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 _____	**12/16/2024**

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
E0000 SS=	Initial Comments On December 16, 2024, an Emergency Preparedness Survey was conducted by the Michigan Department of Licensing and Regulatory Affairs, Bureau of Survey and Certification. At the survey, Medilodge of Gaylord was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.73, Emergency Preparedness.	E0000		
E0025 SS= F	Arrangement with Other Facilities §403.748(b)(7), §418.113(b)(5), §441.184(b)(7), §460.84(b)(8), §482.15(b)(7), §483.73(b)(7), §483.475(b)(7), §485.625(b)(7), §485.920(b)(6), §494.62(b)(6). [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] *[For Hospices at §418.113(b), PRFTs at §441.184,(b) Hospitals at §482.15(b), and LTC Facilities at §483.73(b):] Policies and procedures. (7) [or (5)] The development of arrangements with other [facilities] [and] other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to facility patients. *[For PACE at §460.84(b), ICF/IIDs at §483.475(b), CAHs at §486.625(b), CMHCs at §485.920(b) and ESRD Facilities at	E0025	ELEMENT #1 No residents have been affected by this deficient practice. The facility's Evacuation Transfer Agreement with other facilities/organizations have been signed and dated by both receiving and transferring facilities. ELEMENT #2 All occupants in the facility have the potential to be affected by this deficient practice. Annual review of the facility's Evacuation Transfer Agreement will be completed to ensure they are signed and dated by both receiving and transferring facilities. ELEMENT #3 The Regional Director of Maintenance educated the facility Maintenance Director and NHA on the Emergency Planning Policy related to the need for updated signed/dated agreements between facilities for evacuation	2/5/2025

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

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	694020	A. BUILDING _____ B. WING _____	**12/16/2024**

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

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	§494.62(b):] Policies and procedures. (7) [or (6), (8)] The development of arrangements with other [facilities] [or] other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to facility patients. *[For RNHCIs at §403.748(b):] Policies and procedures. (7) The development of arrangements with other RNHCIs and other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of non-medical services to RNHCI patients. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to develop arrangements with other LTC facilities that were signed and dated by both receiving and transferring facility. This deficient practice could affect all occupants in the event of an emergency requiring resident evacuation. Findings Include: On December 16, 2024, during review of facility's emergency preparedness plan at approximately 3:00 PM, revealed the facility's evacuation transfer agreement with other facilities/organizations were not in compliance as required by 42 CFR 483.73(b)(7). The facility had written transfer agreements that were unsigned and not dated by both receiving and transferring facility. These findings were confirmed through interview with the Maintenance Director, Renovation Employee and Regional Maintenance Director at the time of record review.		transfers. The NHA will ensure annual reviews of the Evacuation Transfer Agreements are completed. ELEMENT #4 The NHA will ensure completion of the Emergency Disaster Plan book and review it annually to ensure information is current. The NHA will review the updated Emergency Disaster Plan with the QAPI Committee to address any issues/concerns. The NHA is responsible for compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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E0026 SS= F	Roles Under a Waiver Declared by Secretary §403.748(b)(8), §416.54(b)(6), §418.113(b)(6)(C)(iv), §441.184(b)(8), §460.84(b)(9), §482.15(b)(8), §483.73(b)(8), §483.475(b)(8), §485.542(b)(7), §485.625(b)(8), §485.920(b)(7), §494.62(b)(7). [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] (8) [(6), (6)(C)(iv), (7), or (9)] The role of the [facility] under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials. *[For RNHCIs at §403.748(b):] Policies and procedures. (8) The role of the RNHCI under a waiver declared by the Secretary, in accordance with section 1135 of Act, in the provision of care at an alternative care site identified by emergency management officials. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to establish the role of the facility under a Waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials. This deficient practice could affect all occupants in the event of an emergency.	E0026	ELEMENT #1 No residents have been affected by this deficient practice. The 1135 Waiver has been completed and placed in the Emergency Disaster Plan Binder. ELEMENT #2 All occupants in the facility have the potential to be affected by this deficient practice. The facility's 1135 Waiver will be reviewed and updated annually. ELEMENT #3 The Regional Director of Maintenance educated the facility Maintenance Director and NHA on the Roles Under a 1135 Policy for reviewing and updating the 1135 Waiver. The NHA will ensure annual review/updates of the 1135 Waiver is completed and added to the Emergency Disaster Plan Binder. ELEMENT #4 The NHA will ensure completion of the 1135 Waiver and review and update it annually. The NHA will review the updated 1135 Waiver with the QAPI Committee to address any issues/concerns. The NHA is responsible for compliance.	2/5/2025

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	Findings Include: On December 16, 2024, during review of facility's emergency preparedness plan at approximately 3:31 PM, revealed the facility could not produce documentation to verify knowledge of 1135 waiver and the process on how to obtain 1135 waiver during a declared emergency. This could potentially lead the facility to be without resources or information during a declared emergency. No document was provided by exit of survey. These findings were confirmed through interview with the Maintenance Director, Renovation Employee and Regional Maintenance Director at the time of record review.			
E0029 SS= F	Development of Communication Plan §403.748(c), §416.54(c), §418.113(c), §441.184(c), §460.84(c), §482.15(c), §483.73(c), §483.475(c), §484.102(c), §485.68(c), §485.542(c), §485.625(c), §485.727(c), §485.920(c), §486.360(c), §491.12(c), §494.62(c). (c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. This REQUIREMENT is not met as evidenced by: Based on record reviewed and interview the facility failed develop and maintain a communication plan for contacting staff and other agencies officials should a disaster occur. This deficient practice could affect all occupants in the event of an emergency.	E0029	ELEMENT #1 No residents have been affected by this deficient practice. The Emergency Disaster Plan Binder has been updated to include a Communication Plan. ELEMENT #2 All occupants in the facility have the potential to be affected by this deficient practice. The Communication Plan will be reviewed and updated annually. ELEMENT #3 The Regional Director of Maintenance educated the facility Maintenance Director	2/5/2025

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	Findings include; On December 16, 2024, during review of facility's emergency preparedness plan at approximately 3:33 PM, revealed the facility's emergency preparedness documentation did not contain a written communication plan that directed how the agency was to communicate with emergency preparedness officials. No documentation was provided by exit of survey. These findings were confirmed through interview with the Maintenance Director, Renovation Employee and Regional Maintenance Director at the time of record review.		and NHA on the Emergency Communication Procedures Policy regarding the need for reviewing and updating the Communication Plan annually. The NHA will ensure annual reviews/updates of the Communication Plan have been added to the Emergency Disaster Plan Binder. ELEMENT #4 The NHA will ensure completion of the Communication Plan and review and update it annually. The NHA will review the updated Communication Plan with the QAPI Committee to address any issues/concerns. The NHA is responsible for compliance.	
E0030 SS= F	Names and Contact Information §403.748(c)(1), §416.54(c)(1), §418.113(c)(1), §441.184(c)(1), §460.84(c)(1), §482.15(c)(1), §483.73(c)(1), §483.475(c)(1), §484.102(c)(1), §485.68(c)(1), §485.542(c)(1), §485.625(c)(1), §485.727(c)(1), §485.920(c)(1), §486.360(c)(1), §491.12(c)(1), §494.62(c)(1). [(c) The [facility must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. The communication plan must include all of the following:] (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians (iv) Other [facilities]. (v) Volunteers. *[For Hospitals at §482.15(c) and CAHs at §485.625(c)] The communication plan must include all of the following: (1)	E0030	ELEMENT #1 No residents have been affected by this deficient practice. The Emergency Disaster Plan Binder has been updated to include names and contact information of administrative staff, emergency staff phone tree, and employee directory. ELEMENT #2 All occupants in the facility have the potential to be affected by this deficient practice. The Emergency Disaster Plan Names & Contact Information will be reviewed and updated at least annually and/or with changes to administrative staff.	2/5/2025

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	Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians (iv) Other [hospitals and CAHs]. (v) Volunteers. *[For RNHCIs at §403.748(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Next of kin, guardian, or custodian. (iv) Other RNHCIs. (v) Volunteers. *[For ASCs at §416.45(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Volunteers. *[For Hospices at §418.113(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Hospice employees. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Other hospices. *[For HHAs at §484.102(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Volunteers. *[For OPOs at §486.360(c):] The communication plan must include all of the following: (2) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Volunteers. (iv) Other OPOs. (v) Transplant and donor hospitals in the OPO's Donation Service Area (DSA). This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility		ELEMENT #3 The Regional Director of Maintenance educated the facility Maintenance Director and NHA on the Emergency Communication Procedures Policy related to updating the Names & Contact Information at least annually and/or when there is a change in administrative staff. The NHA will ensure Names & Contact Information has been updated to the Emergency Disaster Plan Binder annually and/or with changes in administrative staff. ELEMENT #4 The NHA will ensure updated Names & Contact Information has been added to the Emergency Disaster Plan Binder. Annual updates and/or administrative changes will be added to the QAPI Review monthly. The NHA will review the updated Names & Contact Information with the QAPI Committee to address any issues/concerns. The NHA is responsible for compliance.	

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	failed to develop a communication plan including all of the following: up to date names and contact information of administrative staff, emergency staff phone tree, and employee directory. This deficient practice could affect all occupants in the event of an emergency. Findings Include: 1. On December 16, 2024, during review of facility's emergency preparedness plan at approximately 2:21 PM, revealed the facility telephone directory was dated 09/13/19. When interviewed at the time of record review, the maintenance director said, "there are staff on the list that does not work here anymore." 2. On December 16, 2024, during review of facility's emergency preparedness plan at approximately 2:23 PM, revealed the facility emergency staff phone tree listed staff no longer employed at the facility. 3. On December 16, 2024, during review of facility's emergency preparedness plan at approximately 2:25 PM, revealed the document titled, Medilodge of Gaylord Emergency Administrative numbers contained staff no longer employed at the facility. These findings were confirmed through interview with the Maintenance Director, Renovation Employee and Regional Maintenance Director at the time of record review.			
E0036 SS= F	EP Training and Testing §403.748(d), §416.54(d), §418.113(d), §441.184(d), §460.84(d), §482.15(d), §483.73(d), §483.475(d), §484.102(d), §485.68(d), §485.542(d), §485.625(d), §485.727(d), §485.920(d), §486.360(d), §491.12(d), §494.62(d). *[For RNCHIs at §403.748,	E0036	ELEMENT #1 No residents have been affected by this deficient practice. The facility has established a Training and Testing Program and it has been added to the	2/5/2025

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	ASCs at §416.54, Hospice at §418.113, PRTFs at §441.184, PACE at §460.84, Hospitals at §482.15, HHAs at §484.102, CORFs at §485.68, REHs at §485.542, CAHs at §486.625, "Organizations" under 485.727, CMHCs at §485.920, OPOs at §486.360, and RHC/FHQs at §491.12:] (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(d):] (d) Training and testing. The LTC facility must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. *[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every		Emergency Disaster Plan Binder. ELEMENT #2 All occupants in the facility have the potential to be affected by this deficient practice. The Emergency Disaster Plan will include the Training and Testing Program. This will be reviewed and updated annually. ELEMENT #3 The Regional Director of Maintenance educated the facility Maintenance Director and NHA on the Emergency Planning Policy related to the need for a Training and Tesing Program and the importance of reviewing and updating it annually. The NHA will ensure the Training and Testing Program is reviewed and updated annually and placed in the Emergency Disaster Plan Binder. ELEMENT #4 The NHA will ensure annual reviews and updates of the Training and Testing Program are completed and added to the Emergency Disaster Plan Binder. The NHA will review the updated Training and Testing Program with the QAPI Committee to address any issues/concerns. The NHA is responsible for compliance.	

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	2 years. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(i). *[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be evaluated and updated at every 2 years. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to develop and maintain an Emergency Preparedness training and testing program that is based on the emergency plan, risk assessment, policies and procedures, and the communication plan. This deficient practice could affect all occupants in the event of an emergency. Findings Include: On December 16, 2024, during review of facility's emergency preparedness plan at approximately 3:35 PM, revealed the facility failed to provide documentation the facility has a written staff training and testing program that meets the requirements of the regulation. No documentation was provided by exit of survey. These findings were confirmed through interview with the Maintenance Director, Renovation Employee and Regional Maintenance Director at the time of record review.			

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K0000 SS=	INITIAL COMMENTS On December , 2024, a Life Safety Recertification Survey was conducted by the Michigan Department of Licensing and Regulatory Affairs, Bureau of Survey and Certification. At the survey, Medilodge of Gaylord was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR 482.90(a), Life Safety from Fire and the applicable provisions of the 2012 Edition of the National Fire Protection Agency (NFPA) 101, Life Safety Code and the 2012 Edition of NFPA 99, Health Care Facilities Code. The facility is a one story building of type II (000) construction, built in 1976. The building is fully sprinklered and has supervised smoke detection in the corridors and spaces open to the corridors. The facility has 96 certified beds. At the time of the survey the census was 82.	K0000		
K0353 SS= F	Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source	K0353	ELEMENT #1 No residents have been affected by this deficient practice. The spare sprinkler box has been changed and the sprinkler heads have been secured and labeled. The sprinkler heads and bulbs in the kitchen with a build-up of grease and dust coating them have been cleaned. ELEMENT #2	2/5/2025

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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
	_____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to provide sprinkler system maintenance and spare sprinkler heads as required by NFPA. This deficient practice could affect approximately all occupants in the event of a fire emergency. Findings Include: 1. On December 16, 2024, at approximately 11:53 AM, observation revealed the spare sprinkler box in the riser room contained five spare sprinkler heads unsecured in the sprinkler boxes leaving the spare sprinkler heads prone to damage. 2. On December 16, 2024, at approximately 1:50 PM, observation revealed two sprinkler heads within the kitchen had a buildup of grease and dust coating the sprinkler head and bulb, this could delay the activation of the sprinkler heads. These findings were confirmed through interview with the Maintenance Director and Renovation Employee at the time of observation.		All occupants in the facility have the potential to be affected by this deficient practice. The sprinkler heads in the kitchen will be added to a cleaning rotation to ensure they are free of grease and dust build-up. ELEMENT #3 The Regional Director of Maintenance educated the Maintenance Director and NHA on the Preventative Maintenance Program regarding the need for sprinkler heads to be secured and labeled. The Maintenance Director and NHA were also educated on the importance of cleaning sprinkler heads in areas that have a high risk for grease or dust build-up. The Maintenance Director will ensure sprinkler heads and bulbs in the kitchen are free from build-up of dust and grease. ELEMENT #4 The Maintenance Director/Designee will complete weekly audits for 4 weeks or until substantial compliance is achieved to ensure sprinkler heads and bulbs in the kitchen have been cleaned. The Maintenance Director will report the audit results to the QAPI Committee monthly until substantial compliance is achieved and maintained. The NHA is responsible for compliance.	