STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235358	A. Building B. Wing	10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Ludington	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)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 #MI00147480 Based on observation, interview, and record review, the facility filed to provide care to accommodate the needs of 5 of 5 residents reviewed. Findings: During an observation on 10/23/24 at 8:10 AM, the resident in bed 48-1 laid in bed resting with eyes closed. The call light was clipped to the privacy curtain out of sight and out of reach of the resident. During an observation on 10/23/24 at 8:20 AM, the following were noted for the resident in bed 2-1: (a) the touch pad call light laid on the residents lower right quadrant of his torso. The resident stated he could not reach the touch pad to call for assistance because he is a quadriplegic, (b) an empty cup with a straw sat on the over the bed table and the resident stated he was very thirsty but was not able to alert staff that he needed more water, (c) the resident's lips were dry and cracked, (d) both legs had contractures and there was not a pillow between his legs to reduce pressure, and (d) there were no pressure reducing boots or devices on or under the resident's feet/ankles. During an observation on 10/23/24 at 8:55 AM the resident in bed 25-1 laid in bed resting with her eyes closed, her left leg hung off the side of the bed, and her left foot rested on the floor. Certified Nurse Aide (CNA) K entered the room, removed the untouched breakfast tray and did not reposition the resident so that her leg was back up on the bed. During an observation on 10/23/24 at 8:54 AM, the resident in bed 13-1 called out help me help me. From the hallway the resident could be seen making two attempts to stand up on her own. A nurse stood just outside room [ROOM NUMBER] at the medication cart and did not respond to the call for help. When asked about the cognition of the resident in bed 13-1, the nurse indicated that both residents in room [ROOM NUMBER] had dementia and were very confused at baseline and that was why they had been placed in a room closer to the front of the hall, so that staff could keep a closer eye on them. During an observation on 10/23/24 at 9:00 AM, the resident in bed 2-1 did not have a pillow or any pressure reducing devices between his knees or under his feet. The empty cup of water, dated 10-22 sat on the over bed table. (continued on next page)

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 - Some	During an observation on 10/23/24 at 9:50 AM, the resident in bed 64-1 sat in bed awake. The cord for the light fixture above the resident hung behind the head board and on the floor, out of sight and out of reach. During an interview on 10/23/24 at 11:51 AM, CNA G reported that every time staff enter a room they are to check for call light placement, offer something to drink, and make sure things the resident might need are within reach. During an observation on 10/23/24 at 4:00 PM, the resident in bed 2-1 sat in bed and the call light touch pad laid on the bed next to his right hip, out of reach of the resident. The resident stated that he was hungry but could not call for staff to let them know. During an observation on 10/24/24 at 7:50 AM, the resident in bed 2-1 sat in bed and the call light touch pad sat on his chest. When asked if he could reach the touch pad, he attempted and stated that he could not. Review of the facility policy Resident Hydration last reviewed on 01/01/2022, revealed: The facility will endeavor to provide adequate hydration and to prevent and treat dehydration.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 pertains to intake # MI00-147480 Based on observation, interview, and record review, the facility failed to secure 1 of 4 medication carts and failed to follow guidelines for preparing, storing, and dating medications. Findings: During an observation on 10/23/24 at 8:25 AM, the northeast medication cart was unlocked and not attended by nursing staff. During the same observation the following additional observations were made: (a) a small plastic and unlabeled medication cup sat in the top drawer of the unlocked med cart and contained 4 unidentified pills, (b) a novolin 70/30 insulin flex pen prescribed to the resident in bed 26-1 did not have a date identifying when it was opened, (c) a levemir insulin flex pen prescribed to the resident in bed 9-2 did not have a date identifying when it was opened, (d) a toujeo solostar insulin pen prescribed to the resident in bed 29-1 did not have a date identifying when it was opened, (e) a humalog insulin kwik pen prescribed to the resident in bed 22-2 did not have a date identifying when it was opened, (f) a basaglar insulin pen prescribed to the resident in bed 21-1 did not have a date identifying when it was opened, (g) a container of latanoprost 0.005% eye drops prescribed to the resident in bed 28-1 did not have a date identifying when it was opened, (h) a bottle of glargine insulin 100 units/1 milliliter prescribed to the resident in bed 29-2 did not have a date on it identifying when it was opened, and (i) an albuterol inhaler prescribed to the resident in bed 28-2 did not have a date on it identifying when it was opened. During an interview on 10/23/24 at 8:30 AM, Licensed Practical Nurse (LPN) D stated that the 4 pills in the small plastic unlabeled cup located in the top drawer of the unlocked medication cart were medications that were pre-set and should not have been. LPN D also stated that the medication cart should be locked when unattended by a nurse and that insulin, eye drops, and inhalers should be dated the day that they are opened. During an observation on 10/23/24 at 8:40 AM, the following were noted to be bedside for the resident in bed 25-1: a prescribed albuterol sulfate inhaler with no open date and stored in the box and another prescribed albuterol sulfate 90 micrograms that was attached to a spacer. Nursing staff were not present in the room. During an interview on 10/23/24 at 3:30 PM, Registered Nurse (RN) A indicated that pre-setting up medications was not an acceptable practice and led to medication errors. Review of the facility policy Medication Storage last reviewed 01/30/24, revealed the following guidelines: (a) all drugs and biological's will be stored in locked compartments i.e. medication carts .and (c) during a medication pass, medications must be under the direct observation of the person administering medications or locked in the medication area/cart. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of an additional policy provided by the facility and named Storage of Medications last revised 08/2024, reflected the following: 1. General Guidance-(2) medication supplies are locked when they are not attended by persons with authorized access . 3. Expiration dating- (3) certain medications .such as multiple dose injectable vials and eye drops require an expiration date shorter than the manufacturer's expiration date once opened to ensure medication purity and potency .(5) when the manufacturer as specified a useable duration after opening (i.e. beyond use date) the nurse shall place a date opened sticker on the medication and record the date opened and the new date of expiration. Review of an Insulin Reference Guide, last updated February 2024, that provided manufacturer guidelines for how long insulin can be kept once the bottle/pen/or other device was opened, revealed that novolin, toujeo, humalog, and basaglar insulin's were good for 28 days after opening and levemir insulin was good for 42 days after opening.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37577 This citation pertains to intake #MI00147635 Based on observation, interview, and record review, the facility failed to follow standards of practice for enhanced barrier precautions for 3 of 3 resident's reviewed and failed to follow infection control practices for oxygen storage for 1 of 3 resident's, and for laundry services. Findings: Enhanced Barrier Precautions: During an observation on 10/23/24 at 8:05 AM, the resident residing in bed 2-1 was found to have a urostomy (an indwelling medical device that evacuates urine directly from the kidneys to a bag outside the body) and a wound. There were no gowns or gloves readily available to the staff when performing high contact care activities for this resident. There were no signs near the room to alert staff that the resident in bed 2-1 was on enhanced barrier precautions (EBP). During an observation on 10/23/24 at 8:20 AM, the resident residing in bed 64-1 was found to have a PICC (peripherally inserted central catheter) and had returned to the facility last evening (10/22/24) with the new catheter. There were no gowns or gloves readily available to the staff when performing high contact care activities for this resident. There were no signs near the room to alert staff that the resident in bed 64-1 was on enhanced barrier precautions (EBP). During an observation on 10/23/24 at 8:25 AM, the resident residing in bed 58-1 was found to have a PICC (peripherally inserted central catheter). There were no gowns or gloves readily available to the staff when performing high contact care activities for this resident. There were no signs near the room to alert staff that the resident in bed 58-1 was on enhanced barrier precautions (EBP). During an interview on 10/23/24 at 9:00 AM Licensed Practical Nurse (LPN) R indicated that a resident who has a PICC should be placed on EBP's immediately upon return to the facility. During an interview on 10/23/24 at 9:05 AM, Certified Nurse Aide (CENA) J stated that she was not aware that the resident in bed 2-1 was on enhanced barrier precautions. During an interview on 10/23/24 at 12:05 PM Infection Control Preventionist (ICP) H stated that EBP signs and PPE (personal protection equipment) towers had been out near the rooms but did not know where they went. ICP H indicated that perhaps staff had removed them. ICP H also indicated that the resident in 64-1 should have been placed on EBP when returned from the hospital yesterday. During an interview on 10/23/24 at 12:40 PM the resident residing in room [ROOM NUMBER]-1 stated that since his admission to the facility on [DATE], staff have not worn gowns or gloves while providing high contact care. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility policy Enhanced Barrier Precautions last reviewed 03/26/24, reflected the following: It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms. Enhanced barrier precautions refers to an infection control intervention designed to reduce transmission of multidrug-resistant organisms, that employs targeted gown and glove use during high-contact resident care activities .the facility will have discretion on how to communicate to staff which residents require the use of EBP, as long as staff are aware of which residents require the use of EBP prior to providing high-contact care activities .an order for enhanced barrier precautions will be obtained for residents with any of the following: wounds and indwelling medical devices implementation may include but is not limited to making gowns and gloves readily available near or outside a resident's room. OXYGEN: During an observation on 10/23/24 at 8:50 AM the following were noted for the resident that occupied bed 25-1: (a) the resident laid in bed resting with her eyes closed and received oxygen via nasal cannula at 6 liters per minute, (b) the oxygen tubing did not have a date on it to indicate when it had last been changed, (c) the plastic bottle of fluid used to humidify the oxygen was dated 10-15-24, (d) the oxygen tubing between the concentrator and the nasal cannula sat coiled up in the waste basket that was next to the bed, and (e) visible garbage was noted in the waste basket. During an observation on 10/23/24 at 10:50 AM, the oxygen tubing for the resident in bed 25-1 had been removed from the garbage can. The oxygen tubing sat coiled on top of a bedside plastic 3 drawer tower. The oxygen tubing did not have a date on it, and therefore could not discern if the oxygen tubing was new or had been removed from the waste basket and placed on the bedside plastic tower. During an observation on 10/24/24 at 8:00 AM, the bottle of fluid to humidify the oxygen for the resident in bed 25-1 was dated 10/15/24. Review of the facility policy Oxygen Concentrator, last reviewed 05/21/24, reflected the following: (a) change oxygen tubing and cannula every 7 days and as needed if it becomes contaminated, and (b) change humidifier bottle when empty or every 72 hours. LAUNDRY: During an interview on 10/23/24 at 3:05 PM, Environmental Services Manager (ESM) C indicated that over the past several weeks there have been instances when (a) urine soaked briefs and briefs saturated with stool and (b) bed linens with solid stool material, had been placed in with the dirty linens and sent to the laundry. ESM C reported that he had immediately made the administrator, the infection control preventionist and nursing aware of the matter. ESM C also indicated that he was aware that over the past weekend (October 18,19, and 20th) there were two instances of this still occurring and stated that this practice could have serious infection control implications.