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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235410	A. Building B. Wing	04/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Munising	300 W City Park Dr Munising, MI 49862

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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45123 Based on observation, interview, and record review, the facility failed to prevent the development of a pressure ulcer and provide pressure ulcer care per professional standards of practice for two Residents (R4 and R8) of three residents reviewed for pressure ulcer care. Findings include: This citation is linked to intake MI00143371. A review of the Electronic Medical Record (EMR) revealed R4 developed an in house acquired unstageable pressure ulcer area on 2/18/24 which subsequently worsened to an increased size and developed into a stage IV pressure ulcer. The pressure ulcer continued to deteriorate from 2/18/24 through 3/11/24 with worsening measurements. R4 developed a pressure ulcer wound infection, requiring hospitalization , antibiotics, intravenous pain medication, wound debridement, a wound vac, and colostomy placement. The facility failed to consistently measure wound care assessments, failed to follow physician wound care orders, failed to ensure a wound care clinic consult was done timely, failed to implement wound care interventions timely, failed to prevent wound infection, and failed to appropriately turn/reposition R4 for pressure relief. Review of R4's census, revealed an admission to the facility on [DATE] and discharged on [DATE]. Review of R4's medical diagnoses, dated 2/7/24, revealed the following diagnoses: need for personal assistance, muscle weakness, pneumonia, fusion of spine, spinal stenosis cervical region and cervical disc disorder at C4 - C5 level with myelopathy, rheumatoid arthritis, and hallux valgus (a bony bump that forms on the joint at the base of the big toe). Review of R4's Minimum Data Set (MDS) assessment, dated 2/13/24, revealed functional abilities for toileting hygiene, shower/bath, upper and lower body dressing, putting on/off footwear, and rolling from left to right as a substantial/maximal assistance. R4 was dependent for transfers to chair to bed, toileting, and lying to sitting/sitting to lying. MDS Section E Behaviors, dated 3/13/24, revealed no rejection of care. Review of R4's electronic medical record (EMR), nursing assessment, dated 2/7/24, part I section V skin, revealed the following skin conditions; right heel - boggy (blanchable redness) and left buttocks - rash. No other skin condition or open areas were documented in the nursing assessment. Review of R4's EMR, skin assessment, dated 2/13/24, revealed no new abnormal skin areas and no existing abnormal skin areas. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235410	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/03/2024
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F 0686

Level of Harm - Actual harm

Residents Affected - Few

A subsequent wound evaluation for R4, dated 2/19/24, identified an unstageable pressure injury to the sacral coccyx area.

The following measurements are for the same sacral/coccyx wound for R4 as follows:

Review of R4's wound evaluation, dated 2/19/24, revealed a pressure injury, unstageable, measuring 12.47 cm (centimeters) in length x 12.83 cm wide. The wound was identified as one day old, in-house acquired. The surrounding tissue was described as excoriated (Wound picture showed a small amount of fecal matter in the rectal area and skin tissue appeared slough brown in color in the center. Edges near rectal area were white with small amounts of yellow color and edges around the wound were reddened.) and covered with foam boarded dressing. This was labeled as a new wound, healable, and the practitioner was notified.

Review of R4's wound evaluation, dated 2/26/24, revealed a pressure injury, unstageable, measuring 10.37 cm x 10.71 cm (Area pictured appears larger and left side open towards lower torso. Center appeared brown/red in color and bordered edge on the right side had some spotty eschar noted and outer edges yellow slough with reddened edges). The evaluation noted a moderate amount of serosanguineous [blood mixed with light yellow color] drainage and turning and repositioning program was added to the care plan.

Review of R4's wound evaluation, dated 3/4/24, revealed a pressure injury, unstageable, measuring 17.16 cm x 18.93 cm (Area pictured appears to now have depth, approximately 50% of the wound bed appeared to have eschar and increased redness to left buttocks surrounding area when compared to the previous pictured area). There was a heavy amount of purulent drainage with odor. Surrounding tissue had erythema and was noted to be fragile, pain was 3/10 [mild/moderate] intermittent, dressing appearance was saturated, and wound progress was deteriorating. Notes: New orders received to apply medihoney [medical grade honey dressing] to wound bed and new orders to send resident to wound clinic for consultation.

Review of R4's wound evaluation, dated 3/9/24, revealed a stage 4 pressure ulcer, measuring 15.29 cm x 14. 44 cm (Area pictured appears to have increased depth and a mixture of eschar/slough/tissue granulation. Surrounding redness appeared to be extending past the left gluteal cleft, and linens on resident bed in the photo revealed a large amount of drainage which appeared brownish and serosanguinous in color along with smaller amount of fecal matter). A heavy amount of serosanguinous drainage with a strong odor was documented. Surrounding tissue edges were noted to be non-attached, denuded [protected top layer missing] with erythema [redness], excoriated and fragile. Pain was rated 8/10 [severe] continuous. Wound progress was noted as deteriorating.

Review of R4's care plan, dated 2/10/24, read in part, .Focus: Resident has impaired skin integrity as evidence by: Unstageable ulcer to coccyx (revised on 2/19/24) .bowel incontinence (revised on 3/5/24). Goal: Resident will show signs of healing and/or improvement .Interventions: Administer treatment(s) per orders . Assist resident with turning and repositioning .Turning schedule clock in room (revised 3/5/24) .Complete wound evaluation to observe the progress of the resident's skin condition .Pressure redistribution mattress to bed - low air loss mattress (date initiated 3/4/24). Provide incontinence care as needed (date initiated 3/4/24) .Wound consult as needed (date initiated 2/19/24) .

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of R4's physician order, dated 2/19/24, revealed the following, Coccyx, Left & Right buttocks - Gently cleanse with soap and water, pat dry. Apply skin prep and cover with boarder foam dressing. In the morning every Monday, Wednesday, Friday for pressure injury. Review of R4's physician order, dated 2/20/24, revealed the following, Coccyx area - Gently cleanse with soap and water, pat dry. Apply skin prep and cover with boarder foam dressing. In the morning for pressure injury. Review of R4's physician order, dated 3/5/24, revealed the following, Coccyx Pressure injury: 1. Wash wound with wound cleaner 2. Apply skin prep to periwound [skin surrounding wound] 3. Calcium alginate AG [silver] to wound bed 4. Cover with boarder foam dressing until medihoney is available every day shift. Review of R4's physician order, dated 3/5/24, revealed the following, Wound Care Clinic Consult .for unstageable wound to coccyx. *Note: Care plan stated the wound care consult was initiated on 2/19/24. Review of R4's physician order, dated 3/12/24, revealed the following, Coccyx Pressure injury: Wash wound with wound cleaner. Apply skin prep to periwound. Apply calcium alginate AG to wound bed. Fluffed AMD [anti-microbial dressing] gauze. Cover with boarder foam dressing until medihoney is available every day shift. Review of R4's progress note, dated 2/8/24 at 9:21 PM, read in part, [Physician M] in to see resident this am: [Physician M] wrotr (sic) as follows: 1.) Chest x-ray re: pneumonia, cough 2.) F/U (follow-up) with neurosurgery - per discharge order sheet 3.) F/U with Wound Care re: L toe ulcer - per discharge order sheet . Review of R4's progress note revealed the following: 2/18/24 at 5:44 AM, Large excoriated area to both butt cheeks and coccyx, complained of pain to site . bleeding redness and swelling noted . 2/19/24 at 2:48 AM, Unstageable pressure ulcer to coccyx and bilateral butt cheeks, 18 cm x 14 cm, complained of pain to area .center is dark purple and boggy as you extend out skin is open and with small amount of bleeding and serosanguinous drainage noted . 2/22/24 at 4:29 PM, .Wound deep red and black in color. Resident complained of increased pain in this area. 3/1/24 at 1:19 PM, .coccyx wound black with red/pink borders, foul smell .complained of pain when moved . 3/4/24 at 1:57 AM, .Wound to coccyx is getting deeper and larger, black soft very foul smell, complained of pain and burning . (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	3/5/24 at 1:42 PM, .Wound is worsening .Obtained consult to wound care clinic. 3/6/24 at 4:21 PM, .Resident on low air loss mattress. 3/7/24 at 12:40 PM, .Wound culture per MD (medical doctor). 3/9/24 at 5:11 AM, Resident is having large amount of purulent drainage with undermining to left buttock cheek, area is very warm to touch and has extremely foul smell, is close to rectum and you can hear a gas release sound when cleaning the rectal area . 3/9/24 at 7:16 AM, .site is getting worse daily and that it is draining large amounts of purulent matter, undermining noted, complained of pain 10/10 . 3/13/24 at 2:27 PM (late entry), Resident out to wound care appointment. Per wound care clinic resident was sent to [local hospital name] emergency department for treatment of sacral wound. Per [local hospital name] will require overnight stay. *Note: Wound care consult was 23 days after the intervention noted on the care plan and 8 days after the physician order written. Progress notes dated 2/7/24 through 3/13/24 lacked any documentation of non-compliance, behaviors, and/or refusals of care. Review of R4's admission history and physical, dated 2/7/24, completed by Physician M, read in part, . Physical examination: Wound left foot .addition comments: 1. Chest x-ray regarding: pneumonia/cough, 2. Follow-up with neurosurgery on order sheet, 3. Follow-up with wound care regarding left toe ulcer on order sheet .Signed off on 2/8/24 by nursing (unable to identify initials of Licensed Practical Nurse). *Note: Wound care consult was not completed by facility regarding left toe. Review of R4's physician communication fax, dated 2/20/24, read in part, Resident has acquired an unstageable ulcer to coccyx .looking for contributing factors such as ARF (acute respiratory failure), infection . Would like order for wound clinic consult please. Physician response: OK. Wound care consult. Signed 2/20/24. *Note: Physician agreed to the wound care consult on 2/20/24 and an order was not written for the wound care consult until 3/5/24. Review of R4's physician communication fax, dated 2/20/24, read in part, New unstageable pressure ulcer to coccyx and both butt cheeks 20 cm x 14 cm. Physician response: OK. Signed 2/20/24. Review of R4's physician progress note, dated 3/7/24, read in part, .Skin/wounds: Stage 4 coccyx pre . Assessment and plan: .4. Wound care consult. 5. Consider hyperbaric therapy, diverting colostomy. 6. Wound culture. Signed by Physician M and noted by Registered Nurse (RN) O. Review of R4's treatment administration record (TAR), dated 2/7/24 through 3/13/24, revealed three dressing changes were not documented as completed on 2/23/24, 2/29/24, and 3/4/24. There was an as needed dressing change order added on 3/4/24, however this was never documented as completed. Review of R4's Braden scale for predicting pressure sore risk, dated 2/7/24, revealed a risk for developing pressure sores. Review of R4's skilled nursing assessment, dated 2/13/24, revealed activities of daily living for rolling from left to right - substantial/maximum assistance. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of R4's skilled nursing assessments, dated 2/13/24, 2/20/24, 2/22/24, 2/26/24, 3/3/24, and 3/4/24, revealed no documented education provided to R4 by nursing. Review of R4's wound culture, dated 3/11/24, revealed facility cultured coccyx wound positive for bacterial growth. Review of R4's task for turning and repositioning, dated 2/20/24 through 3/13/24, revealed the following: (*Times noted are when resident was documented as being turned and repositioned.) 1.) On 2/20/24 - not documented as turned between 2:21 AM and 2:00 PM, and not turned again between 8:00 PM and 3:08 AM (2/21/24), 2.) On 2/21/24 - not documented as turned between 9:05 AM and 12:03 PM, and not documented as turned again until 6:18 PM, 3.) On 2/22/24 - not turned between 3:26 AM and 8:03 PM, 4.) On 2/23/24 - not turned between 3:07 AM and 6:08 PM, and not turned again until 11:05 PM (last turned), 5.) On 2/24/24 - not documented as turned between 3:12 AM, and next turn was not until 2:00 PM, 6.) On 2/27/24 - not turned until 3:00 AM and then the next turn was not until 1:45 PM. *Note - Further review of turning documentation, dated 2/28/24 through 3/13/24 lacked multiple areas of documentation for turning and repositioning every two hours. Review of R4's hospital emergency department (ED) report, dated 3/13/24, revealed the following: Wound culture obtained was positive for bacterial growth, medications provided two different types of intravenous antibiotics, and an opioid hydromorphone 1 milligram for pain management related to pain 10/10. ED physician history and physical reported development of stage 4 pressure ulcer on coccyx with sacral exposure, necrotic tissue, and patient felt fatigued, weak, upset stomach, miserable, and low-grade fever. Also, reported wound care clinic thought he needed wound debridement and had not been on any antibiotics prior to hospital admission on 3/13/24. Furthermore, extensive large sacral wound with exposed bone, and very malodorous. Review of R4's hospital physician exam report, dated 3/13/24, revealed the following: Stage 4 sacral pressure ulcer measuring 12 cm x 16 cm with deep tunneling, large amounts of yellow drainage, and bone appearing gray and soft. Will likely need surgical debridement. General surgery consulted and reviewed and agrees with needing debridement and placement of wound vac. Diagnoses of stage 4 pressure ulcer to the sacral region and osteomyelitis. Review of R4's hospital general surgeon report, dated 3/13/24, revealed the following: Postoperative sacral decubitus ulcer wound debridement measuring 15 cm x 15 cm. Wound vac not feasible related to wound close proximity to anal margin. Patient will most likely require diverting ostomy to avoid stooling into the wound. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of R4's hospital operative report, dated 3/13/24, revealed the following procedure end-sigmoid colostomy. Review of R4's hospital records, dated 3/18/24, revealed the following placement of a wound vac on the sacral region. On 4/3/24 at 8:15 AM, an interview was conducted with Occupational Therapist (OT) L and was asked about R4 having a pressure reduction cushion in his wheelchair and replied, Nursing came to me on 3/7/24 and that is when a pressure reduction cushion was implemented. OT L was then asked how R4 transferred and what type of locomotion he was and replied, He was a lift the entire time he was here and used a wheelchair for locomotion. OT L stated that if he was aware R4 had a pressure ulcer on his coccyx sooner he would have implemented to nursing the need for a pressure reducing cushion but had not been notified until 3/7/24. OT L was asked if he recalled any type of dressing to R4's left foot and replied, Yes, I do believe he had some type of dressing on his foot. On 4/3/24 at 9:06 AM, a phone call was placed to Registered Nurse (RN) E who initially discovered the coccyx wound on R4 and there was no answer. A message was left for RN E to call this Surveyor back with call back number. *Note: no return call was received during the survey. On 4/3/24 at 9:55 AM, a phone call was placed to Licensed Practical Nurse (LPN) G regarding skilled assessment education and R4's wound. A message was left for LPN G to call this Surveyor back with call back number. At 10:30 AM LPN G came in to the facility to see this Surveyor for an interview. LPN G was asked if she recalled R4 having a dressing on his left foot and replied, I do not recall. LPN G was asked what kind of mattress R4 had on admission and replied, Just the usual pressure reducing mattress. LPN G was not sure about a wheelchair cushion and added the wound was not that bad in the beginning. LPN G indicated the wound was red and excoriated then ended up with an area that was necrotic where it opened up and they were applying a foam gauze dressing 10 cm x 10 cm and it was tunneled. The wound nurse does the wounds and works the floor on Thursdays, and she is not here today. *Note: Wound Care Nurse was unavailable for an interview. On 4/3/24 at 1:10 PM, an interview was conducted with Certified Nurse Assistant (CNA) O, and was asked if they recalled R4 and replied, Yes. CNA O was asked what kind of care R4 required and what kind of person he was like and replied, He was a good guy. He needed extensive assistance and used a lift for transfers to his wheelchair. CNA O was asked if he refused care or was difficult and replied, No. Not that I can recall. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 4/3/24 at 2:00 PM, an interview was conducted with the Director of Nursing (DON) and Regional Clinical Nurse (RCN) H. They were asked if the medihoney ever came in prior to R4 being sent to the wound clinic and admitted back to the local hospital. The DON replied, No. It came in about two weeks ago. I think it was 3/18/24. Both nurses were then asked what their expectation was on wound care documentation and if depth should have been measured sooner when R4's wound showed depth and replied, Yes. Depth should have been measure as soon as the wound presented with depth and wound measurements should have been consistent. The DON was asked why R4 was not seen at the wound clinic sooner and had no reply. Both nurses were asked if they knew how R4's coccyx wound got infected and replied, We do not know. The DON was asked how often dressing changes were being completed on R4 and replied, Twice a day and as needed. The DON was asked if the physician wound dressing change orders reflected that and replied, Nope, it was once a day. Should have been changed if it was saturated. I think there is only one extra change documented. There was a prn order added on 3/4/24 but there are no extra dressing changes signed out. Both nurses were asked what the expectation for wound dressing documentation was and replied, The nurses should be documenting each dressing change in the treatment record. Both nurses were asked if there was not a space to document wound dressing changes as needed then how did they know this was being completed twice or more a day and replied, We do not know. The DON stated physician M did not physically see R4's wound until 3/5/24 and the medical director was requesting that the rounding physician physically see the wound once a month and make a progress note. The DON went on to say that she felt the rounding physician was overwhelmed. Resident # 8 (R8) R8 developed an unstageable pressure ulcer to his coccyx area that was facility acquired and resulted in further deterioration of the wound with increased size and depth. R8 also had placement of a urinary catheter to help promote healing of the coccyx wound. Review of R8's census, revealed an admission to the facility on [DATE]. Review of R8's medical diagnoses, dated 1/16/24, revealed the following diagnoses obesity, chronic obstructive pulmonary disease, cellulitis, and hypertension. Review of R8's MDS, dated [DATE], revealed functional abilities for shower/bath, upper and lower body dressing, and putting on/off footwear as a substantial/maximal assistance. R8 was partial/moderate assistance for toileting, transfers to chair to bed, and lying to sitting/sitting to lying. MDS section E Behaviors, revealed no rejection of care. MDS, dated [DATE], section E behaviors, revealed no rejection of care. The following measurements are for the same coccyx wound for R8 as follows: Wound evaluation, dated 3/4/24, revealed a pressure injury, unstageable, measuring 1.73 cm in length x 0.5 cm in width, seven hours old, in-house acquired, and progress new. Wound evaluation, dated 3/11/24, pressure injury, unstageable, measuring 1.85 cm in length x 0.86 cm in width x 2.1 cm in depth, seven days old, wound bed 80% slough, moderate amount of serosanguineous exudate, and practitioner notified. (continued on next page)

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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 0686 Level of Harm - Actual harm Residents Affected - Few	On 4/3/24 at 3:30 PM, an observation was made of R8's coccyx wound with RCN H and the DON. During the dressing change observation R8's wound was noted to have deteriorated and have a moderate amount of serosanguinous drainage. On 4/3/24 at 3:45 PM, an interview was conducted with the DON and RCN H, regarding the development of R8's coccyx pressure wound and stated that R8 developed the wound in the facility. The DON was asked if she was aware that a large clot was expelled from R8's coccyx wound on 4/2/24 and replied, No. I was not made aware of that. I will look into it. Review of policy titled, Wound Treatment Management, dated 10/26/23, read in part, Policy: To promote wound healing of various types of wounds, it is the policy of this facility to provide evidenced-based treatments in accordance with current standards of practice and physician orders. Policy Explanation and Compliance Guidelines: 1. Wound treatments will be provided in accordance with physician orders, including the cleansing method, type of dressing, and frequency of dressing change . Review of policy titled, Pressure Injury Prevention and Management, dated 1/1/22, read in part, Policy: This facility is committed to the prevention of avoidable pressure injuries and the promotion of healing of existing pressure injuries . Policy Explanation and Compliance Guidelines: .3. Assessment of Pressure Injury Risk .c. Assessment of pressure injuries will be performed by a licensed nurse, and documented in the medical record .4. Interventions for Prevention and to Promote Healing .c. Evidence-based interventions for prevention will be implemented for all residents who are assessed at risk or who have a pressure injury present. Basic or routine care interventions .include .i. Redistribute pressure (such as repositioning, protecting and /or offloading heels, etc.); . iii. Provide appropriate, pressure-redistributing, support surfaces .f. Interventions will be documented in the care plan and communicated to all relevant staff . Review of policy titled, Pressure Ulcer/Skin Breakdown-Clinical Protocol, dated 1/1/22, read in part, Policy: Based on the comprehensive assessment of a resident, a resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers .and a resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice to promote healing, prevent infection . Policy Explanation and Compliance Guidelines: . 4. The interdisciplinary team (IDT) will assess and document and individual's significant risk factors for developing PU/PI [pressure ulcer/pressure injury] .7. Continued assessment and management .PUSH [pressure ulcer scale for healing] tool completed on PU/PI weekly during the weekly wound measurements . 15. The IDT team will review each pressure ulcer weekly for progress and changes .