STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235356	A. Building B. Wing	01/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge at the Shore	900 S Beacon Blvd Grand Haven, MI 49417

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37577 This citation pertains to Intake Number MI00149340. Based on observation, interview, and record review, the facility failed to ensure that (1) Resident's needs were met timely and that (2) Call lights were within reach for two residents (Resident #6, Resident #9) of four residents reviewed for accommodation of needs. Findings include: Resident #6 (R6): Review of an Admission Record reflected R6 was a [AGE] year-old female, last admitted to the facility on [DATE], with pertinent diagnoses of Alzheimer's and rheumatoid arthritis. Review of a BIMS (Brief Interview for Mental Status) revealed R6 had severely impaired cognition. During an observation on 01/08/25 at 7:40 AM, the call light touch pad for R6 sat on the bedside table covered by a hat, out of sight and out of reach of the resident. During an observation on 01/08/25 at 9:35 AM, the call light touch pad for R6 remained on the bedside table, out of sight and out of reach of the resident, and covered by a hat. R6 sat up in bed eating breakfast. During an interview on 01/08/25 at 11:32 AM, CNAO indicated that placement of call lights and other items used frequently were to be checked anytime staff go into a room or walk by and look into a room. During an observation on 01/08/25 at 11:40 AM, R6 sat up in bed with very bright red lipstick on and the call light touch pad sat on the bedside table out of sight and out of reach of the resident. When asked how she would notify staff if she needed something, R6 looked around her bed and replied 'I don't know. During an observation on 01/08/25 at 3:27 PM, R6 remained in bed and the call light touch pad sat on the bedside table out of sight and out of reach of the resident and was no longer covered by the hat. (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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 01/09/25 at 7:54 AM, R6 laid in bed resting with her eyes open and the call light touch pad sat on the bedside table out of sight and out of reach of the resident. Review of the facility policy Call Lights: Accessibility and Timely Response, last reviewed 12/28/23, reflected . staff are educated in the proper use of the resident call system, including how the system works and ensuring resident access to the call light. Resident #9 (R9): Review of an Admission Record revealed R9 was a [AGE] year-old male, originally admitted to the facility on [DATE], with pertinent diagnoses of multiple sclerosis and difficulty speaking and was dependent on staff for bathing and hygiene care. During an interview on 01/08/25 at 12:20 PM, R9 sat at a table in the dining area listening to music. R9 indicated that it took a long time for staff to answer his call light, especially on third shift and that many times when staff did answer the light, they would come in and turn off the light and not come back. During an interview on 01/08/25 at 12:50 PM, R9's roommate stated the following regarding third shift staff answering the call light for R9: if staff answer the light it takes along time, and they have told him (R9) things like you can wait and you are a two hour check and it hasn't been that long yet. During an interview with a confidential staff person (CSP-F) on 01/08/25 at 2:30 PM, the following was indicated: CSP-F has received such complaints from residents (1) nobody checked on me all night, (2) third shift staff were rough and rushed with cares, (3) call lights, if answered, takes a really long time, and (4) I have been soaked all night, please help me. During an interview with a confidential staff person (CSP-B) on 01/09/25 at 8:00 AM, CSP-B reported hearing comments from residents that third shift staff do not answer call lights or if they do, it takes a long time for them to be answered. Review of the facility policy Call Lights: Accessibility and Timely Response, last reviewed 12/28/23, reflected . any staff member who sees or hears an activated call light is responsible for responding.

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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 - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37577 This citation is related to intake Number MI00149340. Based on observation, interview, and record review the facility failed to provide quality care to two residents (Resident#1 and Resident #6) out of 5 residents reviewed. Findings include: Resident #1 (R1): Review of an Admission Record revealed R1 was a [AGE] year-old female, originally admitted to the facility on [DATE], following a 30 day inpatient hospital stay for a cerebral aneurysm with a stent placement, right sided stroke, and required intubation due to hypoxia. R1 admitted to the facility with pertinent diagnoses of left sided weakness and paralysis after a stroke in May 2024 with subsequent difficulty speaking, swallowing and impaired vision, high blood pressure, restlessness, claustrophobia, overactive bladder, broken lumbar fusion hardware (rod) in her back, use of a tube feed for nutrition (placed during recent hospitalization on [DATE]), and muscle weakness. Review of Hospital Wound Care orders for the new tube feed site: wash with dermal wound cleanser once daily (feeding tube site). Dry thoroughly especially under external bolster/bumper. During an interview on 01/08/25 at 3:00 PM, R1's daughter and guardian L reported visiting R1 on 01/06/25 and observed what looked like pus draining from the tube feed insertion site and it smelled awful. During an observation on 01/08/25 at 3:40 PM, R1's tube feed insertion site had pus like drainage (thick yellowish/brown). It hurts. R1 held the drain sponge and it was saturated with a thick brown substance. Review of an electronic medication administration record (Emar) for R1, dated January 2025, reflected an order for staff to clean the tube feed site with normal saline (not a wound cleanser as listed on the hospital discharge wound care orders), dry, and apply a drain sponge daily and as needed. Resident #6 (R6): Review of an Admission Record reflected R6 was a [AGE] year-old female, last admitted to the facility on [DATE], with pertinent diagnoses of Alzheimer's and rheumatoid arthritis. Review of a BIMS (Brief Interview for Mental Status) revealed R6 had severely impaired cognition. On 01/08/25 a review of nursing Progress Notes for R6 revealed the last two nursing notes entered into the EHR (electronic health record) were recorded on 12/03/24 and 11/07/24. The nursing progress note entered on 12/03/24 was a notation regarding a low blood pressure (100/46) that had been taken on 11/17/24. There was no documentation found that, at the time of the low blood pressure reading on 11/17/24, indicated that the physician was notified nor was R6's blood pressure re-checked until 11/21/24.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 37577 This citation is related to Intake Number MI00147654 Based on observation, interview, and record review the facility failed to secure 1 of 4 unattended medication carts. Findings include: During an observation on 01/08/25 at 7:20 AM, the unattended medication cart for rooms 1-15 displayed resident information on the computer screen. Upon further observation, the unattended medication cart was unlocked. Found in the second drawer down on the left side of the medication cart were 14 different loose unidentified pills. Found in the second drawer down on the right side of the medication cart was an unsecured metal box that contained controlled substances. During an interview on 01/08/25 at 7:25 AM, License Practical Nurse (LPN) A approached the unlocked medication cart and stated you busted me, I'm sorry. During an interview on 01/08/25 at 7:35 AM, LPN B indicated that medications carts and narcotic boxes were to be locked at all times when the nurse was not at the medication cart. Review of the facility policy Medication Storage last reviewed on 01/30/24 revealed: It is the policy of this facility to ensure all medications housed on our premises will be stored according to the manufacturer's recommendations and sufficient to ensure .security. All drugs will be stored in locked compartments (i.e., medication carts, drawers) .Schedule 2 drugs and back-up stock of schedule 3, 4, and 5 are stored under double lock and key.