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	12/04/2024

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 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35981 This citation pertains to MI00148054: Based on interview and record review the facility failed to properly transcribe and administer medications per physicians orders for 1 Resident (#3) of 4 residents reviewed for quality of care, resulting in the lack of assessment, monitoring, and documentation and resulted in hospitalization and subsequent delay in treatment/resolution of the infection with the potential for worsening of condition. Findings include: Resident #3 (R3) Review of an Admission Record revealed R3 was originally admitted to the facility on [DATE] with diagnoses including, osteomyelitis (bone infection), left ankle and foot. Review of a Minimum Data Set (MDS) assessment for R3 with an assessment reference date (ARD) of 11/5/24 revealed a Brief Interview for Mental Status (BIMS) score of 4/15 indicating R3 was severely cognitively impaired. In an interview on 12/4/24 at 10:00 AM., R3 reported he was recently admitted to the facility for Rehabilitation and Intravenous (IV) antibiotics for his PICC (Peripherally Inserted Central Catheter-Type of IV) line, and wound care for his left foot. R3 reported the facility nursing staff did not administer his IV-Antibiotics for approximately 5 days that were prescribe for his (foot/wound/bone infection) infection. R3 Reported he had been at the facility a few days and went out on a Leave of Absence (LOA) for overnight with his guardian (whom is also a family member) to spend the night. R3 reported the next day, while at his guardians he was feeling ill. R3 reported his guardian was worried about the way his left foot, and leg looked, she (guardian) took him to the (local hospital name) hospital. R3 reported he was treated for a few things, including the worsened infection in his left foot. R3 reported they (facility nursing staff) didn't give antibiotics in his IV, and they didn't clean his wound properly. R3 reported during his stay for a few days in the hospital the doctors there said, I was going to lose my foot if the infection doesn't get treated immediately. R3 reported the hospital doctor ordered antibiotics IV, to be given once returning to the facility. R3 reported he was very scared and concerned about his left foot. (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

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of R3's Hospital Discharge Paperwork dated 10/31/24, including a Physicians Order-dated 10/30/24 (from the hospital to the facility upon R3s admission to the facility) revealed: Physicians Order-10/30/24 cefTRIAXone Sodium Intravenous Solution Reconstituted 2 GM (grams) PICC line Use 2 gram intravenously every 24 hours for 6 weeks intended use for osteomyelitis left foot .further reviewed in the Hospital Discharge Paperwork discharge instructions on medications to remain on and follow up included: cefTRIAXone Sodium Intravenous Solution Reconstituted 2 GM Use 2 gram intravenously and Normal saline flush 10 ml (milliliters) to (IV/PICC) bid (twice daily) . Review of R3's facility Nursing Progress note revealed: 11/1/24 14:43 p.m., Resident (R3) has wound on left great toe. PICC line present in right arm Review of R3's Care Plan revealed: Date Initiated: 11/01/2024 .Focus: Resident (R3) requires enhanced barrier precautions related to surgical wound, and PICC line. Revision on: 11/14/2024 . Review of R3's November 2024's facility Medication Administration Record (MAR) revealed: Normal saline flush 10 ml to (IV/PICC) bid (twice daily) every morning and at bedtime .discontinue order when line is removed -Start Date 11/04/2024 . further review of the MAR revealed R3 received no NS flushes twice daily 11/1/24-11-4/24 Review of R3's November 2024's facility Medication Administration Record (MAR) revealed: Treatment: Surgical, left 1st metatarsal (Toe). Wash with wound cleanser, pat dry. Apply Xeroform (wound dressing material) to wound bed and cover with silicone bordered foam dressing. in the afternoon every other day for Skin impairment -Start Date 11/02/2024 1100 . Further review of R3's 11/2024 MAR revealed no nursing documentation that the wound care as ordered to treat was completed from 11/2/23-11/5/24. Review of R3's facility Nursing Progress note revealed: 11/5/24 15:31 p.m., called pt. (patients)- next of kin (guardian) and was notified that the antibiotic was being ran (administered) . (guardian) was thankful for the call In an interview/record review on 12/4/24 at 10:55 AM., Registered Nurse' (RN) M reported R3 had went home on a overnight when he first arrived at the facility, about 4-5 days after he admitted . RN M reported R3 had a PICC line and was at the facility for rehabilitation for PICC/IV antibiotics and wound care originally. RN M reported R3 went out early November with his guardian. RN M reported they became concerned about is wound and he was ill, so she took him the hospital. RN M reported R3's guardian reported that R3's wound and leg looked swollen and red. RN M reported according to the MAR and nurses' notes (which were reviewed together with this surveyor) RN M reported something got missed, the flush for the PICC line, and original antibiotic order for 10/30/24 should have been transcribed before actual admission or within a few hours of admitting . RN M reported it appears for R3 November 2024 MAR and nursing notes, the orders were not followed. RN M reported after R3 was back from the hospital she recalls R3 was upset and scared about his left leg and foot might be amputated. RN M reported had the original physician's orders been followed and transcribed properly R3 should have been getting his PICC line flushed twice daily with NS, and this antibiotic administered from date of admission which was 11/1/24. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	In an interview on 12/4/24 at 3:30 PM.,the Director Of Nursing (DON) reported R3's initial hospital discharge paperwork came through on 10/31/24 from the hospital where R3 was discharged from, on admission to the facility. The DON reported R3's PICC/IV line Antibiotic and NS flushes for the PICC was missed during transcription of the physicians' orders. The DON reported the nursing staff missed' or did not catch the physicians' orders because the paperwork was a lot different than the hospital discharge paperwork other local hospitals around the area usually send. The DON reported R3 did in fact go a few days without his IV-Antibiotics and PICC line flush. The DON reported R3 went out with family for a night and it was noticed his foot and leg were swollen and red, so the guardian took him to the hospital. The DON reported R3 should not have missed his medications, and the nursing staff did not follow policy and procedures to ensure proper transcription of medications are administered, and/or ordered if not in stock. Review of R3's facility Incident Reported dated 11/11/24 revealed: Description-(R3) was admitted to the facility on [DATE]. The resident (R3) was found to have missed the start of his IV antibiotic (abx) medication on 11/11/24, it wasn't started until 11/5/24 . Resident admitted to the facility on [DATE]. Staff did not see the order for the IV abx . Staff were interviewed . thru that weekend (nurses who worked R3's admission weekend) 11/2 and 11/3. He (R3) was noted to have a PICC in place, but this was not researched by staff at the time Antibiotic order was noted to be in the admission paperwork as a separate order. Staff consensus was that they never saw an order for it. Monday AM it was initiated - (multiple nurses on the incident reported) stated it was the first time they knew anything about the IV abx, although they saw the PICC line) It is noted that the guardian was updated when the abx was running. Management was not aware of the delay until 11/11/24. Review of Nursing References Materials for medication transcription and physicians ordered revealed: Nurses must obey the orders of the physician in charge of a patient, unless an order would lead a reasonable person to anticipate injury if it were carried out, according to [NAME] in Law Every Nurse Should Know, 5th Edition, page 98 The Professional Standard of Quality for documentation of the residents health care in a medical record is the information must be true and complete. Under no circumstances should erroneous records be removed from the overall record and new pages submitted. (Fundamentals of Nursing, Concepts, and Practice. Mosby. [NAME], P.A., [NAME], A.G., 1985) The nurse is obligated to follow the physician's orders unless they believe the order is in error or would be detrimental to the resident. (fundamentals of nursing, concepts, process, and practice, mosby, [NAME] a. [NAME], [NAME] g. [NAME], 1985) The nurse is obligated to follow the physician's orders unless they believe the order is in error or would be detrimental to the resident. (Fundamentals of Nursing, Concepts, Process, and, Practice, Mosby, [NAME], P., [NAME], A., 1985) . The six rights of medication administration include: 1) the right medication, 2) the right dose, 3) the right client, 4) the right route, 5) the right time, 6) the right documentation. To identify a client correctly, the nurse checks the medication administration form against the client's identification bracelet. When asking the client's name, the nurse should not merely speak the name and assume that the client's response indicates that he or she is the right person. Instead, the nurse asks the client to state his or her name. (Fundamentals of Nursing, 6th edition, 2005, pgs. 841-842.)