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	02/04/2026

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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake 2720794.Based in observation, interview and record review, the facility failed to implement timely interventions to prevent the development and worsening of pressure ulcers for two Residents (#10 and (#14) of three residents reviewed. This deficient practice resulted in R10 developing an unstageable (a severe, full-thickness wound covered with necrotic tissue covering the wound bed causing inability to determine true wound depth) requiring surgical debridement (surgical removal of dead tissue), intravenous (IV) antibiotic therapy and hospitalization.Findings include:Resident #10 (R10)Review of a confidential complaint submitted to the State Agency (SA) on 1/12/2026 at 12:25 p.m. revealed an allegation that the facility failed to provide care to prevent the development and worsening of pressure ulcers for R10. The information submitted cited, On 01/08/2026, [R10] was admitted to the hospital for the second time in about three months since being at [facility name]. [R10] was admitted for severe bed sores with exposed bone on his buttocks. While at [facility name], [R10] was neglected. He was not moved regularly . The neglect of [R10] led to the occurrence of his severe wounds. He was admitted to [facility name] in August 2025 without any bedsores . He will remain admitted to the hospital until there is a bed open in a hospice house.Review of R10's electronic medical record (EMR) revealed the following:1/7/2026 at 10:41 p.m. Resident vomited during cares . He could not catch his breath after vomiting and oxygen saturations are 83% . MD [physician] stated to send resident to the hospital and EMS was contacted.12/30/2025 at 9:15 a.m. Skin Issues . Right gluteus . Pressure ulcer/injury . Stage 3 pressure ulcer/injury - full thickness skin loss . Wound acquired in-house. Length (cm) [centimeters]: 3.53. Width (cm) 6.76. Depth (cm): 2. Area (cm2) [centimeters squared]: 20.05. Undermining: Yes . Undermining length (cm): 3.5 .Review of the resident profile information retrieved from the EMR revealed R10 was initially admitted to the facility on [DATE] with diagnoses including Alzheimer's Disease, adult failure to thrive, weakness, and cognitive communication deficit. Review of R10's, Nursing admission Evaluation, dated 9/17/2025, revealed R10 was assessed as having bilateral lower leg arterial/venous wounds, scabs/bruising on both arms and had bowel incontinence. The Evaluation noted R10 was at risk for and had actual skin impairment with interventions indicated including a pressure redistribution mattress to bed.Review of R10's EMR from the time of admission on [DATE] through the date of re-hospitalization on 10/27/2025, revealed the following:9/18/2025 at 2:52 a.m. Braden Scale for Predicting Pressure Sore Risk . Mobility: Very limited. Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes . The assessment scored R10 at 15, at risk for pressure ulcers.A physician progress note, dated 9/24/2025 at 3:57 p.m., revealed R10 was assessed as having no open wounds.9/24/2025 12:30 p.m. IDT - Interdisciplinary Progress Note . Max Ax2 [assistance of two staff] for transfers, Max A [assistance] ADLs. Pertinent Charting - Skin, dated 9/26/2025 at 10:25 a.m., revealed identification of MASD [Moisture-Associated Skin Damage] on BL [bilateral] buttocks. 3.54 cm [centimeters] x 5.65 cm . New Orders: calmoseptin (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 0686 Level of Harm - Actual harm Residents Affected - Few	bid [twice daily] to BL buttocks.9/26/2025 at 10:48 a.m. Resident was noted to have a new skin issue to his bilateral buttocks. In review of wound it was noted that the skin was red with several areas where the skin was eroded. He was noted to be having loose stools .10/1/2025 at 8:00 p.m. bilateral buttocks area not improving as he has had recent loose stools . continue to apply cream and off load while in bed.10/2/2025 at 10:37 a.m. OT [Occupational Therapy] 10/01/2025 - Upon initiation of OT, [R10] was found lying in liquid stool in brief. [R10] reported he was not aware he was incontinent.10/4/2025 at 8:59 p.m. sheering of both buttocks .10/5/2025 at 6:58 p.m. sheering of both buttocks .10/7/2025 at 2:22 a.m. and 5:45 p.m. sheering of both buttocks .10/8/2025 at 3:01 a.m. and 7:23 p.m. sheering of bilat [bilateral] buttocks .10/9/2025 at 4:12 a.m. and 7:47 p.m. sheering of bilat buttocks .10/10/2025 at 3:48 p.m. dressing placed on buttocks this [morning] after peri-care done. [R10] does have ve [sic] liquid stools.10/15/2025 at 7:41 p.m. buttocks are purple in areas with scattered open superficial area .10/17/2025 at 4:29 p.m. buttocks are purple in areas with scattered open superficial area .10/18/2025 at 5:36 p.m. buttocks in [sic] deteriorating. Low air loss mattress ordered .10/20/2025 at 12:45 a.m. Low air mattress is on as ordered .A physician progress note dated 10/23/2025 at 4:03 p.m. Patient is seen for follow-up of wound care. He presents with deteriorating and [sic] left gluteal wounds. The wound initially began as MASD mid-September and has since progressed to what appears to be suspected deep tissue wounds as there is a moderate amount of slough [versus] eschar.A physician progress note dated 10/27/2025 at 11:06 p.m. Patient is seen for follow-up of wound care. Last Thursday he presented with deteriorating buttock wounds which have progressed to unstageable pressure ulcers. Today he presents with nearly 100% black necrotic [dead] tissues, purulence from wound and erythema [redness] with induration quite concerning for wound infection [versus] necrotizing fasciitis as his wounds have worsened with haste. He has a low grade [temperature] and lower blood pressures from his norm along with elevated [heart rate]. He will be shipped to ER for evaluation and treatment as his wound advancement is beyond our care here.Review of R10's Inpatient Discharge Summary, dated 11/3/2025, revealed R10 was hospitalized on [DATE] with return to the facility on [DATE]. Further review of the Discharge Summary revealed the following: On arrival to the emergency department patient was noted to be ill-appearing and tachycardic with a heart rate of 106 and respiratory rate of 28. A physical exam revealed a necrotizing, foul-smelling wound over the sacrum and bilateral buttocks. A sepsis workup was initiated, and CT of the pelvis was obtained, which revealed soft tissue ulceration, edema and gas within the right sacral and proximal gluteal region consistent with a decubitus ulcer . Labs were significant for leukocytosis of 34.0, CRP of 29.9 and sed rate of 87. The patient received a sepsis fluid bolus and was started on broad-spectrum antibiotics including vancomycin, clindamycin and meropenem. General surgery was consulted and [surgeon name] took the patient to the operating room for an urgent incision and debridement . The patient was admitted to the ICU [intensive care unit] . the patient was started on midodrine 10mg 3 times daily for suspect vasoplegia [a form of severe shock characterized by dangerously low blood pressure] secondary to sepsis . Physical exam at discharge . Skin . large surgical dressing to sacral area with wound VAC in place .Review of physician orders for R10 revealed and order dated 10/17/2025 for Low air loss mattress: Staff to ensure mattress is working properly. If any noted malfunctions or suspected malfunctions notify charge nurse immediately.During an interview on 2/4/2026 at 2:30 p.m. Maintenance Director (Staff) C was queried regarding the process for receiving work orders for placement of low air loss mattresses. Staff C reported nursing staff enter the order into communication program and upon receiving the order, maintenance staff complete the order generally within 48 hours since the facility has a large supply of low air loss mattresses on hand. When asked for the tracking data for the (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	work order for the placement of R10's low air loss mattress, Staff C reported once the work order is completed, there was no way to retrieve the data. When asked to clarify, Staff C reported there was no record of when work orders are placed or completed to reference.During an interview on 2/4/2026 at 2:45 p.m., Unit Manager/Licensed Practical Nurse (LPN) A was queried regarding the indications for use of low air loss mattresses. LPN A reported indications included a variety of assessment data and discussion with the IDT (interdisciplinary team). The LPN A confirmed indications for use of low air loss mattresses to aid in the prevention of pressure ulcers included the presence of MASD, moisture, Braden assessments indicating residents at risk and decreased mobility. LPN A added that she defers the decision to the DON. Review of R10's September 2025 and October 2025 MARs (Medication Administration Records) and TARs [Treatment Administration Records) revealed no documented order, application or monitoring of a low air loss mattress.Review of POC (point of care) documentation for September 2025, October 2025 and November 2025 revealed consistent documentation of the presence of a Pressure Redistribution Mattress to Bed, from the time of R10's admission on [DATE] through the Resident's hospitalization on 10/27/2025. Further review revealed bed mobility documentation of R14 being totally dependent on two-person assistance on 12 days and of requiring extensive two-person assistance on 14 days of 30 days reviewed.During an interview on 2/4/2026 at 3:15 p.m., Unit Manager, LPN B reported POC tasks originated from nursing assessment findings and applicable interventions marked on the assessment form deemed appropriate for implementation. LPN B reported the nursing interventions listed in the evaluations were not orders but identified recommendations. During an interview on 2/4/2026 at 3:54 p.m., the DON reported indications for the use of low air loss mattresses included a diagnosis of failure to thrive, which increased the risk of pressure ulcer development. The DON reported R10 was very ill and was frequently incontinent of stool. The DON was asked if consistent moisture related to bowel incontinence posed an increased risk for skin breakdown to which she reported moisture does increase risk of developing pressure ulcers. The DON was aware the facility had a supply of low air loss mattresses on hand, but the placement of the mattresses required nursing staff to obtain a physician's order. The DON reported she was not involved in R10's care until she took over the position from the facility's previous DON who resigned unexpectedly in December 2025. The DON stated she could not account for nursing or POC documentation of the presence of a low air loss mattress prior to 10/17/2025 or prior to placement of the mattress. The DON confirmed the low air loss mattress would not have been placed until after the order was obtained and maintenance notified of the need.Review of the Completed Work Order #4451, provided by the Nursing Home Administrator (NHA) and Senior Nursing Home Administrator (NHA) E at 4:20 p.m. revealed the order for the placement of the low air loss mattress was placed by the NHA on 10/17/2025. Review of the timeline with NHA E revealed the order was created on 10/17/2025 at 4:43 p.m. with documented completion of the air mattress placement on 11/04/2025 at 10:51 a.m. NHA E stated, It's not really what we wanted to see. It was noted in review, the air mattress was not placed on R10's bed until after the Resident returned from hospitalization on 11/03/2025 and post-surgical debridement, wound vac placement and treatment for sepsis.Resident #14 (R14)Review of the resident profile documentation gleaned from the EMR revealed R14 was admitted to the facility on [DATE] and had diagnoses including diabetes, adult failure to thrive, dehydration, difficulty walking, and osteoarthritis. Review of the MDS assessment, dated 1/25/2026, revealed R14 required substantial/maximal assistance with bed mobility and was dependent on staff for transfers. Further review of the MDS assessment revealed the presence of one stage 2 (partial-thickness tissue loss) pressure ulcer/injury and the risk of developing pressure ulcer/injuries.An observation on 2/4/2026 at 10:10 a.m. revealed R14 seated in bed with the head of the bed at (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	approximately 45 degrees. R14 was noted to have a pillow under her knees and upper portion of lower legs with her heels directly on mattress. Heel protection boots were observed to be on nightstand in corner of the room. When asked if staff put the boots on her while in bed, the Resident reported no, they bother me. That's what the pillow is for. When asked if resident had any open wounds, she reported yes and motioned her left outer thigh. It was noted during the observation that there was no low air loss mattress on R14's bed.Review of R14's, Nursing admission Evaluation, dated 1/19/2026, revealed the Resident was assessed as having a right buttock rash, a left buttock blister, and a pressure wound on her right rear thigh and left gluteus on admission. The Assessment care plan interventions to be implemented included Pressure redistribution mattress to bed.Review of physician orders from the time of admission on [DATE] through 2/04/2026 revealed no order for placement or monitoring of a low air loss mattress for R14.Further review of the EMR revealed the following:1/20/2026 at 8:27 a.m. Resident admitted with multiple areas of skin concerns . She had two pressure ulcers one on the left and right gluteus.An observation on 2/4/2026 at 12:10 p.m., revealed R14 seated in bed directly on her buttocks. No wedge pillow or positioning device was observed in R14's bed to offer offloading from buttocks. A pillow was noted to be under R14's knees but R14's heels were resting directly on the mattress. It was noted during the observation that there was no low air loss mattress on R14's bed.An observation on 2/4/2026 at 2:18 p.m., revealed R14 seated in bed. R14's heels were observed to be resting directly on the mattress, and a pillow was noted to be on the bed to the right of the resident's right lower leg. R14 was asked if she could move around independently in bed at which time she raised her right leg approximately 3 inches off the bed. R14 reported she could not move her left leg up off the bed due to severe knee pain. Heel protection boots were observed atop a nightstand in the corner of R14's room. It was noted during the observation that there was no low air loss mattress on R14's bed.During an interview on 2/4/2026 at 2:20 p.m., Registered Nurse (RN) D stated R14 was very leery and fearful when it comes to turning and repositioning. RN D confirmed R14 had left knee pain and was unable to move left leg consistently or reposition herself in bed. RN D stated she does not like to wear the heel boots and is at risk for developing further pressure injuries. RN D confirmed there was no low air loss mattress on R14's bed.During an interview on 2/4/2026 at 2:45 Unit Manager, LPN A reported she was unaware of R14's declination to wear heel protection boots. LPN A reported she was aware R14 was admitted with pressure injuries which placed the Resident at higher risk for development of future wounds.No declaration or documentation related to facility past non-compliance was offered by the facility through survey completion and exit on 2/4/2025 at 5:00 p.m.Review of the facility policy titled, This facility is committed to the prevention of avoidable pressure injuries and the promotion of healing of existing pressure injuries . Avoidable means that the resident developed a pressure ulcer/injury and that the facility did not do one or more of the following: evaluate the resident's clinical condition and risk factors, define and implement interventions that are consistent with resident needs, resident goals and professional standards of practice . Interventions will be based on specific factors identified in the risk assessment, skin assessment and any pressure injury assessment (e.g., moisture management, impaired mobility . wound characteristics . Evidence-based interventions for prevention will be implement for all residents who are assessed at risk or who have a pressure injury present. Basic or routine care interventions could include but are not limited to: Minimize exposure to moisture and keep skin clean, especially of fecal contamination. Provide appropriate pressure-redistributing support surfaces.