

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  235399	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/04/2025
NAME OF PROVIDER OR SUPPLIER  Medilodge of Portage		STREET ADDRESS, CITY, STATE, ZIP CODE  7855 Currier Dr Portage, MI 49002	
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 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>47955</p> <p>Based on observation, interview, and record review the facility failed to revise a person-centered care plan for 1 (Resident #106) of 7 residents reviewed for person-centered care plan revisions resulting in an inaccurate reflection of the resident's current care needs.</p> <p>Findings include:</p> <p>Review of an Admission Record revealed Resident #106 had pertinent diagnoses which included: adult failure to thrive, restlessness and agitation, and severe protein calorie malnutrition.</p> <p>Review of a Minimum Data Set (MDS) assessment for Resident #106, with a reference date of 12/20/2024 revealed a Brief Interview for Mental Status (BIMS) score of 1/15 which indicated Resident #106 was severely cognitively impaired. (BIMS score 0-7 indicates severe cognitive impairment).</p> <p>Review of Order Summary for Resident #106 revealed Adaptive equipment: plate guard, built-up utensils (a piece of foam with a slit in the center for the handle of eating utensils to be inserted to create a greater gripping surface area), 2-handled cup with straw with a start date of 8/26/2024.</p> <p>Review of Care Plan for Resident #106 revealed Focus/Interventions Resident has an ADL (activity of daily living) self-care performance deficit related to physical debility, generalized muscle weakness .adult failure to thrive; Intervention eating: 1 person assist; utilize plate guard, built-up utensils, 2-handled cup with straw with meals with an initiation date of 8/26/2024.</p> <p>Review of Therapy to Nursing Communication Form for Resident #106 dated 8/26/24 revealed plate guard, built-up utensils, 2-handled cup w/ straw (with).</p> <p>During an observation on 2/5/25 at 8:40 AM Resident #106 was sitting his high back wheelchair, in the dining room, with his legs pulled up and his knees bent. Resident #106 had a breakfast tray on the table in front of him, that included 2 coffee cups with lids and straws and Resident #106 was holding and drinking from a coffee cup with a lid and a straw in it. Restorative Aide (RA) AA was observed scraping Resident #106's scrambled eggs into a bowl and handing the bowl and a built-up utensil to Resident #106 to eat.</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 235399
		If continuation sheet Page 1 of 9

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  235399	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/04/2025
NAME OF PROVIDER OR SUPPLIER  Medilodge of Portage		STREET ADDRESS, CITY, STATE, ZIP CODE  7855 Currier Dr Portage, MI 49002	
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 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 2/5/25 at 10:20 AM, Occupational Therapist (OT) GG reported Resident #106 did not use built up utensils anymore. OT GG reported she had upgraded Resident #106 to regular silverware, and she had communicated the changes to nursing and dietary departments. OT GG reported that Resident #106 did not always need a 2-handled cup, but she had not changed that yet. OT GG reviewed the care plan for Resident #106 with this surveyor and confirmed the care plan indicated plate guard, built-up utensils, and 2-handled cups for liquids and it had not been revised to reflect the changed OT GG had communicated.</p> <p>Review of Therapy to Nursing Communication Form for Resident #106 dated 12/11/24 revealed Return to regular utensils-D/C (discontinue) built-up. The form was signed by nursing and dated 12/11/24 as acknowledged.</p> <p>In an interview on 2/5/25 at 10:31 AM, Dietary Manager (DM) JJ reported that Resident #106 was to have coffee cups with lids and straws, built up utensils, and a plate guard. DM JJ reported that dietary staff knew the resident's needs because they were listed on the Resident's meal ticket.</p> <p>Review of meal tickets for Resident #106 dated 2/5/25 revealed Breakfast- Coffee cups w/lids for all liquids, built up utensils, plate guard; Lunch - built up utensils, coffee cups w/lids for all liquids, plate guard; Dinner- Built up utensils, coffee cup w/lids for all liquids, plate guard.</p> <p>During an observation on 2/5/25 at 12:40 PM Resident #106 was sitting in his wheelchair in the dining room, up to a table, drinking from a coffee cup with a lid and a straw that he was holding.</p> <p>Review of Order Summary for Resident #106 dated 2/5/25 at 11:02 AM, revealed adaptive equipment: plate guard, 2-handled cup with straw</p> <p>In an interview on 2/5/25 at 12:43 PM, Unit Manager/Licensed Practical Nurse (UM/LPN) O reported she had made updates today to Resident #106's orders for adaptive equipment because she was given a communication that was signed in December and the changes had not yet been made. UM/LPN O reported the nursing department communicates changes to the dietary department. UM/LPN reported when the changes did not happen in the nursing department, they did not happen in the dietary department either.</p> <p>In an observation on 2/5/25 at 12:53 PM, Resident #106 was sitting in his wheelchair, in the dining room, drinking from a coffee cup with a lid and straw that he was holding. OT GG was present, observing and interacting with Resident #106.</p> <p>In an observation on 2/5/25 at 12:56 PM, Resident #106 was sitting in his wheelchair, in the dining room, up to the table, with his meal tray present in front of him. Resident #106 meal tray included built-up utensils, a plate guard, and 3 2-handled cups of liquids. OT GG joined Resident #106 and replaced his built-up utensils with regular ones.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  235399	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/04/2025
NAME OF PROVIDER OR SUPPLIER  Medilodge of Portage		STREET ADDRESS, CITY, STATE, ZIP CODE  7855 Currier Dr Portage, MI 49002	
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 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>47955</p> <p>This citation pertains to intake #MI00146503</p> <p>Based on interview and record review the facility failed to ensure that professional standards of nursing practice were maintained related to physician orders for 1 (Resident #100) of 1 resident reviewed for professional nursing standards and physician orders resulting in inaccurate physician orders and the potential for medication error.</p> <p>Findings include:</p> <p>Review of an Admission Record revealed Resident #100 had pertinent diagnoses which included: pain, muscle spasm, contracture of the left foot, and muscle weakness.</p> <p>Review of a Minimum Data Set (MDS) assessment for Resident #100, with a reference date of 12/16/2024 revealed a Brief Interview for Mental Status (BIMS) score of 15/15 which indicated Resident #100 was cognitively intact. (BIMS score 12-15 indicates little or no cognitive impairment).</p> <p>Review of Medication Administration Record (MAR) for Resident #100 for the month of December 2024 revealed Oxycodone-acetaminophen (Percocet) Oral Tablet 10-325 mg (milligrams) (Oxycodone w/ (with) acetaminophen) Give 1 tablet by mouth every 8 hours as needed for pain until 12/11/24 at 23:59 (11:59pm) with a start date of 12/10/2024 at 17:30 (5:30 pm). Documentation was noted on the MAR indicating at 17:30 pm on 12/10/24 this medication was administered to Resident #100.</p> <p>In a telephone interview on 1/30/25 at 2:25 PM, Family Member (FM) DD reported the facility did not dispense Resident #100's pain medication as her physician was ordering/prescribing it. FM DD reported the facility had given Resident #100 Percocet, and Resident #100 never had an order for Percocet. FM DD reported Resident #100 should have had an order for Norco. FM DD reported he was told this was a near miss (a serious error or mishap that has the potential to cause an adverse event but fails to do so because of chance or because it is intercepted) and not a medication error.</p> <p>Review of Nurses' Notes for Resident #100 dated 12/10/2024 at 19:20 (7:20 PM) and authored by Registered Nurse/Supervisor (RN/S) K revealed Resident's PCP (primary care physician) was in to visit resident and gave verbal order for Norco 10-325mg q8 (every 8 hours) PRN (as needed) until 12-11 at 23:59 .</p> <p>In a telephone interview on 1/30/25 at 3:33 PM., Resident #100 reported she remembered she was supposed to take Norco for pain and the facility tried to give her something else.</p> <p>In an interview on 2/4/25 at 12:10 PM., Director of Nursing (DON) B reported the order for Percocet was entered inaccurately, the order should have been for Norco.</p> <p>In an interview on 2/4/25 at 12:10 PM., Nursing Home Administrator (NHA) A reported the order for Percocet for Resident #100 was entered into the computer (Electronic Health Record/EHR) inaccurately, it should have been an order for Norco.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  235399	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/04/2025
NAME OF PROVIDER OR SUPPLIER  Medilodge of Portage		STREET ADDRESS, CITY, STATE, ZIP CODE  7855 Currier Dr Portage, MI 49002	
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 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 2/4/25 at 3:24 PM., Education Training Director/RN (ETD/RN) W reported Resident #100's order for Percocet was a clerical error, the order was inputted into the EHR wrong. ETD/RN W reported there was no written prescription and no verbal order for Resident #100 to have Percocet. ETD/RN W reported there was never a delivery of Percocet for Resident #100 to the facility.</p> <p>In an interview on 2/5/25 at 10:49 AM., RN/S K reported on 12/10/24 Resident #100's doctor gave her a verbal order and she wrote it down wrong. RN/S K reported the actual verbal order was for hydrocodone (Norco), not Percocet. RN/S K reported she entered the order into Resident #100's EHR as Percocet. RN/S K did not recall if she documented she had administered Percocet to Resident #100 on that day. RN/S K reported Percocet was never available in the medication cart for Resident #100 and she did not administer Percocet to Resident #100 when her doctor gave her a verbal order. RN/S K stated I gave her what was available in the medication cart and that was Norco.</p> <p>Review of Controlled Substance Record for Resident #100 revealed Hydrocodone-APAP (acetaminophen) (Norco) 10-325 mg tab (tablet). On 12/10/24 at 17:30 (5:30pm) RN/S K initialed for the removal of one tablet for administration to Resident #100.</p> <p>Review of MAR for Resident #100 for the month of December revealed no active order for Hydrocodone-Acetaminophen (Norco) Tablet 10-325 mg give one tablet by mouth every 8 hours as needed for pain on 12/10/2024.</p> <p>Review of Quality Assistance Form dated 1/16/25, completed by NHA A and reviewed by DON B, concerning Resident #100 revealed The order for Norco (hydrocodone) was written for oxycodone (Percocet). Findings: orders only written for Norco; Plan/Action: reordered the next day; resolved, yes, correct order written.</p> <p>In an interview on 2/5/25 at 12:16 PM., RN Q reported the medication given should match the order in the EHR.</p> <p>In an interview on 2/5/25 at 12:18 PM., Licensed Practical Nurse (LPN) BB reported verifying the medication order and the medication available was part of the 5 rights to medication administration.</p> <p>In an interview on 2/5/25 at 12:36 PM., DON B reported her expectations were when a medication was administered the order EHR and the medication given should match.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  235399	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/04/2025
NAME OF PROVIDER OR SUPPLIER  Medilodge of Portage		STREET ADDRESS, CITY, STATE, ZIP CODE  7855 Currier Dr Portage, MI 49002	
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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>47955</p> <p>Based on observation, interview, and record review the facility failed to ensure proper placement of an aspen collar (immobilization brace for the neck) was in place during a transfer for 1 (Resident #105) of 1 resident reviewed for aspen collar use resulting in the potential for re-fracturing, delayed healing and/or potential re-injury.</p> <p>Findings include:</p> <p>Review of an Admission Record revealed Resident #105 had pertinent diagnoses which included: unspecified nondisplaced fracture of the second cervical vertebra (a break in a bone in the neck near the base of the skull).</p> <p>Review of a Minimum Data Set (MDS) assessment for Resident #105, with a reference date of 11/6/24 revealed a Brief Interview for Mental Status (BIMS) score of 3/15 which indicated Resident #105 was severely cognitively impaired (BIMS score 0-7 indicates severe cognitive impairment).</p> <p>Review of Order Summary for Resident #105 revealed Apply Aspen collar prior to rising in the morning with a start date of 5/30/2023; Aspen collar to be worn when up in w/c (wheelchair) (even with showers), Okay to remove while in bed; monitor skin under and surrounding collar for s/sx (signs and symptoms) of breakdown with a start date of 5/26/2023; Remove Aspen Collar at HS (evening) at bedtime with a start date of 11/10/2024; Remove Aspen collar to monitor skin under collar and surround skin for any s/sx of breakdown and notify MD/NP (medical doctor/nurse practitioner) with a start date of 11/10/2024</p> <p>Review of Care Plan for Resident #105 revealed Focus/Interventions Resident has an ADL (activity of daily living) self-care performance deficit related to .fx (fracture) of base of skull right side .fx of 2nd cervical vertebra .Transfers: 1 person assist to stand and pivot. Leave cervical collar on when transferring from chair to bed, initiated on 9/27/23 with a revision date of 1/30/25.</p> <p>In an interview on 1/30/25 at 9:30 AM, Resident #105 was sitting in the doorway of her room in her wheelchair with her aspen collar in place on her neck. Resident #105 asked this surveyor if I would put her to bed. Certified Nursing Assistant (CNA) L overheard Resident #105 ask to lay down and approached Resident #105 to assist her.</p> <p>During an observation on 1/30/25 at 9:35 AM, CNA L positioned Resident #105 in her wheelchair next to her bed, removed Resident #105's aspen collar and placed it onto the dresser. CNA L then retrieved a gait belt (belt used during a transfer to provide a place to hold on to a person), applied it around Resident #105's waist and assisted Resident #105 to stand and pivot transfer from her wheelchair into her bed.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  235399	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/04/2025
NAME OF PROVIDER OR SUPPLIER  Medilodge of Portage		STREET ADDRESS, CITY, STATE, ZIP CODE  7855 Currier Dr Portage, MI 49002	
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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 1/30/25 at 9:45 AM, CNA L reported Resident #105 wears her aspen collar only when she was up. CNA L asked Registered Nurse (RN) Q who was walking by to confirm that Resident #105 needed her aspen collar when she was up. RN Q agreed, Resident #105 wore her aspen collar when up and not when she was in bed. When queried, RN Q reported that Resident #105's aspen collar should be removed after she was transferred to bed, as she has a fracture in her neck. RN Q reported Resident #105 should wear her aspen collar during transfers. CNA L reported she had no idea it mattered if the aspen collar was removed before or after the transfer because it did not specify in the Kardex (a condensed report of the care plan for the staff to access specific information about the resident's care needs), which was where she got resident specific information.</p> <p>In an interview on 2/3/25 at 2:46 PM, Unit Manager/Licensed Practical Nurse (UM/LPN) O reported Resident #105 was to wear an aspen collar when up out of bed and the collar should not be removed before a transfer, it should be removed after the transfer, as Resident #105 was still at risk for a fracture. UM/LPN O reported Resident #105's care plan was updated to include wearing the aspen collar during transfers.</p> <p>Review of Nurses' Notes for Resident #105 dated 4/22/24 at 17:53 (5:53 pm) revealed Received phone call back form (Name Omitted) doctor's office and spoke with (Name Omitted) whom stated that (Name Omitted) doctor is going to recommend the aspen collar for life at this time .</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  235399	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/04/2025
NAME OF PROVIDER OR SUPPLIER  Medilodge of Portage		STREET ADDRESS, CITY, STATE, ZIP CODE  7855 Currier Dr Portage, MI 49002	
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 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>47955</p> <p>This citation pertains to intake #MI00146503</p> <p>Based on interview and record review the facility failed to maintain clear, concise, and accurate medical records for 1 (Resident #100) of 7 residents reviewed for clear, concise, and accurate medical records resulting in inaccurate documentation of medication orders and the potential for a diminished medical outcome.</p> <p>Findings include:</p> <p>Review of an Admission Record revealed Resident #100 had pertinent diagnoses which included: pain, muscle spasm, contracture of the left foot, and muscle weakness.</p> <p>Review of a Minimum Data Set (MDS) assessment for Resident #100, with a reference date of 12/16/2024 revealed a Brief Interview for Mental Status (BIMS) score of 15/15 which indicated Resident #100 was cognitively intact. (BIMS score 12-15 indicates little or no cognitive impairment).</p> <p>Review of Order Summary for Resident #100 revealed Oxycodone-acetaminophen (Percocet) Oral Tablet 10-325 mg (milligrams) (Oxycodone w/ (with) acetaminophen) Give 1 tablet by mouth every 8 hours as needed for pain until 12/11/24 at 23:59 (11:59pm) with a start date of 12/10/2024 at 17:30 (5:30 pm).</p> <p>In a telephone interview on 1/30/25 at 2:25 PM, Family Member (FM) DD reported Resident #100 never had an order for Percocet. FM DD reported Resident #100 had an order for Norco.</p> <p>Review of Nurses' Notes for Resident #100 dated 12/10/2024 at 19:20 (7:20 PM) and authored by Registered Nurse/Supervisor (RN/S) K revealed Resident's PCP (primary care physician) was in to visit resident and gave verbal order for Norco 10-325mg q8 (every 8 hours) PRN (as needed) until 12-11 at 23:59 .</p> <p>In an interview on 2/4/25 at 12:10 PM., Director of Nursing (DON) B reported the order for Percocet was entered inaccurately, the order should have been for Norco.</p> <p>In an interview on 2/4/25 at 3:24 PM., Education Training Director/RN (ETD/RN) W reported Resident #100's order for Percocet was a clerical error, the order was inputted into the electronic health record (EHR) wrong. ETD/RN W reported there was no written prescription and no verbal order for Resident #100 to have Percocet.</p> <p>In an interview on 2/5/25 at 10:49 AM., RN/S K reported on 12/10/24 Resident #100's doctor gave her a verbal order and she wrote it down wrong. RN/S K reported the actual verbal order was for hydrocodone (Norco), not Percocet. RN/S K reported she entered the order into Resident #100's EHR as Percocet, not Norco.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  235399	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/04/2025
NAME OF PROVIDER OR SUPPLIER  Medilodge of Portage		STREET ADDRESS, CITY, STATE, ZIP CODE  7855 Currier Dr Portage, MI 49002	
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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>47955</p> <p>Based on observation, interview, and record review, the facility failed to ensure personal protective equipment (PPE) specifically face masks, was worn correctly by staff throughout the facility during a covid outbreak, resulting in the potential for the spread of infection and disease transmission for residents residing in the facility.</p> <p>Findings include:</p> <p>On 1/30/25 at 8:19 AM., signage on the entry door to the facility revealed a Covid outbreak and that face masks were required to be worn in the building.</p> <p>On 1/30/25 at 8:22 AM., Office Receptionist (OR) SS unlocked the facility door and when queried, she responded that face masks were required to be worn by staff, but per the Infection Preventionist, visitors could not be forced to wear face masks.</p> <p>On 1/30/25 at 10:30 AM Dietary Aide (DA) LL was observed in the main dining room with his face mask under his nose.</p> <p>On 1/30/25 at 11:23 AM., Registered Nurse (RN) C was observed on the A Hall, moving between the medication cart, supply closet, and resident's rooms with her face mask positioned under her chin and not covering her mouth and nose.</p> <p>During an observation and interview on 1/30/25 at 11:34 AM., RN C was observed preparing medications for a resident at the medication cart on A Hall with her mask under her chin. RN C reported when the facility experiences a Covid outbreak the Infection Preventionist initiates masks to be worn by staff throughout the building. When queried, RN C confirmed that her mask was under her chin and the correct way to wear a face mask was to have it cover her nose and mouth. RN C stated I am not approaching residents with my mask below my chin, I do it at the cart. This surveyor noted droplet isolation and airborne precaution signage posted on the wall next to the room behind where RN C's medication cart was located on A Hall.</p> <p>On 1/30/25 at 11:40 AM., Certified Nurse Assistant (CNA) P was observed exiting a resident's room on A Hall with her face mask below her chin. When CNA P made eye contact with this surveyor, she adjusted her face mask to cover her nose and mouth.</p> <p>On 1/30/25 at 1:38 PM., DA LL was observed in the dining room without a face mask on, interacting with residents in the dining room, and providing requested items from the cabinet to residents.</p> <p>On 2/4/25 at 10:27 AM., Housekeeper (H) QQ was observed exiting a resident room on C Hall with her face mask positioned below her nose. When queried, H QQ reported facemask were to be worn over the nose and mouth.</p> <p>On 2/4/25 at 10:29 AM Floor Tech (FT) OO was observed pushing a floor cleaning machine down B Hall with his face mask below his nose.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  235399	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/04/2025
NAME OF PROVIDER OR SUPPLIER  Medilodge of Portage		STREET ADDRESS, CITY, STATE, ZIP CODE  7855 Currier Dr Portage, MI 49002	
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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 2/4/25 at 10:32 AM., CNA R was observed in a resident's room, at the bedside, assisting with the resident's blankets, with her face mask below her nose.</p> <p>On 2/4/25 at 10:33 AM H RR was observed on B Hall with her face mask below her nose.</p> <p>In an interview on 2/4/25 at 10:39 AM., CNA R reported that face masks were required to be worn by the staff throughout the facility and that proper placement of a face mask was covering the nose and mouth. CNA R reported the droplet precautions and airborne precautions signage indicated the room had a Covid positive resident in it.</p> <p>During an observation and interview on 2/4/25 at 11:01 AM., DA MM was sitting in the dining room preparing silverware at a table without a face mask on, a face mask was noted to be laying on the table. Residents were present in the dining room. When queried, DA MM reported that infection control practices for the dietary staff included wearing a face mask (DA MM) reached for the discarded face mask on the table and applied it to his face) and hand washing when in the kitchen. When queried, DA MM reported proper wearing of a face mask included covering the nose and mouth.</p> <p>On 2/4/25 at 11:10 AM., Dietary Manager (DM) JJ was observed in the kitchen through the serving window with her face mask below her chin. DA LL was observed exiting the kitchen through the door next to the serving window without a face mask on.</p> <p>In an interview on 2/4/25 at 2:48 PM., Unit Manager/Licensed Practical Nurse (UM/LPN) O reported during a Covid outbreak face masks were required to be worn by all staff and should cover the nose and mouth.</p> <p>In an interview on 2/4/25 at 4:10 PM., Infection Preventionist (IP) T reported one positive Covid resident was considered a Covid outbreak. IP T reported staff was required to wear a face mask throughout the building during an outbreak. IP T reported the proper way to wear a face mask was to ensure the nose and mouth were covered. IP T had a laminated picture of a face with a face mask covering their mouth and nose, and a log of employee signatures, when queried, he reported he was re-educating all staff on the proper way to wear a face mask as it was an ongoing problem.</p>		