| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 235356 | A. Building<br>B. Wing | 08/15/2025 |

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| Medilodge at the Shore | 900 South Beacon Boulevard<br>Grand Haven, MI 49417 |

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|---|---|
| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure services provided by the nursing facility meet professional standards of quality.<br><br>(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 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to follow professional standards for medication administration for 3 residents (R124, R81 and R86) out of 8 residents reviewed for nursing professional standards of practice.Findings:Resident #124 (R124)Review of an admission Record revealed R124 was a [AGE] year-old male, admitted to the facility on [DATE].Review of R124's Order Summary dated 8/1/25-8/6/24 revealed, HYDROcodone-Acetaminophen (Norco) Oral Tablet 7.5-325 MG.Give 1 tablet by mouth every 4 hours as needed for breakthrough pain.Review of R124's Control Substance Record revealed that on 8/6/24 a dose of Norco was administered at 6:00 AM and a dose of Norco was administered at 9:00 AM. (Administered 3 hours apart).Review of R124's August Medication Administration Record revealed that the Norco was documented as administered for the 6:00 AM or the 9:00 AM doses.Review of R124's Electronic Medical Record revealed no documentation for a rationale for administering the Norco outside of the ordered 4 hours. Resident #81(R81)Review of an admission Record revealed R81 was a [AGE] year-old male, admitted to the facility on [DATE].Review of R81's Order Summary dated 7/7/25 revealed, Percocet Oral Tablet 10-325 MG (Oxycodone w/ Acetaminophen) Controlled Drug Give 1 tablet by mouth every 4 hours for pain. To be administered at 12:00 AM, 4:00 AM, 8:00 AM, 12:00 PM, 4:00 PM, and 8:00 PM.Review of R81's Control Substance Record revealed:*On 8/8/25 a dose of Percocet was administered at 5:36 PM (approximately 1.5 hours after it was due) and the subsequent dose administered at 7:50 PM. The doses of Percocet were administered approximately 2 hours apart.*On 8/10/25 a dose of Percocet was administered at 5:30 PM (approximately 1.5 hours after it was due) and the subsequent dose was administered at 7:25 PM. The doses of Percocet were administered approximately 2 hours apart.*On 8/11/24 a dose of Percocet was administered at 4:30 PM and the subsequent dose was administered at 7:00 PM. The doses of Percocet were administered approximately 2.5 hours apart.Review of R81's's Electronic Medical Record revealed no documentation for a rationale for administering the Percocet 2-2.5 hours apart instead of the ordered 4 hours. Resident #86 (R86)Review of an admission Record revealed R86 was a [AGE] year-old male, admitted to the facility on [DATE].Review of R86's Order Summary dated 2/3/25 revealed, Metoprolol Tartrate Tablet 50 MG Give 25 mg by mouth every morning and at bedtime for HTN (hypertension) Hold for systolic (top blood pressure number) < (less than) 100 or hold if HR (heart rate) < 60. To be administered in the morning and in the evening.Review of R86's Blood Pressure Summary, Pulse Summary, and August Medication Administration Record (MAR) revealed:*On 8/4/25 R86's blood pressure and pulse were not assessed prior to the evening dose of Metoprolol and morning results of the blood pressure and pulse assessments were documented in the MAR (indicating the assessments were completed prior to the evening dose of Metoprolol).*On 8/6/25 R86's blood pressure and pulse were not assessed prior to the evening dose of Metoprolol and morning results of the blood pressure and pulse assessments were documented in the MAR. *On 8/9/25 R86's blood pressure and pulse were not assessed prior to the evening dose of Metoprolol and morning results of the blood pressure and pulse assessments were documented in the MAR.During an interview via email on 08/15/2025 at 9:25 AM, Nursing Home Administrator (NHA) confirmed the above errors and reported there was no additional information/documentation to disprove the medication errors. Review of the facility policy Medication Administration dated 1/17/23 revealed, .8. Obtain and record vital signs, when applicable or per physician orders. When applicable, hold medication for those vital signs outside the physician's prescribed parameters. |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate pressure ulcer care and prevent new ulcers from developing.<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to follow policies and procedures and physician orders for pressure ulcer care for 1 (R108) of 4 residents reviewed for pressure ulcers.Findings include:Review of a policy titled Pressure Injury Prevention and Management dated 3/20/24 revealed: . 4. Interventions for Prevention and to Promote Healing: a. the interdisciplinary team shall develop a relevant care plan that includes measurable goals for prevention and management of pressure injuries with appropriate interventions. b. Interventions will be based on specific factors identified in the risk assessment, skin assessment, and any pressure assessment . Basic or routine care interventions could include, but are not limited: i. Redistribute pressure (such as repositioning, protecting and/or offloading heels, ect.); . iii. Provide appropriate, pressure-redistributing, support surfaces; . f. Interventions will be documented in the care plan and communicated to all relevant staff. 5. Monitoring: a. The attending physician will be notified of: i. The presence of a new pressure injury upon identification. ii. The progression towards healing, lack of healing, or worsening of any pressure injuries weekly. Review of a Face Sheet revealed R108 has pertinent diagnoses of spastic quadriplegic cerebral palsy and neuromuscular scoliosis. Review of the Minimum Data Set (MDS) dated [DATE] for R108 revealed she is cognitively intact, nonverbal, bilateral upper and lower extremities are impaired, and is totally dependent on staff for care. R108 was at risk for pressure ulcers (PU) and had none at this time. R108 required nutrition through tube feeding. Review of a risk for impaired skin integrity care plan for R108 initiated on 12/23/23 and revised on 7/18/25 revealed on 7/18/25 a re-occurred stage 4 PU to sacrum. Interventions dated 12/23/23 included but not limited to: Assist resident with turning and repositioning as needed (does not indicate an objective time frame). On 1/5/24 If resident refuses interventions/treatments, encourage compliance to minimize skin impairment.Review of a Skin assessment dated [DATE] for R108 revealed a new stage 4 pressure ulcer reopened on her sacrum on 7/18/25. On 8/12/25 R108's wound measured 4.7 cm (centimeters) x 2.1 cm x 2.8 cm x 0.1 depth and on 7/18/25 the pressure ulcer measured < 0.1cm x 0.4 cm x 0.4 cm x 0.1 cm depth. A significant increase between 7/18/25 and 8/12/25.During an observation on 8/12/25 at 9:19 AM, R108 was observed sitting upright in the common area of the hallway in an electric wheelchair with tube feeding infusing. Shortly after observation, R108 was taken to her room for oral care and came back out to the common area sitting upright in her electric wheelchair.During the following observations on 8/12/25 at 12:00 PM, 1:50 PM, and 4:07 PM, R108 was observed in the same common area in her electric wheelchair sitting upright. During an observation on 8/13/25 at 8:15 and 8:42 AM, R108 was in her room lying on her back at a 45-degree angle with the tube feeding infusing. (this position puts pressure on sacrum)During an observation on 8/13/25 at 10:17 AM, Certified Nursing Assistant (CNA) F provided morning care for R108 and transferred her to her electric wheelchair. R108 observed sitting upright in the common area of the hallway when care was completed. During an observation and an interview on 8/13/25 at 2:24 PM, CNA K and CNA L were questioned about R108 observed in the common area all day without being repositioned. Both CNAs reported R108's wheelchair does recline back but if R108 reclined, she would not be able to people watch or see her iPad that R108 really enjoys. They indicated that R108 will get upset if she cannot do that. Review of the Nursing Progress notes for R108 revealed no documentation indicating resident refused to be repositioned. Review of the July 2025 Medication Administration and Treatment Administration Record (MAR/TAR) for R108 revealed on 7/19/25 an order to Cleanse sacral wound with wound cleanser. Apply small piece of calcium alginate to wound bed. Cover with foam dressing as needed for disruption, was discontinued on 7/23/25 and was not documented as done all 5 days before it was discontinued. On 7/23/25 a new order to cleanse sacral wound with soap and water, apply Triad wound paste, every dayshift was not documented as done on 7/24, and on 7/29 and 7/31 it was coded not done and to see the nursing notes. Review of the August 2025 MAR/TAR for R108 revealed the sacral wound care was not done on 8/2, 8/3, 8/7, and 8/8 with no supporting documentation as to why. Review of the nursing notes do not address the reason wound care was not done on the above indicated dates in July and August and no indication the physician was notified. Review of the Practitioner progress notes since the onset of R108's pressure ulcer on 7/23/25 revealed on 8/1/25 the resident was seen, and no practitioner oversight of the wound was documented. During an observation on 8/13/25 at 10:17 AM, Certified Nursing Assistant (CNA) F provided peri care for R108 when a 4x4 dressing was observed on R108's sacrum and the right lower corner of the dressing was not adhered to |

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| F 0688<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to follow physician orders and the care plan for 1 (R25) of one resident reviewed for range of motion. Findings include:Review of a Face Sheet revealed R25 had pertinent diagnoses of hemiplegia and hemiparesis (one sided weakness), vascular dementia, and pseudobulbar affect (uncontrolled episodes of crying). Review of the Minimum Data Set (MDS) dated [DATE] revealed R25 is moderately cognitively impaired and has an impairment on the upper and lower extremities on one side. Review of the Order Summary for R25 revealed on 2/3/25 an order for a splint to the left upper extremity is to be placed upon rising as the resident allows, removed for lunch, reapplied after lunch and removed at bedtime. During an observation on 8/12/25 at 10:17 AM, R25 was observed in bed with her left hand contracted. When asked if she had splints, R25 said they never did it and didn't know where they were. During an observation on 8/12/25 at approximately 1:00 PM after lunch, R25 did not have any splints on her left hand. During an observation on 8/13/25 at approximately 1:00 PM, R25 was observed not wearing her splint in her left hand. Review of the risk for impaired skin integrity Care Plan for R25 revealed: interventions that may contribute to wound development with use of braces to left hand and left leg/foot for contractures ., initiated 8/23/23. Interventions included: If resident refuses interventions/treatments, encourage compliance to minimize skin impairment, initiated 8/23/23. Review of the Resident has an impaired musculoskeletal status related to contractures of left elbow, left wrist, left hand, left ankle, abnormal posture, osteoporosis. Resident often declines/removes splint, last revised on 7/25/24. Interventions included but not limited to: Apply and remove splints as ordered, initiated on 8/23/23. During an observation and an interview on 8/13/25 at 1:11 PM, the Physical Therapy Director (PT) Z reported that according to R25's care plan, staff are to apply splints to R25's left extremity twice a day. PT Z was informed that R25 has not had them on for 2 days now and did not know where they were. At this time, PT Z went to R25's room and found the splint in her top drawer. R25 allowed PT Z to put them on without resistance or difficulty. Review of a 30-day documentation dated 7/14/25 to 8/12/25 for R25 regarding Splint/Brace assistance: L (left) hand orthotic (WHO) to left upper extremity to be applied in AM during morning care and removed at HS (bedtime) during care or per resident's tolerance (resident removes at times). During this time, there were 21 times it was documented Did not occur. There was no follow up documentation to show the resident was reapproached or the potential root cause of refusals by a licensed professional. In an interview on 8/14/25 at 11:29 AM, Registered Nurse (RN) G was questioned about R25 not wearing her splints. RN G reported that R25 can put up a fight at times when its time to put on her splints. RN G reported that she does expect the Certified Nursing Assistants (CNAs) to follow the care plan, and if the resident refuses, she expects them to tell her so she can reapproach or try another time. If the resident still refuses, the nurse should document it. |

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| F 0693<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.<br><br>(continued on next page) |

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| F 0693<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to have policies and procedures for tube feed positioning, follow standards of practice for positioning, and follow physician orders for 1 (R108) of 2 residents reviewed for tube feedings.Findings include:Review of a policy titled Feeding Tubes last revised 10/15/24 revealed: . 8. The plan of care will reflect the use of a feeding tube and potential complications. 9. The facility will utilize the Registered Dietician in estimating and calculating a resident's daily nutritional and hydration needs. This policy does not address the positioning of a resident while receiving tube feeding. Review of the Nutrients Journal, ([NAME], J. (2022). Enteral nutrition overview. Nutrients, 14(11th ed.), 11. https://doi.org/10.3390/nu14112180) revealed The head of the bed should be elevated 30-45 degrees, if possible, for any patient in the supine position who is at risk for aspiration [44-49].Review of a Face Sheet revealed R108 has pertinent diagnoses of spastic quadriplegic cerebral palsy and neuromuscular scoliosis. Review of the Minimum Data Set (MDS) dated [DATE] for R108 revealed she is cognitively intact, nonverbal, bilateral upper and lower extremities are impaired, and is totally dependent on staff for care. R108 was at risk for pressure ulcers (PU) and had none at this time. R108 required nutrition through tube feeding. During an observation on 8/13/25 at 10:17 AM, Certified Nursing Assistant (CNA) F was providing morning are for R108. At this time R108 was receiving a tube feeding (TF) at 50 mL (milliliters)/hour (hr). CNA F lowered the head of the bed flat while it was infusing. CNA F continued to clean and dress R108 alone and R108 was not able to assist. The tubing line was taut when R108 was turned to the left side with one hand of CNA F and his other hand was providing care. When CNA F completed care, the TF machine read complete, and the nurse came in to disconnect the TF. In an interview on 8/14/25 at 11:29 AM, Registered Nurse (RN) G was questioned about R108s tube feeding and reported that the TF should not be infusing when the head of the bed is lower than 30 degrees and the CNA should have informed the nurse so she could turn it off or disconnect the resident during care. When asked about R108 needing 2 staff for ADL (activities of daily living) care but observed only one staff providing care, RN G reported there would be less potential for mishaps if R108 had 2 staff providing care. RN G reported they have plenty of staff and it was just a matter of coordinating care with other staff. Review of a Nursing progress note dated 2/1/25 for R108 revealed a new event started on 1/23/25- Location of skin area being documented: peg tube site continues to be red with drainage present .Review of the Nursing progress notes dated 4/19/25 at 9:23 PM for R108 revealed: . While staff continued ADL care feeding tube became displaced. On-call provider notified and ok to send to ER for replacement.Review of a Practitioner progress note dated 6/17/25 for R108 revealed: . cerebral palsy, quadriplegia dysphagia with PEG tube. She is unable to provide any information. Reportedly had problems with her PEG tube and was sent to hospital and had that replaced. No reported issues since.Review of the July 2025 Medication Administration/Treatment Administration Record (MAR/TAR) for R108 revealed an order dated 6/16/25 to infuse Jevity 1.5 at 50 mL/hr (milliliters per hour) x 18 hours until a full dose of 900 mL was administered and was documented R108 received only 750 mLs from 7/1/25 to 7/31/25. No supporting documentation supporting the change in the amount received. Review of the August MAR/TAR for R108 revealed an order dated 7/17/25 to cleanse the gastrostomy tube (G-tube) site with soap and water daily and as needed. This was not done on 8/2, 8/3, 8/7, and 8/8. Another order dated 6/16/25 to infuse Jevity 1.5 at 50 mL/hr (milliliters per hour) x 18 hours until a full dose of 900 mL (milliliters) was administered and 8/1/25-8/7/25 only had 750 mL documented as administered. Review of the Nursing progress notes dated 7/30/25 at 8:19 AM for R108 revealed: Nurse found resident unhooked from tube feed this morning. Resident refusing to allow me to hook her up at this time. Tube flushing ok. No follow up documentation and incident report provided. Review of the Practitioner progress notes dated 8/5/25 revealed: Nurse reported yesterday evening that resident had a large emesis of TF formula. Pump was found to be set at a higher rate at that time, so TF was turned off and holding at this time. She was sitting up at time of emesis so at this time there is no concern for aspiration. Order given to hold x 2 hours, and if there were no further episodes of emesis, may resume TF @ the ordered 50ml/hr. Nurse then called back later to report that she obtained 260ml residual of feeding in stomach 2 hours after incident. Instructed to discard residual, give Zofran 4mg a6h as needed, then if no further emesis 1 hour after Zofran given, may resume TF. Nurse voiced understanding. Review of the Nursing progress notes dated 8/5/25 at 2:32 AM for R108 revealed: pt's (patient's) complaining of stomach pain, residual l volume came to 250 in PEG Tube. Tube feed is currently on hold. Called the |

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| F 0712<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that the resident and his/her doctor meet face-to-face at all required visits.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that the physician, or non-physician practitioner conducted a face-to-face visit at least once every 60 days after the initial 90 days post-admission visits for 1 of 23 sampled residents (R7). Findings include:A review of R7's admission Record, dated 8/14/25, revealed they were a [AGE] year-old resident admitted to the facility on [DATE]. In addition, R7 had multiple diagnoses that included dementia, diabetes, bipolar disorder, depression, and hepatic encephalopathy (a loss of brain function when a damaged liver does not remove toxins from the blood). A review of R7's Minimum Data Set (MDS) (a tool used for assessing a resident's care needs), dated 7/11/25, revealed a Brief Interview for Mental Status (BIMS) (a scale used to determine a resident's cognitive status) score of 0 which revealed R7 was severely cognitively impaired. A review of R7's electronic medical record (EMR), dated 10/3/24 to 8/14/25, failed to reveal that a physician (or non-physician practitioner- a nurse practitioner, a physician assistant, or a clinical nurse specialist) had conducted face-to-face visit with R7 since 2/27/25 (over 5 months prior to the survey). During an interview on 08/14/2025 at 3:30 PM, the Director of Nursing (DON) was informed that R7 did not have any physician visits notes in their EMR after 2/27/25. The DON stated R7 also receives physician services from an outside company. She stated she would call them and see if they had any documentation that a physician or non-physician practitioner from that company had conducted a face-to-face visit with R7 since 2/27/25. During a second interview on 08/14/2025 at 4:00 PM, the DON stated the outside company that also provides physician services to R7 sent her documentation that a non-physician practitioner (a nurse practitioner) had conducted a face-to-face visit with R7 on 6/25/25, 7/16/25, and 8/6/25. The DON also stated that R7 had been hospitalized from [DATE] to 6/24/25. The DON verbally confirmed that R7 had not been seen by a physician or non-physician practitioner between 2/27/25 and 6/1/25 (a period of 93 days prior to hospitalization). The DON also confirmed that the facility did not have any documentation that R7 was seen by the facility's physician or non-physician practitioner during that time period. The DON verbally agreed with the surveyor that a physician or non-physician practitioner should have had a face-to-face visit with R7 by 4/27/25, but no later than 5/4/25. |

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| F 0756<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the pharmacist sent a report for a medication recommendation/comment and/or a physician reviewed the pharmacy recommendation for 1 of 5 residents (R7) reviewed for monthly pharmacy medication regimen reviews. Findings include:A review of R7's admission Record, dated 8/14/25, revealed they were a [AGE] year-old resident admitted to the facility on [DATE]. In addition, R7 had multiple diagnoses that included dementia, bipolar disorder, and depression. A review of R7's Minimum Data Set (MDS) (a tool used for assessing a resident's care needs), dated 7/11/25, revealed a Brief Interview for Mental Status (BIMS) (a scale used to determine a resident's cognitive status) score of 0 which revealed R7 was severely cognitively impaired. A review of R7's Pharmacy Medication Review Progress Note, dated 3/31/25, revealed that the line for Comment/Recommendation noted-see report was checked. This indicated that the pharmacist had made a recommendation to the physician or had noted an irregularity in R7's medication regimen. A review of R7's electronic medical record (EMR), dated 3/1/25 to 8/14/25, failed to reveal documentation (e.g., a Physician Recommendations for, a Nursing Recommendation form, a progress note, a physician note) that would indicate what the pharmacy comment/recommendation was on 3/31/25. During an interview on 08/14/2025 at 3:18 PM, the Director of Nursing (DON) was informed that the pharmacist had made a comment/recommendation on 3/31/25, however the report and/or any other documentation that would indicate what the comment/recommendation was could not be located in R7's EMR. The DON stated the report should have been scanned into R7's EMR under the Miscellaneous (Misc) tab under the subheading Pharmacy. The DON stated she would look and see if she could locate the 3/31/25 pharmacy recommendation report and she would provide a copy to the surveyor, if she could locate it. During a second interview on 08/14/2025 at 3:30 PM, the DON stated she had called the outside company that also provides physician services to R7 to see if they had a copy of the pharmacy report that would indicate what their comment/recommendation was on 3/31/25. The DON indicated during the interview that the facility has had issues with the outside company providing documentation to them in the past, but she would provide copies of any documentation that they sent to the survey team. During a third interview on 08/14/2025 at 4:00 PM, the DON stated the outside company that also provides physician services to R7 had said they did not have a copy of the report that would reveal what the pharmacist's recommendation/comment was for 3/31/25. The DON stated because the facility did not have a copy of that report and the outside company did not have a copy of that report, then she had no way of knowing if the pharmacy sent a report, what the pharmacy recommendation/comment was, and if the physician was ever made aware of it. A review of the facility's Addressing Medication Regimen Review Irregularities policy, reviewed/revised 12/28/23, revealed, It is the policy of this facility to provide a Medication Regimen Review (MRR) for each resident to identify irregularities and respond in a timely manner to prevent the occurrence of an adverse drug event. 4. The pharmacist must report any irregularities to the attending physician, the facility's medical director and director of nursing, and the reports must be acted upon. Any irregularities noted by the physician during this review must be documented on a separate, written report which may be in paper or electronic form. The attending physician must document in the resident medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. The report should be submitted to the DON within 10 working days of the review. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 235356 | A. Building<br>B. Wing | 08/15/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Medilodge at the Shore | 900 South Beacon Boulevard<br>Grand Haven, MI 49417 |

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|---|---|
| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>Based on observation and interview, the facility failed to appropriately label medications in 1 of 2 medication carts inspected (Southwest Medication Cart).Findings include:During an inspection of the Southwest Medication Cart with Registered Nurse (RN) B on 08/12/2025 at 4:20 PM, the following observations and interview were made: - A box of Desmopressin Nasal Spray 10 mcg/ 0.1 ml (10 micrograms per 0.1 milliliters) was observed with Resident #7's name on it. However, the nasal spray container inside the box was not labeled with R7's name or any other identifying information that would indicate the spray was his if it became separated from the box. - A box of fluticasone and salmeterol was observed with Resident #32's name on it. However, the diskus inside the box was not labeled with R32's name or any other identifying information that would indicate the spray was hers if it became separated from the box. - RN B stated that the pharmacy usually labels the individual vials, inhalers, and diskus' in the boxes with the resident's name and other identifying information in case the vial/ inhaler/diskus becomes separated from the box. RN B stated if the vial/inhaler/diskus was not labeled by pharmacy, then she would label it with the resident's name. She also stated she does this in case the vial/inhaler/diskus becomes separated from their respective boxes, so she knows who they belong to. RN B further stated this was especially important if more than one resident had the same medications. She stated otherwise, It would be just plain gross if a resident used another resident's inhaler or diskus. During an interview on 08/13/2025 at 8:30 AM, Licensed Practical Nurse (LPN) D stated she labels the individual nasal sprays, diskus', and inhalers with the residents' names. LPN D stated the medication labels on the boxes contain a smaller label with the resident's identifying information that can be peeled off the larger label and placed on the individual nasal spray, diskus, and inhaler in the box. She further stated if a smaller label was not available, then she would write the resident's name on the individual inhaler, diskus, or nasal spray. LPN D stated the reason that the individual nasal sprays, inhaler, or diskus' should be labeled with the residents' name was in case they fall out of the box. That way I know whose they are. During an interview on 08/14/2025 at 2:25 PM, RN C stated medications in boxes in the medication cart should be labeled on the vial/inhaler/diskus with the resident's name and the date opened. She stated this should be done in case the vial/inhaler/diskus fell out of the box and they need to identify who the vial/inhaler/diskus belonged to. |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.<br><br>(continued on next page) |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the medical records for 1 of 23 sample residents (R7) was complete and accurate. Findings include:A review of R7's admission Record, dated 8/14/25, revealed they were a [AGE] year-old resident admitted to the facility on [DATE]. In addition, R7 had multiple diagnoses that included dementia, bipolar disorder, and depression. A review of R7's Minimum Data Set (MDS) (a tool used for assessing a resident's care needs), dated 7/11/25, revealed a Brief Interview for Mental Status (BIMS) (a scale used to determine a resident's cognitive status) score of 0 which revealed R7 was severely cognitively impaired. A review of R7's Pharmacy Medication Review Progress Note, dated 3/31/25, revealed that the line for Comment/Recommendation noted-see report was checked. This indicated that the pharmacist had made a recommendation to the physician or had noted an irregularity in R7's medication regimen. A review of R7's electronic medical record (EMR), dated 3/1/25 to 8/14/25, failed to reveal documentation (e.g., a Physician Recommendations for, a Nursing Recommendation form, a progress note, a physician note) that would indicate what the pharmacy comment/recommendation was on 3/31/25. During an interview on 08/14/2025 at 3:18 PM, the Director of Nursing (DON) was informed that the pharmacist had made a comment/recommendation on 3/31/25, however the report and/or any other documentation that would indicate what the comment/recommendation was could not be located in R7's EMR. The DON stated the report should have been scanned into R7's EMR under the Miscellaneous (Misc) tab under the subheading Pharmacy. The DON stated she would look and see if she could locate the 3/31/25 pharmacy recommendation report and she would provide a copy to the surveyor, if she could locate it. A second review of R7's EMR, dated 10/3/24 to 8/14/25, failed to reveal that a physician (or non-physician practitioner- a nurse practitioner, a physician assistant, or a clinical nurse specialist) had conducted a face-to-face visit with R7 since 2/27/25 (over 5 months prior to the survey). During a second interview on 08/14/2025 at 3:30 PM, the DON stated she had called the outside company that also provides physician services to R7 to see if they had a copy of the pharmacy report that would indicate what their comment/recommendation was on 3/31/25. She stated she could not locate this documentation in R7's EMR. The DON was also informed that R7 did not have any physician visits notes in their EMR after 2/27/25. The DON stated she would call the outside company again and see if they had any documentation that a physician or non-physician practitioner from that company had conducted a face-to-face visit with R7 since 2/27/25. The DON indicated during the interview that the facility has had issues with the outside company providing documentation to them in the past, but she would provide copies of any documentation that they sent to the survey team. During a third interview on 08/14/2025 at 4:00 PM, the DON stated the outside company that also provides physician services to R7 sent her documentation that a non-physician practitioner (a nurse practitioner) had conducted a face-to-face visit with R7 on 6/25/25, 7/16/25, and 8/6/25. The DON stated the facility did not have this documentation prior to the outside company sending it to her. She also stated that the outside company had said they did not have a report that would reveal what the pharmacist's recommendation/comment was for 3/31/25. Clear, accurate, and accessible documentation is an essential element of safe, quality, evidence-based nursing practice. Documentation of nurses' work is critical as well for effective communication with each other and with other disciplines. It is how nurses create a record of their services for use by payors, the legal system, government agencies, accrediting bodies, researchers, and other groups and individuals directly or indirectly involved with health care. It also provides a basis for demonstrating and understanding nursing's contributions both to patient care outcomes and to the viability and effectiveness of the organizations that provide and support quality patient care. Documentation is sometimes viewed as burdensome and even as a distraction from patient care. High quality documentation, however, is a necessary and integral aspect of the work of registered nurses in all roles and settings. Timely documentation of the following types of information should be made and maintained in a patient's EHR (electronic health record) to support the ability of the health care team to ensure informed decisions and high quality care in the continuity of patient care. Communications with other health care professionals regarding the patient. Order acknowledgement, implementation, and management. Patient documentation frequently is used by professionals who are not directly involved with the patient's care. If patient documentation is not timely, accurate, accessible, complete, legible, readable, and standardized, it will interfere with the ability of those who were not involved in and are not familiar with the patient's care to use the documentation. (ANA's |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to implement their infection control programs policies and procedures.<br><br>Resident #6 (R6)<br><br>Review of an admission Record reflected R6 admitted to the facility on [DATE] with diagnosis that included hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, legal blindness, dysphagia following cerebral infarction and gastrostomy status (a feeding tube).<br><br>Review of a quarterly Minimum Data Set (MDS) assessment dated [DATE] reflected R6 was severely cognitively impaired and is dependent on staff for care.<br><br>Review of a Care Plan initiated 4/5/2024 reflected R6 required Enhanced Barrier Precautions related to feeding tube. The goal of the care plan was that R6 would have a reduced risk of acquiring an infection.<br><br>During an observation on 08/13/2025 at 9:40 AM, Certified Nurse Aide (CNA) X and CNA Y were observed providing a bed bath for R6. Neither CNA X or CNA Y wore a gown, despite signage on R6's room and closet door indicating R6 required Enhanced Barrier Precautions (EBP). A feeding tube site was observed on R6's abdomen. R6's brief was soiled, and it was noted R6 was menstruating. CNA Y removed the soiled brief and continued bathing R6, never changing gloves between soiled activities and obtaining clean supplies. When CNA Y identified additional clean, dry washcloths were needed, CNA Y removed her soiled gloves, kept the soiled gloves in her hands, left the room, did not clean her hands, and proceeded down the hall to the supply room to retrieve additional supplies. Upon returning to the room, CNA Y then washed her hands with soap and water for less than 15 seconds, applied gloves and continued to provide incontinence care to R6, removing a menstrual discharge soiled cloth from R6's front perineal area when she was rolled onto her back and secured a clean brief and maxi-pad under her. CNA X and CNA Y then log rolled R6 over a feces soiled fitted sheet and draw sheet, pulled up her pants, placed a mechanical lift sling under her and completed a transfer of the resident into a Broda chair.<br><br>During an interview after the observation on 8/13/2025 at 9:55 AM, CNA X and CNA Y said they both knew R6 was supposed to be in EBP, but they forgot to don appropriate personal protective equipment (PPE). When asked, both CNA's pointed out that the PPE (gown and gloves) were in a drawer next to the resident's bed. CNA Y said, The nurse told us to be sure to use enhanced barrier precautions, and we didn't.<br><br>R108<br><br>Review of a Face Sheet revealed R108 has pertinent diagnoses of spastic quadriplegic cerebral palsy and neuromuscular scoliosis.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Review of the Minimum Data Set (MDS) dated [DATE] for R108 revealed she is cognitively intact, nonverbal, bilateral upper and lower extremities are impaired, and is totally dependent on staff for care. R108 was at risk for pressure ulcers (PU) and had none at this time. R108 required nutrition through tube feeding and had a foley catheter.<br><br>During an observation on 8/13/25 at 10:17 AM, Certified Nursing Assistant (CNA) “F” was observed providing morning ADL (activities of daily living) care for R108 with no PPE (personal protective equipment). The closet door inside the room had a sign that indicated R108 required enhanced barrier precautions while providing care. On the bedside table there was a plastic bag with clean, wet wash cloths. R108 was lying in bed with a tube feeding infusing and the foley urinary catheter was hanging on the side of the bed. CNA “F” started with providing peri/catheter care using a clean washcloth. When he was done with the washcloth, the CNA placed the soiled washcloth in the same clean bag with other clean washcloths and pulled out another “clean” washcloth to clean the stool from R108s buttocks. R108 also had a pressure ulcer dressing that was not adhered well to the skin on the lower right corner. When the CNA finished with cleaning R108s buttocks, he placed the soiled was cloth in the same “clean” bag with the now mixed clean/dirty washcloths. CNA “F” then proceeded to pull another “clean” washcloth from the bag and washed R108’s face. CNA “F” continued providing care using the same gloves moving from dirty to clean. CNA “F” continued to dress R108 and removed a hair clip from her hair with the same gloves and opened the nightstand to pull out toiletries. CNA “F” left the room after removing his gloves to get supplies down the hall with no hand hygiene. CNA “F” came back and emptied the foley urinary catheter, gathered the soiled linen bag, and left the room again after removing his gloves and no hand hygiene. CNA “F” returned to R108s room with Registered Nurse (RN) “G” who donned with a gown and gloves to assist CNA “F” who still did not don up with appropriate PPE and transferred R108 to her wheelchair. RN “G” did not direct CNA “F” to don up with the appropriate PPE.<br><br>During an interview on 8/14/25 at 11:29 AM, RN “G” was aware that CNA “F” did not have the appropriate PPE on the day before while providing care for R108. When questioned about the nurses supervising the CNAs, RN “G” nodded her head yes, indicating they are to supervise/direct CNAs when needed. RN “G” reported CNA “F” is aware that EBP were needed when providing care for R108 and was re-educated.<br><br>In an interview on 8/14/25 at 1:32 PM, the Director of Nursing (DON) was informed of the infection control concerns for R108 while care was provided the day before and the DON reported the CNAs do know they are to follow EBP for R108. Staff are not to clean residents starting with their peri care and then clean their faces. Staff are not to combine soiled linens with clean linens in the same bag while providing care. Staff are not to provide care moving from dirty to clean areas without removing gloves and appropriate hand hygiene. Staff are not to leave the room without appropriate hand hygiene.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | During an interview on 08/14/2025 at 1:07 PM, Infection Control Preventionist (ICP) “A” reported that the process for employee call ins was for the call in slip to be completed and forwarded to the Human Resources staff member and the scheduler. If the call in was illness related it was then forwarded to ICP “A.” ICP “A” confirmed that the “Call-In Log” did not identify the unit the staff member worked because she was familiar with the facility staff and knows where the staff are “typically assigned.” ICP “A” reported that if the reason for calling in was identified as illness related without specific symptoms she would call and follow up the staff member. ICP “A” reported that staff are aware of when they can return to work and an “Employee Illness signs and symptoms/return to work guideline” is available for review for all staff where they clock into work.<br><br>Review of the July and August “Call-In Log” revealed:<br><br>*On 7/6/25 Certified Nursing Assistant (CNA) “M” “left sick.” There was no additional follow up documentation for symptoms noted.<br><br>*On 7/6/25 CNA “N” called in for vomiting.<br><br>*On 7/7/25 CNA “O” called in for “??” (indicating an unknown reason). There was no additional follow up documentation for symptoms noted.<br><br>*On 7/18/25 Licensed Practical Nurse (LPN) “P” called in for cough, sore throat, and body aches.<br><br>*On 7/20/25 CNA “Q” called in for fever, vomiting, and diarrhea.<br><br>*On 7/28/25 Housekeeping Aide (HA) “R” called in for “N/V” (nausea and vomiting).<br><br>*On 8/4/25 CNA “S” called in for “not feeling well.” There was no additional follow up documentation for symptoms noted.<br><br>*On 8/7/25 CNA “T” called in for “C/I” (call in). There was no additional follow up documentation for symptoms noted.<br><br>*On 8/12/25 HA “U” called in for vomiting.<br><br>*On 8/13/25 HA “V” called in for “nauseous.”<br><br>*On 8/14/25 a CNA “W” called in for vomiting.<br><br>*On 8/14/25 HA “V” called in for “nauseous.”<br><br>There was no documentation that ICP “A” identified the unit the employees worked, the residents they came into contact with, the date they last worked, confirmed/suspected illness, or a date they could return to work in order to prevent the spread of infection to the vulnerable residents.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | During an interview on 08/15/2025 at 9:45 AM, ICP “A” confirmed the “Call-In Log” did not include the unit the staff members worked, the onset date of the symptoms, specific symptoms, or a return-to-work date.<br><br>Review of the “Employee Call In/Absence Procedure” revealed, “…When the employee calls in to report off work the supervisor taking the call in will complete the call in sheet notating the reason for the call off. The call in sheet will be routed to the Infection Preventionist, and or DON (Director of Nursing) to review the line listing of staff and residents for any clusters of respiratory illness and take appropriate action. On weekends the call in information will be reported to the nurse manager on call. The call in sheet provides data collection and active monitoring of staff during suspected respiratory illness cluster or outbreak at a nursing home…”<br><br>Review of the facility policy “Infection Surveillance” last revised 10/26/2023 revealed, “Policy: A system of infection surveillance serves as a core activity of the facility’s infection prevention and control program. Its purpose is to identify infections, monitor adherence to recommended infection prevention and control practices in order to reduce infections and prevent the spread of infection…6. The facility will collect data to properly identify possible communicable diseases or infections before they spread by identifying: a. Data to be collected, including how often and the type of data to be documented, including: i. The infection site, pathogen (if applicable), signs and symptoms, and resident location, including summary and analysis of the number of residents (and staff, if applicable) who developed infections…9. Employee, volunteer, and contract employee infections will be tracked, as appropriate, such as influenza or gastrointestinal infection outbreaks…”<br><br>Review of the “Infection Preventionist Checklist Playbook” provided by ICP “A” revealed, “…3.) Enter staff infections into Infection Watch a. Transcribe staff info and symptoms into Infection Watch. 4.) Review line listing for outbreaks and trends…”<br><br>Review of the “Infection Preventionist Checklist” provided by ICP “A” revealed, “DAILY Infection Watch…Enter staff infections into Infection Watch…” |

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| F 0883<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Develop and implement policies and procedures for flu and pneumonia vaccinations.<br><br>(continued on next page) |

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| F 0883<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide the influenza immunizations and pneumococcal immunization per consent and the recommendation by the Centers for Disease Control and Prevention (CDC) for 4 residents (Resident #124, #11, #96, and #1) out of 5 residents reviewed for immunizations, resulting in residents not receiving the pneumococcal and/or influenza immunization.Findings:Resident #124 (R124)Review of an admission Record revealed R124 was a [AGE] year-old male, admitted to the facility on [DATE]. R124 was his own responsible party. Review of R124's Electronic Medical Record revealed no documentation of R124's last influenza immunization or pneumococcal immunization. There was no consent or other supporting documentation of the last time it was administered, offered, or declined.During an interview on 08/14/2025 at 1:07 PM, Infection Control Preventionist (ICP) A reported that R124 was a new admission within the last 2 weeks and confirmed that she had not met with him to obtain the consent and/or declination for the influenza or the pneumococcal immunizations. ICP A reported she attempted to meet with new admissions within the first 2-3 weeks to obtain consents and administer the vaccinations. Resident #11 (R11)Review of an admission Record revealed R11 was a [AGE] year-old female, admitted to the facility on [DATE], with pertinent diagnoses which included: Type 2 Diabetes Mellitus.Review of R11's Electronic Medical Record revealed no documentation of R11's last pneumococcal immunization. There was no consent or other supporting documentation of the last time it was administered, offered, or declined.During an interview on 08/14/2025 at 1:07 PM, ICP A confirmed there was no pneumonia immunization administered, or consent obtained because R11 was not 60 and per the facility policy the pneumococcal immunization is recommended for all adults 65 years and older.Review of the CDC Adult Immunization Schedule (dated 7/2/25) revealed it was recommended for adults ages 50 years or older who had not previously received a dose of PCV13, PCV15, PCV20, or PCV21 or whose previous vaccination history is unknown to receive 1 dose of PCV15 or 1 dose of PCV20, or 1 dose PCV21.Resident #96 (R96)Review of an admission Record revealed R96 was a [AGE] year-old male, admitted to the facility on [DATE].Review of R96's Electronic Medical Record revealed no documentation of R96's pneumococcal immunization. There was no consent or other supporting documentation of the last time it was administered, offered, or declined. During an interview on 08/14/2025 at 1:07 PM, ICP A reported she was waiting to hear back from an outside entity regarding R96's immunization history and therefore did not know if R96 was due for any immunizations. ICP A reported that she did not have access to MCIR (Michigan immunization portal) to look up resident immunization history and reported only the MDS (Minimum Data Set) nurse was able to access that information. ICP A confirmed she had not obtained a MCIR report from the MDS nurse.Review of R96's Electronic Medical Record revealed an immunization history form from his admission documentation dated 7/15/25. The form revealed that R96 had never received a pneumococcal immunization. Further review of the immunization history revealed R96 was DUE NOW for PCV15/PCV20/PCV21.Resident #1 (R1)Review of an admission Record revealed R1 was a [AGE] year-old female, admitted to the facility on [DATE].Review of R1's immunization history revealed she received the PCV13 on 03/28/2018 and the PCV23 on 08/29/2014. Review of the CDC PneumoRecs Vax Advisor revealed a recommendation to give one dose of PCV20 or PCV21 at least 5 years after the last pneumococcal vaccine dose for residents that received the PCV13 and PCV23 prior to the age of 65.Review of R1's Electronic Medical Record revealed no consent or other supporting documentation that PCV20 or PCV21 had been administered, offered, or declined.During an interview on 08/14/2025 at 1:07 PM, ICP A reported she would follow up with R1 on receiving the additional recommended pneumococcal immunization.Review of the facility policy Pneumococcal Vaccine (Series) last reviewed/revised 10/30/23 revealed, .1. Each resident will be assessed for pneumococcal immunization upon admission. Self-report of immunization shall be accepted. Any additional efforts to obtain information shall be documented, including efforts to determine date of immunization or type of vaccine received. 2. Each resident will be offered a pneumococcal immunization unless it is medically contraindicated, or the resident has already been immunized. Following assessment for any medical contraindications, the immunization may be administered in accordance with physician-approved standing orders.5. The type of pneumococcal vaccine (PCV15, PCV20, or PPSV23/PPSV) offered will depend upon the recipient's age and susceptibility to pneumonia, in accordance with current CDC guidelines and recommendations.8. A pneumococcal vaccination is recommended for all adults 19-64 years' and older and based on the following |