on agraph (a) sment at p n, policies aph (b) of unication p n, policies	A, Hospice at §418.113, 184, PACE at §460.84, 2.15, HHAs at §484.102, 68, REHs at §485.920, OPOs at HC/FHQs at §491.12:] (d) ting. The [facility] must ntain an emergency aning and testing program the emergency plan set forth of this section, risk aragraph (a)(1) of this and updated at least every C facilities at §483.73(d):] testing. The LTC facility d maintain an emergency aning and testing program the emergency plan set forth of this section, risk aragraph (a)(1) of this and updated at least every C facilities at §483.73(d):] testing. The LTC facility d maintain an emergency and procedures at this section, risk aragraph (a)(1) of this and procedures at this section, and the blan at paragraph (c) of this ning and testing program d and updated at least DF/IIDs at §483.475(d):] ting. The ICF/IID must ntain an emergency aning and testing program the emergency plan set forth of this section, risk aragraph (a)(1) of this and procedures at this section, and the blan at paragraph (c) of this ning and testing program the emergency plan set forth of this section, risk aragraph (a)(1) of this and procedures at this section, risk aragraph (a)(1) of this and procedures at this section, risk aragraph (a)(1) of this and procedures at this section, and the blan at paragraph (c) of this ing and testing program the emergency plan set forth of this section, risk aragraph (a)(1) of this and procedures at this section, and the blan at paragraph (c) of this ing and testing program the emergency plan set forth of this section, risk aragraph (a)(1) of this and procedures at this section, and the blan at paragraph (c) of this ing and testing program d and updated at least every		ELEME All occu to be af The Err Training reviewe ELEME The Re educate and NH related Prograr updatin The NH Prograr and pla Binder. ELEME The NH updates are con Disaste The NH	upants in the facility have th fected by this deficient prace of and Testing Program. This and and updated annually. NT #3 gional Director of Maintenance I A on the Emergency Plann to the need for a Training a n and the importance of rev g it annually. IA will ensure the Training a n is reviewed and updated ced in the Emergency Disa	include the s will be nce Director ing Policy nd Tesing riewing and and Testing annually ster Plan vs and g Program mergency rraining and mmittee to		

STATEMENT O AND PLAN OF (F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLI IDENTIFICATION NUMBER:	IA	(X2) MULTIF A. BUILDING		STRUCTION	(X3) DATE SURVEY COMPLETED	
		694020		B. WING _			12/16/	2024
NAME OF PRO	VIDER OR SUPPLIE	R				STREET ADDRESS, CITY, STATE	, ZIP CO	DE
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)	I	ID PREFIX TAG	COR	IDER'S PLAN OF CORRECTION (E RECTIVE ACTION SHOULD BE CR FERENCED TO THE APPROPRIAT DEFICIENCY)	OSS-	(X5) COMPLETION DATE
	requirements for training at §483.4 at §494.62(d):] T orientation. The of and maintain an training, testing a program that is b plan set forth in p risk assessment section, policies paragraph (b) of communication p section. The train program must be every 2 years. This REQUIREM evidenced by: Based on record re failed to develop a Preparedness train based on the emerg policies and proce- plan. This deficien occupants in the eve Findings Include: On December 16, facility's emergence approximately 3:33 failed to provide d written staff trainin meets the requiren documentation wa These findings we with the Maintenan	//ID must meet the evacuation drills and 470(i). *[For ESRD Facilities raining, testing, and dialysis facility must develop emergency preparedness and patient orientation wased on the emergency baragraph (a) of this section, at paragraph (a)(1) of this and procedures at this section, and the blan at paragraph (c) of this ning, testing and orientation e evaluated and updated at IENT is not met as eview and interview, the facility nd maintain an Emergency ing and testing program that is gency plan, risk assessment, dures, and the communication it practice could affect all vent of an emergency. 2024, during review of cy preparedness plan at 5 PM, revealed the facility ocumentation the facility has a ng and testing program that ents of the regulation. No s provided by exit of survey. re confirmed through interview nce Director, Renovation gional Maintenance Director at review.						

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI	TIPLE CON		(3) DATE SURVEY OMPLETED	
		694020	B. WING		1	12/16/2024	
NAME OF PRO	VIDER OR SUPPLIE	R			STREET ADDRESS, CITY, STATE, ZI	P CODE	
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 TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	IDER'S PLAN OF CORRECTION (EAC RECTIVE ACTION SHOULD BE CROS FERENCED TO THE APPROPRIATE DEFICIENCY)		
K0000	INITIAL COMME	INTS	K0000				
SS=	Recertification S Michigan Depart Regulatory Affair Certification. At t Gaylord was fou compliance with participation in M 482.90(a), Life S applicable provis the National Fire 101, Life Safety of NFPA 99, Hea The facility is a c (000) constructio is fully sprinklere smoke detection open to the corri	6 certified beds. At the time					
K0353 SS= F	Sprinkler System Automatic sprink are inspected, te accordance with Inspection, Testi Water-based Fin Records of syste inspection and te	b) Who provided c) Water	K0353	deficier The spa and the and lab The spi with a b	dents have been affected by this are sprinkler box has been changed sprinkler heads have been secure eled. rinkler heads and bulbs in the kitche puild-up of grease and dust coating ave been cleaned.	d en	

	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED 12/16/2024	
		694020	B. WING		12/16/		
		ER		STREET ADDRESS, CITY	, STATE, ZIP CO	DE	
EDILODGE	OF GATLORD			GAYLORD, MI 49735			
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULA	ATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOUL CORRECTIVE ACTION SHOUL REFERENCED TO THE APPI DEFICIENCY)	D BE CROSS-	(X5) COMPLETIO DATE	
	 non-required or system. 9.7.5, 9. This REQUIREM evidenced by: Based on observat failed to provide s and spare sprinkle This deficient pracall occupants in the Findings Include: 1. On December 1 11:53 AM, observ sprinkler box in the spare sprinkler box in the spare sprinkler head and the sprinkler head and the sprinkler head the damage. 2. On December 1 PM, observation r within the kitchen dust coating the sprinkler head thead the sprinkler head thead the spri	Provide in mation on coverage for any partial automatic sprinkler 7.7, 9.7.8, and NFPA 25 MENT is not met as tion and interview, the facility prinkler system maintenance r heads as required by NFPA. ctice could affect approximately ie event of a fire emergency. 6, 2024, at approximately ads unsecured in the sprinkler spare sprinkler heads prone to 6, 2024, at approximately 1:50 evealed two sprinkler heads had a buildup of grease and orinkler head and bulb, this tivation of the sprinkler heads. ere confirmed through interview ince Director and Renovation ime of observation.		All occupants in the facility have to be affected by this deficient p The sprinkler heads in the kitch added to a cleaning rotation to are free of grease and dust buil ELEMENT #3 The Regional Director of Mainte educated the Maintenance Direc on the Preventative Maintenance regarding the need for sprinkler secured and labeled. The Main Director and NHA were also ed importance of cleaning sprinkle areas that have a high risk for g build-up. The Maintenance Director will e sprinkler heads and bulbs in the free from build-up of dust and g ELEMENT #4 The Maintenance Director/Desi complete weekly audits for 4 we substantial compliance is achie sprinkler heads and bulbs in the been cleaned. The Maintenance Director will r results to the QAPI Committee substantial compliance is achie maintained. The NHA is responsible for com	en will be ensure they d-up. enance ctor and NHA ce Program heads to be tenance ucated on the r heads in grease or dust ensure e kitchen are rease. gnee will eeks or until ved to ensure e kitchen have e port the audit monthly until ved and		