STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235292	A. Building B. Wing	01/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Sault Ste Marie	1011 Meridian Rd Sault Sainte Marie, MI 49783

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45123 Based on interview and record review, the facility failed to protect a resident from verbal abuse for one Resident (#37) of four residents reviewed for abuse. This deficient practice resulted in mental distress and anguish after a staff member used inappropriate language towards a resident. Findings include: This citation is linked to Facility Reported Incident (FRI) MI00148016. Resident #37 (R37) Review of R37's electronic medical record (EMR) revealed initial admission to the facility on [DATE] with diagnoses including cerebral infarction (a stroke referring to damage to tissues in the brain due to loss of oxygen), dementia, muscle weakness (generalized), difficulty walking, and need for assistance with personal care. Record review of R37's most recent Minimum Data Set (MDS) assessment, dated 11/1/24, revealed a Brief Interview for Mental Status (BIMS) score of 10, indicative of moderate cognitive impairment. Review of the FRI submitted to the State Agency (SA) included an incident summary which read, in part: .received report from [Certified Nursing Assistant (CNA) M] that two non-certified aides were in the shower room nearby and overheard C.N.A. [N] in the resident's room yelling and swearing at resident about defecating in his pants and immediately came to get C.N.A. [M] to intervene. Per C.N.A. [M], they heard C.N. A. [N] state this is the fourth f*ck*ng time you f*ck*ng did this .Upon receiving report .immediately went to resident's [R37] room to ensure resident safety. When asked if there was a C.N.A. in the room yelling at him resident stated Yes, [CNA 'N'] . On 1/8/25 at 9:11 AM, an interview was conducted with R37 who verified the allegation details. R37 stated, I put my light on to use the bathroom and (CNA N) came in and told me I had to wait and turned my TV off and left. I had an accident in my pants. (CNA N) later returned to my room and then started to curse and yell at me loudly. R37 was asked how that made them feel and replied, It made me feel bad. (continued on next page)

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.

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/8/25 at 12:30 PM, an interview was conducted with Nursing Assistant G who verified their witness statement details. Nursing Assistant G stated, I was in the shower room at the start of B-hall when I heard yelling. The yelling sounded vulgar and there was swearing. I came out and got another aide to assist. On 1/8/25 at 12:45 PM, an interview was conducted with Regional Clinical Nurse K who verified the allegation details. Regional Clinical Nurse K stated, (CNA N) should not have acted out at R37 the way they did, and that kind of staff behavior is unacceptable. On 1/8/25 at 12:55 PM, an interview was conducted with CNA D who verified their witness statement details. CNA D stated, I was working on D-hall near the nurses' station, and I heard yelling. The yelling was coming from a B-hall resident's room and sounded hostile. I heard (CNA N) say b*llsh*t and other curse words. On 1/8/25 at 2:10 PM, an interview was conducted with the Nursing Home Administrator (NHA) who verified the allegation details. The NHA stated, (CNA N's) behavior was unacceptable, and their employment was terminated without hesitation. On 1/8/25 at 3:45 PM, an attempt was made to confirm CNA M's witness statement, dated 11/3/24 which read in part, CNA came frantically looking for me to diffuse a situation .down B-hall. I walked into a residents [R37] room and a CNA [CNA N] was yelling at the resident and cursing at the resident. You [R37] can't f*ck*ng expect your CNAs to come here and do that .I relieved the CNA [CNA N] . Review of R37's Plan of Care revealed the following focus, initiated on 8/4/23: Resident has an ADL [activities of daily living] self-care performance deficit related to dementia .upper body weakness .personal hygiene: 2 person-assist, toileting: 2 person-assist . Review of policy titled, Abuse, Neglect and Exploitation, date implemented 01/01/2021, read in part, Policy: It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property .

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40383 Based on interview, and record review, the facility failed to ensure care plans were updated promptly and revised appropriately for four Residents (R15, R24, R25, and R36) out of 18 Resident care plans reviewed. This deficient practice resulted in care plans which did not reflect resident needs. Findings include: Resident #15 (R15) On 11/5/24 a Facility Reported Incident (FRI) was submitted to the State Agency (SA) which read in part, Incident Summary: Resident #23 (R23) was witnessed yelling (obscenities) at resident (R15) staff immediately intervened and separated the 2 residents. The care plan for R15 included a Focus: Resident has impaired cognitive function related to disorganized thinking, Traumatic Brain Injury. Date Initiated: 08/03/2023. This care plan was updated 1/8/25 with an intervention to prevent further altercations which read, Make sure (initials of R23) is not seated close to resident (R15). Redirect resident by offering coffee or going for a walk when frustrated. During an interview on 1/9/25 at 10:44 AM, Certified Nurse Aide (CNA) V stated she worked throughout the building and knew R15. When asked to identify the resident with the initials listed in the care plan who should be seated further away from R15, CNA V named two residents with the care planned initials but was not sure who the care plan was referring to. During an interview on 1/9/25 at 10:47 AM, CNA W stated she worked with R15 at times and named one resident with the initials as stated in the care plan, but those initials were not of R23. During an interview on 1/9/25 at 10:50 AM, Nurse Aide (NA) Q stated she knew R15 but did not know who had the initials listed on the care plan for R15 to avoid. NA Q asked if the initials referred to a male or a female resident as she could think of one of each with the stated initials. Neither resident stated by NA Q were R23. During an interview on 1/9/25 at 1:16 PM, the Regional Clinical Registered Nurse (RN) K stated she had updated the care plan yesterday (1/8/25) and . did not update the care plan at the time (of the resident-to-resident altercation on 11/5/24). Resident #24 (R24) Review of R24's electronic medical record (EMR) indicated an initial admission to the facility on [DATE] with diagnoses including complete traumatic below the left knee amputation, diabetes and neuromuscular dysfunction of the bladder. During an interview on 1/8/25 at 8:42 AM, R24 stated he had been out to the hospital a few times due to his catheter and he continued to have a catheter for urinary elimination. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The nursing progress notes for R24 on 11/30/2024 read in part, . Dr (name) called about resident continuous bleeding around foley cath (catheter) and blood collection in cath bag. Dr. (name) giving V.O. (verbal orders) to send resident and to contact family to help support resident needs. Resident brother (name) contacted and agrees he wants resident sent to ER (emergency room) . The care plan for R24 included a focus of alteration in elimination related to need for supra pubic catheter related to neurogenic bladder. Date initiated: 2/8/24 with the last revision 2/8/24. The goal for this care plan focus had been revised on 5/10/24, but the interventions had not been revised since 2/15/24. R24's care plan also included another focus of Resident has need for a suprapubic catheter. Date initiated 9/17/24 with all interventions dated as initiated 9/17/24. There were no intervention updates after the hospitalization on [DATE]. During an interview on 1/9/25 at 11:48 AM, Registered Nurse (RN) K stated she had reviewed the care plan for R24 and there was no updated care plan interventions to prevent dislodging of the catheter so that another hospital admission could be avoided. She stated the expectation was a care plan should be updated after a hospitalization to include interventions to prevent rehospitalization . Resident #25 (R25) Review of R25's EMR revealed admission to the facility on [DATE] with diagnoses including cerebral palsy, contractures, lack of coordination, and dementia. The most recent Minimum Data Set (MDS) assessment, dated 11/25/24, revealed a Brief Interview for Mental Status (BIMS) score of 0, indicative of severe cognitive impairment. During a room visit on 1/7/25 at 12:47 PM, R25 was alert but non-verbal in bed grasping his TV remote with his clenched fists. He did not have any protective device such as a rolled cloth in his contracted closed fists to prevent skin breakdown. When asked if he could open his fists, he did not make eye contact or respond. During a room visit on 1/7/25 at 3:40 PM, R25 again was in bed gripping the TV remote and did not have any protective device such as a rolled cloth in his contracted closed fists to prevent skin breakdown. The care plan for R25 included a focus of Resident has pain related to contractures, cerebral palsy, dysthymic disorder (depressive disorder).Date Initiated: 08/11/2023 Revision on: 08/11/2023. Upon review of the care plan there were no interventions to prevent further decline of the contractures or to prevent negative outcomes due to the contractures. During an interview on 1/9/25 at 1:13 PM, the Director of Nursing (DON) revealed that she had reviewed the medical record and did not find anything in the care plan for services to prevent contractures or prevent further decline. The DON stated, I am not finding how to wash them (hand contractures) or care for them (hand contractures). It was her expectation that this would be part of the care plan. 45123 Resident 36 (R36) (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R36's EMR revealed initial admission to the facility on [DATE] with diagnoses including dementia, hypertension, and cognitive communication deficit. Record review of R36's most recent Minimum Data Set (MDS) assessment, dated 9/4/24, revealed a Brief Interview for Mental Status (BIMS) score of 01, indicative of severe cognitive impairment. Review of the FRI submitted to the State Agency (SA) included an incident summary dated 12/28/24, which read, in part: .[R36] was behind resident [Resident #50 (R50)] in the hall and reached up to grab resident [R50] on the shoulder, grabbing at his t-shirt and causing scratches to his right upper back and shoulder . Review of R36's Plan of Care revealed the following focus, initiated on 6/1/24: Resident has impaired communication .maintain eye contact, approach resident from the front, pay attention to resident's body language and facial expressions . On 1/8/25 at 3:55 PM, an interview was conducted with the Director of Nursing (DON) who was asked, if altercations between residents occur, what interventions take place to ensure residents are psychosocially stable and additional altercations do not occur. The DON replied, Social services will do an initial follow up with both residents and care plans are updated. The DON was asked if R36's care plan was updated and replied, Yes, and social services did the follow ups. The DON was asked to show where R36's care plan was updated and was unable to do so. The DON then acknowledged R36's care plan was never updated following the resident-to-resident altercation. The facility policy titled Comprehensive Care Plans dated as reviewed/revised 6/30/22, read in part: It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment. Review of policy titled, Behavior Management Program, dated 10/27/23, read in part .Policy Explanation and Compliance Guidelines: 1.) Procedure .The team will explore the root cause of behavior/mood. The team will identify target behaviors and an individualized plan of care .