

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  235358	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/09/2024
NAME OF PROVIDER OR SUPPLIER  Medilodge of Ludington		STREET ADDRESS, CITY, STATE, ZIP CODE  1000 E Tinkham Ave Ludington, MI 49431	

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)
<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>30120</p> <p>This Citation pertains to Intake Number MI00145415.</p> <p>Based on observation, interview, and record review, the facility failed to secure 1 of 5 medication carts (Southwest Medication Cart), resulting in narcotics/controlled substances not being under double lock, resident medications not being secured, the potential for unauthorized individuals gaining access to the medication cart, and the potential for medication theft.</p> <p>Findings include:</p> <p>During an observation on 7/8/24 at 3:25 PM, the Southwest Medication Cart was observed in the hallway unlocked (the red dot on the locking mechanism was visible) and unattended. Staff were not within visual range of the medication cart at the time it was observed unlocked. Therefore, surveyor was able to open the drawers on the medication cart that contained individual residents' medications and floor stock medications (i. e., bottles that contained medications that could be used by multiple residents- e.g., Tylenol, general use multivitamins, antacids) unobserved by facility staff. The nurse assigned to the medication cart (Registered Nurse (RN) C) was in a resident's room administering medications at the time of the observation.</p> <p>During an interview on 7/8/24 at 3:45 PM, RN A stated she is supposed to lock her medication cart when she leaves it. She stated that prevents people from taking medications from it that are not theirs and without her knowledge.</p> <p>During an interview on 7/8/24 at 3:50 PM, RN B stated when she walks away from her medication cart she is supposed to lock the medication cart to prevent people who are walking by from opening it and taking medications from it.</p> <p>During an interview on 7/8/24 at 4:00 PM, RN C stated she is supposed to lock the medication cart when she is not at it to prevent people from accessing it and taking medications from it without her knowledge. She also stated sometimes she gets busy and may forget to lock the medication cart when she walks away from it to give residents their medications.</p> <p>(continued on next page)</p>

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 0761  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	A review of the facility's Medication Storage policy, dated 1/30/24, revealed, c. During a medication pass, medications must be under the direct observation of the person administering medications or locked in the medication storage area/cart. 2. Narcotics and Controlled Substances: a. Schedule II drugs and back-up stock of Schedule III, IV, and V medications are stored under double-lock and key .		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>30120</p> <p>This Citation pertains to Intake Number MI00145415.</p> <p>Based on observation, interview, and record review, the facility failed to safeguard the confidentiality of medical records for 12 of 73 residents (R6, R7, R8, R9, R10, R11, R12, R13, R14, R15, R16, and R17), resulting in the potential for unauthorized access to residents' medical records and the potential for the loss of resident privacy and the confidentiality of their personal health information.</p> <p>Findings include:</p> <p>During an observation on 7/8/24 at 11:20 AM, the computer screen on top of the Northeast Wing Medication Cart (for Rooms 17 to 23- as identified by facility staff) was observed open to multiple residents' (R6, R7, R8, R9, R10, R11, R12, R13, R14, R15, R16, and R17) electronic Medication Administration Records (e-MAR), which included personal and health identifying information (i.e., residents' names, room numbers, and medical record numbers). This information was visible to anyone walking by the medication cart. In addition, anyone walking by the medication cart could have stopped and accessed any of the residents' medication records just by hovering over a resident's name and clicking a button. There were not any staff in sight of the medication cart at the time of the initial observation.</p> <p>During an interview immediately following the observation on 7/8/24 at 11:20 AM (within about 5 minutes while the surveyor was writing down the observed information), Registered Nurse (RN) A stated, Oh my. I'm sorry. I'm so sorry. Sorry. RN A stated she should not have left the computer screen open when she walked away from the medication cart to give a resident their medications.</p> <p>During a second interview on 7/8/24 at 3:45 PM, RN A stated she is supposed to lock her medication cart when she leaves it. She stated that prevents people from taking medications from it that are not theirs and without her knowledge. RN A also stated she is supposed to hide (close and lock) the computer screen on the medication cart (indicated by a hidden message on the screen) to protect residents' HIPPA ((Health Insurance Portability and Accountability Act- a federal law that sets a national standard for the protection of medical records and other personal health information) information. She stated she knew she was supposed to do that this morning when the surveyor saw the open computer screen. RN A further stated she got busy and forgot to do that. RN A stated, We're human. We make mistakes.</p> <p>During an interview on 7/8/24 at 3:50 PM, RN B stated when she walks away from her medication cart she is supposed to hide the computer screen on the medication cart. She stated she is supposed to do this to protect residents' privacy and HIPPA information.</p> <p>During an interview on 7/8/24 at 4:00 PM, RN C stated she walks away from her medication cart she is supposed to hide the computer screen to prevent people from viewing resident HIPPA information. She stated sometimes she gets busy and may forget to hide the computer screen.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of the facility's Workforce Security Information System Access Control policy, dated 1/1/22, revealed, 15. When leaving a workstation, the user should properly log out of all applications and networks.</p>		