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	06/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Sault Ste. Marie	1011 Meridian Road Sault Ste. 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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. This citation pertains to intake MI00153461. Based on observation, interview, and record review the facility failed to maintain a safe, sanitary community shower room area for the facility population. Findings include: On 6/17/25 at 7:24 PM, an interview was conducted with Complainant I regarding their concerns about a recent short stay at the facility. The complainant stated the D-Hall shower had mold growing around the shower drain and at the base of the shower, and it, looked disgusting and was gross. The complainant felt the facility was doing a very poor job cleaning and was mortified to take a shower in the shower room. Complainant I stated they were glad they were in a shower chair during their shower to avoid making direct contact with the shower floor. On 6/18/25 at 8:00 AM, an observation of the D-hall shower room found mold in the double shower along the base of the shower on the right and back side and around the shower drain. On 6/18/25 at 8:05 AM, an interview was conducted with Certified Nurse Aide (CNA) F who was responsible for assisting with showers. CNA F was asked what they thought of the mold in the shower room and replied, It is yucky, and I would not leave it that way at my house. CNA F was asked about a cleaning scheduled for the shower room and replied, It is cleaned daily and then once a month it gets a deep clean. On 6/18/25 at 8:10 AM, during an interview, Housekeeping Manager H was asked when then monthly deep cleaning was scheduled and who completed the last deep cleaning, and replied, There is a sign-off sheet on the cleaning cart. Housekeeping Manger H confirmed the deep cleaning in the D-hall shower room was completed on 6/12/25 by Housekeeper E. Housekeeping Manager H was asked if the mold visualized in the D-hall shower room was an acceptable homelike environment and replied, No, it is not. It needs to be re-caulked. I would not want mold in my shower at home. On 6/18/25 at 8:13 AM, during an interview, Housekeeper E was asked if they noticed the mold in the D-hall shower room when they did the deep cleaning on 6/12/25 and stated they had not noticed the mold. Housekeeper E was asked their course of action should they notice mold and they were unable to answer. On 6/18/25 at 9:30 AM, during an interview, Maintenance Director C was asked if they were made aware of any mold in the D-hall shower room and replied, No, I haven't received any work orders or text alerts notifying me of any mold in the shower room. (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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/18/25 at 9:45 AM, during an interview, Regional Director of Operations (RDO) G confirmed no messages or alerts were sent to maintenance regarding mold in any of the shower rooms in the past year. On 6/18/25 at 10:00 AM, during an interview, the Nursing Home Administrator (NHA) was asked about the mold in the D-hall shower room and replied, The whole building needs an overhaul. There should not be mold in any of the shower rooms. The shower rooms need to be re-caulked.

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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 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. This citation pertains to intake MI00153461. Based on interview, and record review, the facility failed to implement a timely dressing change to a post-operative surgical area, correctly document an initial skin assessment, and communicate a change in wound condition to facility physician for one resident (Resident #11) of six residents reviewed for quality of care. This deficient practice resulted in a secondary surgery which included an incision and drainage and re-closure of the wound, antibiotics, and hospital admission. Findings include: Resident #11 (R11) Review of R11's admission face sheet, dated 6/18/25, revealed an admission to the facility on 2/1/25 with diagnoses including fracture of the right hip, fusion of the spine, diabetes mellitus, adrenal insufficiency, and arthritis. The discharge date was recorded as 2/12/25. On 6/17/25 at 7:24 PM, an interview was conducted with Complainant I regarding the intake allegations and replied, I begged the facility to change the dressing on my back from my spinal surgery. The nurses told me they were only to do the dressing on my right hip. Finally, they did after several days. The nurse did not do the dressing change on my back on 2/7/25. I went to have a follow-up appointment on my hip on 2/11/25 and I asked the orthopedic doctor to please look at my back because I was having increased pain in my back. The orthopedic surgeon looked at my back and stated that the incision was reddened, had some yellow drainage, and asked if the facility could get in contact with my back surgeon immediately. I had the facility staff take a picture of my back and the back surgeon's office called me and told me to get to the emergency room at 6:00 AM on 2/13/25, down state where I had my original back surgery done. On 2/13/25, the back surgeon took me to the operating room and washed out my back incision and put me on intravenous antibiotics for four days. I was discharged home on the fourth day (2/17/25) with oral antibiotics that I had to take until the beginning of March. R11 stated she was originally admitted to the facility after a fall at home and fracturing her right hip. Review of R11's hospital discharge, dated 1/13/25 revealed the reason for hospitalization was a L(lumbar)4-5 and L5-S(sacral)1 lumbar fusion on 1/10/25 and was discharged to home on 1/13/25. Review of the hospital history of present illness document, dated 2/13/25, read in part, .Sutures (to back surgery on 1/10/25) were apparently removed in rehab (nursing facility) all at once .patient began experiencing incisional drainage .Assessment/Plan .Discussed option of local rehab post-operatively so we can progressively remove sutures one at a time, which is what I recommend in patients on chronic steroids . Review of emergency room visit, dated 2/13/25 at 10:28 AM, read in part, .Patient has back surgery about a month ago and was sent in by (back surgeon's name) for infected incision site on the back .Patient developed infection lower back complains of pain .Back: There is tenderness lower back area incision site there is some wound dehiscence and swelling erythema (redness) .Case was discussed with (back surgeon's name) patient will be admitted and taken to OR (operating room) for cleanout of wound. Patient will be given vancomycin pharmacy to dose . (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of R11's hospital discharge, dated 2/17/25, revealed the reason for hospitalization was, the patient underwent a lumbar fusion last month. Past few days, patient began experiencing incisional drainage. She was admitted to hospital for wound washout and ID (incision and drainage) recommendations. Patient had a lumbar wound washout on 2/14/25. (name brand drain) removed today. Surgical site infection. Wound infection. Review of R11's discharge summary from the local hospital, dated 2/1/25, read in part, .R (right) hip dressing in place post op [operation] . some dried blood on dressing but no surrounding erythema. Sutures on back noted from recent back surgery. Good wound healing and no dehiscence noted . Review of admission report to facility from local hospital, dated 2/1/25, read in part, .Fall at home, R (right) hip fx (fracture) - post op day 4 .Skin & Wounds: Small dressing, upper buttock, foam dressing . Review of nursing admission evaluation, Section V. Skin, dated 2/1/25 at 3:48 PM, read in part, .Other, right midline buttock, pressure . Further review of the nursing admission evaluation revealed no documentation of R11's post-operative back incision. Review of R11's facility physician order, dated 2/3/25 at 11:00 AM, revealed an order to monitor wound to central lower back, wash with wound cleanser, pat dry and cover with foam dressing daily and PRN (as needed), in the afternoon for the wound present from admission. R11 had their first surgical back wound care dressing change on 2/3/25 on the third day of her initial admission date to the facility. No dressing change was provided on 2/7/25 and on 2/11/25 which was marked as 9in the electronic medical record (EMR), indicating a nursing note was associated with the treatment. Further review of the EMR revealed no nurses note was documented. Review of R11's physician progress note, dated 2/4/25 at 3:27 PM, read in part, .admitted for therapy services s/p (status post) hospitalization for fall with .fracture of the right hip joint. She continues participating with therapies per orders .Plan: Continue with therapies as directed, update provider with changes or concerns. The physician note lacked any documentation of observing the surgical back wound that was still in the healing process. Review of R11's progress note, dated 2/5/25 at 1:22 PM, read in part, .Nursing .dehiscence to surgical wound to lower back . Review of R11's physician progress note, dated 2/6/25 at 10:53 AM, Patient continues participating with therapy as ordered .Assessment: femur fracture, admission .Plan: No changes to plan of care . The physician note lacked any documentation of observing the surgical back wound that was dehiscence. Review of R11's facility physician order, dated 2/6/25 at 11:00 AM, revealed an order to cleanse surgical incision to spine with wound cleaner, pat dry, apply medi-honey to wound bed, then cover with silicone dressing, change daily and PRN, in the afternoon for wound. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of R11's post op orthopedic progress note for right hip fracture, dated 2/12/25 at 12:06 PM, read in part, .Patient and her husband wanted me to look at her lumbar incision when she had lumbar surgery approximately 4 weeks ago does appear to be having some wound dehiscence and some mild drainage from the area .she in independent enough now to be stable at home we will refill her pain medications for I have urged her to go see her spine surgeon as soon as possible and she may need a washout of that wound . Review of R11's progress note, dated 2/12/25 at 1:03 PM, read in part, .Nursing .dehiscence to surgical wound to lower back, daily wound care . Review of R11's progress note, dated 2/12/25 at 4:55 PM, read in part, Wound care asked to go to resident's room and follow up on surgical incision to back .Nurse asked how the incision has been feeling resident states that she is having more pain. Resident's (sic) states a nurse has told her that she will not receive treatment to that surgical incision due to it being from another surgeon's office .removed dressing, light drainageon (sic) dressing, skin around wound is reddened, slough in wound bed . Review of R11's progress note, dated 2/12/25 at 7:13 PM, read in part, (back surgeon's name) office phoned and inquired about surgical incision .(back surgeon's name) office would like to see her in ER (emergency room) .tomorrow . On 6/18/25 at 11:00 AM, an interview was conducted with Nurse Practitioner (NP) J, who was asked if they were notified or were made aware R11 had a post-op spinal incision and whether they assessed the site. NP Jreplied, I don't recall one on R11's back. If I observed that area, I would have stated in my provider notes under assessments that I had. NP J was asked if they were notified of R11's surgical back incision dehiscence, and replied, No, if it is not in my notes, I was not made aware. I would have referred the wound care nurse to the original surgeon for further direction and wound dressing care orders. On 6/18/25 at 12:35 PM, during an interview, the Director of Nursing (DON) was asked if skin assessments should be accurately documented by nursing and replied, Yes. R11's skin assessment was incorrectly documented. The DON was asked the expectation should floor staff identify a new wound or deterioration of an existing wound and replied, The nurse should have called the physician and notified them and make a progress note indicating the communication such as new orders. The DON was asked if R11 should have had back wound dressing change orders on the first day of their admission and replied, Yes. The DON was asked if the physician should have been made aware of R11's wound dehiscence and replied, Yes. The nurse should also document the response of the physician. Review of policy titled, Wound Treatment Management, dated 10/30/20, read in part, Policy: To promote wound healing of various types of wounds, it is the policy of this facility to provide evidence-based treatments in accordance with current standards of practice and physician orders. Policy Explanation and Compliance Guidelines: 1. Wound treatments will be provided in accordance with physician orders, including the cleansing method, type of dressing, and frequency of dressing change. 2. In the absence of treatment orders, the licensed nurse will notify physician to obtain treatment orders .