STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235284	A. Building B. Wing	09/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Midland	4900 Hedgewood Dr Midland, MI 48640

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31771 Based on interview and record review, the facility failed to notify responsible parties and family of changes in medication and condition and failed to notify the medical provider of blood pressures outside of established parameters for two Residents (R24 and R23) of three residents reviewed for notification of change. Findings: Resident #24 Review of the Electronic Medical Record (EMR) reflected Resident #24 (R24) admitted to the facility 4/7/24 with pertinent diagnoses that included dementia and hypertension. Review of the Minimum Data Set (MDS) dated [DATE] reflected R24 was severely cognitively impaired with a Brief Interview for Mental Status (BIMS) score of 0 out of 15. The medical record reflected a Durable Power of Attorney (DPOA) was in place that designated Responsible Party (RP) Q as the contact person with the authority to oversee the care and to make informed medical decisions for R24. During a telephone interview conducted 9/9/24 at 1:54 PM, RP Q reported the facility does not always ensure he is notified of medication changes. Review of the Medical Provider Progress Note dated 9/5/24 at 0000 revealed, I will start amlodipine 10 milligrams (mg) once a day for hypertension. The EMR reflected a corresponding Physicians Order for the medication. Neither this entry, or any on or near this date, reflected RP Q was contacted and informed of the the reason for, or the addition of, the medication. Review of EMR Progress Notes for R24 reflected an entry with a corresponding Physician's Order dated 8/20/24 at 10:39 AM for an increase in the frequency of the diuretic (water pill) Lasix 40 mg and a potassium supplement to twice a day for five days then return the frequency to once a day for edema and (hypertension). No documentation was found in the EMR that RP Q was notified of the medication frequency change or why it was being implemented. Additional Progress Notes with medication changes were identified on: 4/30/24 at 6:27 PM for Roxanol (opioid) for pain and Zofran for nausea and vomiting. (continued on next page)

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4/29/24 at 5:18 PM for Lasix daily (times) 5 doses. Neither of the above entries reflected RP Q was contacted and informed. The Physician Assistant (PA) Progress Note dated 4/17/24 at 0000 revealed nurse stated (RP Q) states (R24) has a severe allergy to morphine, nurse would like to switch to dilaudid, gave ok. nurse also stated (R24) has allergies, order given to nurse for Flonase . Neither this entry or prior and post entries in the Progress Notes (reflected) that RP Q was aware of the medication change to dilaudid or the addition of Flonase. On 9/11/24 at 11:58 AM an interview was conducted with the Director of Nursing (DON) in the DON office. The DON was informed of the dates that medication changes were documented in the EMR without documentation that RP Q had been informed of the changes and the reason for the changes. The DON indicated a review would be conducted. As of survey exit no further documentation or information regarding notification to RP Q of medication and treatment changes was provided. R24 Continued Review of the documentation binder provided by the facility reflected Education/ In-service Record dated 7/9/24. Topic/Title: Provider notification and vitals outside parameters/ complete documentation on (Medication Administration Records) and (Treatment Administration Records) in (EMR). Objectives/ Content: - Monitor and follow all orders that have parameters .Following standing provider parameters if not listed in (Doctor's)order. - Rechecking vital signs (related to) premedication time, activity .and any .chronic condition prior to notifying provider. - Report vitals outside thresholds parameters to provider and document all notifications in (EMR). -Ensure you are checking the alerts (red bell in ((EMR)) for any outside of threshold parameters for follow-up throughout the shift. -Ensure all tasks are completed and documented in (EMR) prior to end of shifts. Reminder: treatments not documented are not done. Included in the Education binder was the document titled Threshold Vitals for ALL (sic) residents. The document reflected Notify provider if vital trends are outside these parameters. These listed notification parameters included a systolic (top number) blood pressure of either a finding lower than 90 millimeters of mercury (mm hg) or a finding of higher than 170mm hg. Also listed is the diastolic (bottom number) blood pressure parameter of a finding of less than 50 mm hg and a finding greater than 100 mm hg. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Threshold Vitals for ALL residents document further reflected Red Dot Alerts noted under red bell in (EMR) Should be checked by nursing throughout the shift to (sic) for vitals outside of threshold. And Nurses need to note in (EMR) that re-check is completed and any new provider orders (related to) vitals outside threshold. (ie physician aware, no new orders, or medications given, vitals rechecked and (within normal limits). Lastly, the document reflected *Reminder to notify and document in (EMR) any and all vitals outside parameters, medications held, and/or given (related to) parameters. The Education binder included a sign-in sheet that revealed the signatures of twenty Registered Nurses (RN) and Licensed Practical Nurses LPN) as attending the meeting on 7/9/24. Review of the EMR blood pressure history for R24 after 7/9/24 revealed: 7/18/24 at 12:54 AM - BP 177/70 mm hg - the next BP documented was taken on 7/20/24 at 9:49 AM, approximately 32 hours later, indicating no recheck was taken of a systolic finding above the 170 mm hg notification parameter. Furthermore, the finding on 7/20/24 was 176/86. The next BP documented approximately 24 hours later on 7/21/24 at 8:28 AM was 190/80 mm hg with no rechecks or EMR entries found that the provider had been notified. The BP history continued to reveal blood pressure results outside the notifying parameters on 7/26/24 (190/78), 7/28/24 (170/91), 7/30/24 (184/86), 7/31/24 (171/76), and another five elevated BPs until 8/15/24 at 8:30 AM when a BP finding of 178/111 is documented without a recheck until 8/16/24 at 9:00 AM which also was elevated at 180/83. On 8/19/24 at 8:28 AM a BP of 204/91 is documented without a recheck until 9:57 PM, more than 13 hours later. Review of the EMR did not reflect any nursing documentation of red bell alerts or that BPs were rechecked or that the provider had been contacted and tasks completed consistent with the Objectives/ Content of the education that was provided on 7/9/24. On 9/11/24 at 11:58 AM an interview was conducted with the DON in the DON office. The DON was informed a review of the blood pressure history of R24 had been completed. The DON was asked about the elevated blood pressures and the lack of physician notification and the absence of documented recheck blood pressures. The DON reported the facility uses a texting system and that the medical providers were likely notified through this. The DON indicated she expects a blood pressure be rechecked after a finding outside of the normal parameters. The DON reported she will review for physician notifications and provide an update. On 9/11/24 at 1:43 PM the DON reported that the texting communications to the medical providers could not be obtained. The DON did not indicate that the texting communications were consistent with the protocols and documentation that were reviewed at the education meeting of 7/9/24. However, the DON reported recheck blood pressures should be documented in the EMR. On 9/11/24 at 12:44 PM Registered Nurse (RN) I reported if a blood pressure is obtained outside of the notifying parameters, she would assess the resident, recheck the blood pressure, and notify the physician if the blood pressure remained elevated. On 9/11/24 at 12:45 AM Licensed Practical Nurse (LPN) H reported she would recheck an elevated blood pressure and contact the medical provider if needed. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/11/24 at 12:49 PM RN D reported she would recheck the blood pressure and check to see if the resident had any (as needed) medication for blood pressure control, then notify the (medical) provider for further direction. As of survey exit no further pertinent information or documentation was provided by the facility. 45410 Resident #23 Review of an Admission Record revealed Resident #23 (R23) admitted to the facility on [DATE] with pertinent diagnoses which included chronic obstructive pulmonary disorder and dementia. Further review revealed Family Member P to be R23's designated emergency contact. Review of a Minimum Data Set (MDS) assessment for R23, with a reference date of 6/22/2024 revealed a Brief Interview for Mental Status (BIMS) score of 13, out of a total possible score of 15, which indicated R23 was cognitively intact. Review of R23's Nurses Notes, dated 9/9/2024 at 11:38 AM, revealed the medical provider ordered an x-ray to rule out pneumonia. Review of R23's Physician's Orders revealed an order for doxycycline hyclate oral capsule 100 mg's, written 9/10/2024 at 6:35 AM, with instructions to take 1 capsule two times a day for pneumonia. In an interview on 9/11/2024 at 10:35 AM, Staff Development RN E reported the medical provider ordered doxycycline for R23 on 9/10/2024 after his chest x-ray resulted positive for pneumonia. Staff Development RN E reported she was not aware whether R23's emergency contact had been notified of this change in condition. In a telephone interview on 9/11/2024 at 11:02 AM, Family Member P reported she was not aware of R23's pneumonia diagnosis and treatment and she would like to have been contacted by the facility about this. In an interview on 9/11/2024 at 11:28 AM, R23 reported he had not notified Family Member P of his pneumonia diagnosis and treatment, and he preferred the facility to keep Family Member P informed of things like this. In an interview on 9/11/2024 at 10:47 AM, the Director of Nursing (DON) reported she was not aware whether R23's emergency contact had been notified of his pneumonia diagnosis and treatment. The DON reported the nurse who placed the antibiotic order on 9/10/2024 should have notified Family Member P and documented this in a progress note. The DON was unable to find documentation that Family Member P had been notified of this change of condition. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of facility policy/procedure Notification of Changes, revised 8/29/2024, revealed .The facility must inform the resident, consult with the resident's physician and/or notify the resident's family member or legal representative when there is a change requiring such notification . Circumstances requiring notification include . Accidents . Significant change in the resident's physical, mental or psychosocial condition such as deterioration in health, mental or psychosocial status . Circumstances that require a need to alter treatment . Additional considerations . Competent individuals . The facility must still contact the resident's physician and notify resident's representative .