

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 05/28/2024
NAME OF PROVIDER OR SUPPLIER Medilodge of Munising		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49735</p> <p>Based on observation, interview, and record review, the facility failed to assess a change in condition for one Resident (R2) of three residents reviewed for a change in condition. Findings include:</p> <p>Resident 2 (R2)</p> <p>A review of R2 Minimum Data Set (MDS) assessment, dated 3/9/24, revealed admission to the facility on [DATE] with active diagnoses that included: hereditary and idiopathic neuropathy, anxiety disorder, major depressive disorder, chronic pain, repeated falls, muscle weakness, and compression fracture of lumbar vertebra. R2 scored a 15 of 15 on the Brief Interview for Mental Status (BIMS) reflective of intact cognition.</p> <p>During an interview on 5/28/24 at approximately 11:00 a.m., R2 said the event happened around the 6th of May . I came into the building from outside, I was shaking uncontrollably and leaning up against the wall, it was so scary, I have never felt that way before, and something could have happened to me I have never been refused medical care before, but the nurse would not help me. Certified Nursing Assistant (CNA) D saw me and came to help me. CNA D went to the Licensed Practical Nurse (LPN) C working on the wing and she shook her head no and would not help me. R2 said he had filed a grievance with the Director of Nursing (DON) about his change in condition and lack of an assessment from the LPN. This surveyor attempted to call LPN C and left a voicemail with no returned call by survey exit.</p> <p>During an interview on 5/28/24 at 12:20 p.m., the DON acknowledged the resident had filled out a grievance and LPN C was educated on the prioritization of care.</p> <p>During a phone interview on 5/29/24 at 10:58 a.m., CNA D stated I have never seen him like that the resident was going down to his room, was leaning on the rail with his right arm and his left arm was shaking really bad. I asked him what was going on and asked if he needed help, he said yes. I told the nurse (LPN C) and the nurse said he just wanted attention and she was busy passing meds. I went back to the resident and comforted him for 10 to 15 minutes and then he was coming out of what he was going thru. After I comforted him, he seemed to be doing fine but he was upset that the LPN would not take care of him.</p> <p>During an interview on 5/29/24 at 11:30 a.m., the DON acknowledged LPN C was the nurse on the unit that day, and did not assess the resident for a change in condition, and there were not any progress notes or assessments in the medical record for R2 regarding a change in condition.</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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