

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 10/24/2024
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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40383</p> <p>Based on observation, interview, and record review, the facility failed to provide a dignified existence regarding privacy during care by failure to knock on doors or request permission before entering resident's rooms as expressed by 8 Residents (R6, R19, R25, R42, R45, R55, R61, and R67) of 9 residents reviewed for dignity and respect. This deficient practice resulted in frustration, embarrassment, and lack of privacy. Findings include:</p> <p>On 10/21/24 at 3:35 PM, the Activity Director S agreed to set up a group meeting with oriented residents who would be interested in sharing their views of the facility.</p> <p>On 10/22/24 at 10:30 AM, a group meeting was held with the President of Resident Council and seven other interested residents. A record review revealed all residents present had a recent Brief Interview for Mental Status (BIMS) score in the range of 13-15 indicating they were cognitively intact.</p> <p>During the meeting, an issue concerning dignity was voiced by seven of the eight residents present. R42 stated the staff often did not knock during care or they just knocked and entered without receiving permission. R42 continued, stating the staff enter and come through the privacy curtain saying, It's just me while care was occurring (such as a bed bath), and it was embarrassing. R67 stated the staff was not waiting after knocking, they just come in. R19 said the staff either do not knock or knock very quietly and just enter the room. R67 said, All of us have had this happen. They (staff) just knock and walk (in). R19 added, My covers are off because I am hot, and they come in so quickly when they are at the door that I do not have time to cover back up. R6 added, They (staff) don't wait for permission, but just walk in. R45 said, Yes I have had that happen too.</p> <p>On 10/23/24 at 7:49 AM, the housekeeping staff was delivering clean clothes to the resident rooms. Staff T was observed to enter a room without knocking. Staff T was interviewed and acknowledged she did not knock but just proceeded into the room. The resident (R61) in the room was interviewed and stated staff just entered the room without knocking frequently.</p> <p>On 10/23/24 at 07:53 AM, Certified Nurse Aide (CNA) U was observed entering room [ROOM NUMBER] without knocking.</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
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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The facility policy titled: Promoting/Maintaining Resident Dignity dated as reviewed 10/26/23 read in part, It is the practice of this facility to protect and promote resident rights and treat each resident with respect and dignity as well as care for each resident in a manner and in an environment, that maintains or enhances resident's quality of life by recognizing each resident's individuality. Compliance Guidelines: 1. All staff members are involved in providing care to residents to promote and maintain resident dignity and respect</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40383</p> <p>Based on interview and record review, the facility failed to protect residents from verbal abuse for one resident (R61) of four residents reviewed for abuse. This deficient practice resulted in mental distress and anguish after a staff member suggested the resident end his life. Findings include:</p> <p>The medical record for R61 revealed an admitted [DATE] with diagnoses which included spinal stenosis (bone deterioration resulting in pressure/pain to the spine), repeated falls, pressure ulcer of the sacral region and heel , diabetes (T2DM), heart failure (CHF), and kidney disease (CKD), The Minimum Data Set (MDS) assessment included a Brief Interview for Mental Status (BIMS) score of 15 of 15 indicating cognitively intact.</p> <p>On 10/22/24 at 7:59 AM, R61 was asked about his interactions with the staff and the care he had been receiving. R61 stated one nurse said, When I get your age and have your problems I am going out in the woods and end it. He said he understood he had many problems, but he was upset stating that for her to say that was inappropriate. He was able to describe the nurse and the circumstances and stated he had told several staff members of this concern.</p> <p>The facility documented this incident occurred on 10/13/24 and reported it to the State Agency (SA) on 10/17/24. The facility investigation included a statement from R61 which read, She (Registered Nurse- RN W) came to me and told me I need to stop complaining about pain and using my call light so much. Some of the girls are not as gentle with moving me around. Some are good and others are rough. Then she told me that if I were in your shoes I would take myself out back and end it all. I felt it was very inappropriate and I don't want her to be my nurse anymore. I couldn't believe she said that.</p> <p>The facility investigation on this incident also contained disciplinary action taken by the facility for corrective action for RN W including the following for performance issues.</p> <ul style="list-style-type: none"> - verbal counseling, - written warning, - final written warning, - termination <p>There was a Recommendation for discharge date d 3/29/18 with a final paragraph which read, Because of the above- as well as (RNW's) blatantly rude communication style with her coworkers and management, I see (RNW) as toxic to our team and unable to perform as a team player, non-compliant with regulatory tasks, and unwilling to grow or evolve as a nurse within our new company culture.</p> <p>A further statement was found in the incident investigation dated 4/13/18 which read, In conclusion, (RNW) has worked here a very long time . It also may be she's been a floor nurse long enough - too long? - and her talents could be better utilized in a management position, if she is willing.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 10/23/24 at 4:17 PM, Certified Nurse Aide (CNA) F stated she was interviewed regarding the behavior of RNW. CNA F stated while not present for the incident involving R61, she added Well that was not the first time she (RN W) talked to someone like that . She doesn't talk very nice to the residents. She should not be talking to our residents that way . She (RN W) has a harsh voice, like she is demanding. I don't want her talking to the residents like that, they can't help it.</p> <p>During an interview on 10/24/24 at 10:09 AM, Licensed Practical Nurse (LPN) M stated he heard about the incident between RN W and R61. LPN M was giving care to R61, and R61 stated the night nurse over the weekend said R61 was complaining about pain too much and if she was in the same position as he was, she would go out into the woods and end it all. LPN M stated, I would consider that abuse.</p> <p>During an interview on 10/24/24 at 10:40 AM, the Nursing Home Administrator (NHA) and Director of Nursing (DON) confirmed RN W had been repeatedly/educated and nearly terminated for inappropriate care issues. The facility allowed the member of the staff to continue to work.</p> <p>The facility policy titled, Abuse, Neglect and Exploitation dated as reviewed/ revised 1/10/24 read in part: The facility will implement policies and procedures to prevent and prohibit all types of abuse, neglect, misappropriation of resident property, and exploitation that achieves: . B. Identifying, correction and intervening in situations in which abuse, neglect, exploitation, and/or misappropriation of resident property is more likely to occur with the deployment of trained and qualified, registered, licensed, and certified staff on each shift in sufficient numbers to meet the needs of the residents . H. Assigning responsibility for the supervision of staff for identifying inappropriate staff behaviors .</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40383</p> <p>Based on interview and record review the facility failed to report alleged abuse timely for two Residents (R61 and R124) out of four residents reviewed for abuse reporting to the State Agency (SA). This deficient practice resulted in the potential for ongoing abuse. Findings include:</p> <p>The medical record for R61 revealed an admitted [DATE] with diagnoses which included spinal stenosis (bone deterioration resulting in pressure/pain to the spine), diabetes, heart failure, and kidney disease. The Minimum Data Set (MDS) assessment included a Brief Interview for Mental Status (BIMS) score of 15 of 15 indicating R61 was cognitively intact.</p> <p>On 10/22/24 at 7:59 AM, R61 was asked about his interactions with the staff and the care he had been receiving. R61 stated one nurse said, When I get your age and have your problems I am going out in the woods and end it. He said he understood he had many problems, but he was upset stating that for her to say that was inappropriate. He was able to describe the nurse and the circumstances and stated he had told several staff members of this concern.</p> <p>During an interview on 10/24/24 at 10:09 AM, Licensed Practical Nurse (LPN) M, the unit manager stated, I heard about it (the incident between RN W and R61) after the weekend on Monday when I went in for care with him (R61). LPN M reported R61 said The night nurse over the weekend said I was complaining about pain too much and if she was in the same position, she would go out into the woods and end it all. LPN M stated, I would consider that abuse. LPN M stated, I started to look into it and asked questions, but lost track of things and was dealing with other things and didn't report it . I should have gone straight to (the Nursing Home Administrator NHA).</p> <p>During the facility investigation and staff interviews into the incident between R61 and RN W, a Trigger Event - Call Summary Worksheet was completed and revealed R124 experienced alleged abuse on 10/4/24 which was reported 10/17/24.</p> <p>On 10/23/24 at 4:17 PM, an interview was conducted with CNA F and reported the alleged abuse experienced by R124. CNA F stated on 10/4/24, R124 fell out of bed three times and RN W was frustrated for sure as she was behind in her med pass . She has a harsh voice. Like she is demanding. I don't want her talking to the residents like that. They can't help it. When CNA F was asked if RN W was abusive she said, I know about abuse . I certainly would think it was abuse. This CNA did not report the event of 10/4/24 to administration until she was asked about the incident of 10/14/24 with R61. This was not reported to the SA until 10/17/24.</p> <p>On 10/24/24 at 10:40 AM, the NHA and Director of Nursing (DON) confirmed the two events with R61 (on 10/14/24) and R124 (on 10/4/24), both involving RN W occurred on 10/13/24 and was reported to several staff members but was not reported to the SA until 10/17/24.</p> <p>(continued on next page)</p>		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy titled, Abuse, Neglect and Exploitation dated as reviewed/ revised 1/10/24 read in part: . Reporting of alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (e.g. law enforcement when applicable) within specified timeframes as required by state and federal regulations: a. Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or b. Not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury.		

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<p>F 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40383</p> <p>Based on interview and record review, the facility failed to notify the Resident and Resident Representative in writing with the reason for a transfer out of the facility for four Residents (R124, R22, R29, R64) of four residents reviewed for transfers out of the facility. This deficient practice resulted in the potential for the Resident's Representatives to be uninformed regarding the Resident's conditions and location, as well as a potential for inappropriate discharge/transfers. Findings include:</p> <p>Resident 124 (R124)</p> <p>On 10/6/24, R124 was sent out to the hospital due to unresponsiveness and was returned/readmitted to the facility on [DATE].</p> <p>On 10/20/2024, R124 was sent out to the hospital after discussion with the on-call physician. R124 was readmitted on the same day.</p> <p>A review of the Electronic Medical Record (EMR) for R124 revealed no written transfer notice.</p> <p>During an interview on 10/23/24 at 12:01 PM, the Nursing Home Administrator (NHA) and Regional Clinical Nurse (RN) N stated there currently was an interim social worker and she was not sending written notifications to the residents or family members regarding hospital transfers. RN N stated sending written notifications generally was the social worker function.</p> <p>45123</p> <p>Resident #22 (R22)</p> <p>Review of the Minimum Data Set (MDS) assessment, dated 12/6/23, revealed R22 was admitted to the facility on [DATE] with a primary diagnosis of sepsis (a potentially life-threatening condition that arises when the body's response to infection causes injury to its own tissues and organs).</p> <p>Review of R22's electronic medical records (EMR) revealed R22 was transferred out of the facility on 7/29/24 with a readmit back to the facility on [DATE].</p> <p>Review of R22's EMR revealed R22 was transferred to the emergency department (ED) for deteriorating wound 5/3/24 with a readmit back to the facility on [DATE].</p> <p>Review of R22's EMR revealed R22 was transferred to the ED from wound care clinic for deteriorating wound on 4/17/24 with a readmit back to the facility on [DATE].</p> <p>On 10/22/24 at 10:25 AM, R22 was asked about their transfers out and if they recalled it being two or three times in the last six months and replied, I do not recall. R22 was then asked if they recalled receiving any transfer paperwork and replied, Not that I remember. No one gave me any papers when I was sent to the hospital.</p> <p>(continued on next page)</p>		

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<p>F 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>49302</p> <p>Resident #29 (R29):</p> <p>A review of the facility census revealed R29 was sent to an acute care hospital from 8/19/24 - 9/6/24 with the primary diagnosis of a left heel wound.</p> <p>A review of R129's progress notes revealed the following:</p> <p>8/19/24: Wound to left heel has progressively worsened showing majority necrotic tissue with small area of bone showing Resident was sent to hospital for evaluation .</p> <p>Review of the Electronic Medical Record (EMR) for R29 revealed no written transfer notice.</p> <p>Resident #64 (R64):</p> <p>A review of the facility census revealed R64 was sent to an acute care hospital from 10/20/24 - 10/22/24 following a fall with injury.</p> <p>A review of R64's progress notes revealed the following:</p> <p>10/20/24: Called by CNA [certified nursing assistant] to come quick resident was on the floor in front of her wheelchair laying on her right side with right arm behind her . had significant noted skin tear to forehead, left outer eye and left wrist .order to transfer to emergency room obtained .taken to [acute care hospital] .</p> <p>Review of the EMR for R64 revealed no written transfer notice.</p> <p>On 10/24/24 at 9:01 AM, an interview was conducted with the Nursing Home Administrator (NHA) who verified transfer notifications were not being completed. The NHA stated, I didn't realize it wasn't getting done.</p> <p>Review of facility policy titled, Involuntary Transfer and Discharge Policy reviewed 4/12/18, read, in part:</p> <p>.Notice concerning the transfer or discharge shall be provided to the resident, resident representative, long term care ombudsman, state survey agency, and the physician. A copy shall also be placed in the resident's file .</p>		

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<p>F 0625</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49397</p> <p>Based on interview and record review, the facility failed to provide written notification of the bed-hold policy to residents or their representatives prior to hospital transfer for five residents (Resident #18, Resident #124, Resident #64, Resident #22, and Resident #29) including details of duration of the bed-hold and conditions of readmission.</p> <p>Findings include:</p> <p>During a review of Resident #18's (R18) medical record, it was noted there was not a bed-hold document listed in R18's clinical documentation for his transfers to the emergency department on 10/11/24, or 10/12/24.</p> <p>While conducting an interview on 10/23/24 at 10:17 AM, R18 stated he did not recall being educated on his bed being held when he was sent to the hospital. R18 stated he just assumed it would be there waiting for him, since he had been in the facility since December of 2023.</p> <p>During an interview conducted on 10/23/24 at 11:55 AM, the Director of Nursing (DON) and Regional Clinical Nurse N could not locate the notice of bed holds in R18's chart.</p> <p>40383</p> <p>Resident 124 (R124)</p> <p>On 10/6/24, R124 was sent out to the hospital due to unresponsiveness and was returned/readmitted to the facility on [DATE].</p> <p>On 10/20/2024, R124 was sent out to the hospital after discussion with the on-call physician. R124 was readmitted on the same day.</p> <p>A review of the Electronic Medical Record (EMR) revealed no evidence a written bed hold notice was provided to R124 or the Resident Representative for R124's transfers to the hospital on 10/06/24 or 10/20/24.</p> <p>45123</p> <p>Resident #22 (R22)</p> <p>Review of the Minimum Data Set (MDS) assessment, dated 12/6/23, revealed R22 was admitted to the facility on [DATE] with a primary diagnosis of sepsis (a potentially life-threatening condition that arises when the body's response to infection causes injury to its own tissues and organs).</p> <p>Review of R22's electronic medical records (EMR) revealed R22 was transferred out of the facility on 7/29/24 with a readmit back to the facility on [DATE].</p> <p>(continued on next page)</p>

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<p>F 0625</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of R22's EMR revealed R22 was transferred to the ED from wound care clinic for deteriorating wound on 4/17/24 with a readmit back to the facility on [DATE].</p> <p>On 10/22/24 at 10:25 AM, R22 was asked about their transfers out and if they recalled it being two or three times in the last six months and replied, I do not recall. R22 was then asked if they recalled receiving any bed hold paperwork and replied, Not that I remember. No one gave me any papers when I was sent to the hospital.</p> <p>49302</p> <p>Resident #29 (R29):</p> <p>A review of the facility census revealed R29 was sent to an acute care hospital from 8/19/24 - 9/6/24 with the primary diagnosis of a left heel wound.</p> <p>A review of R129's progress notes revealed the following:</p> <p>8/19/24: Wound to left heel has progressively worsened showing majority necrotic tissue with small area of bone showing Resident was sent to hospital for evaluation .</p> <p>A review of the Electronic Medical Record (EMR) revealed no evidence of a written bed hold notice provided to R29 or a Resident Representative.</p> <p>Resident #64 (R64):</p> <p>A review of the facility census revealed R64 was sent to an acute care hospital from 10/20/24 - 10/22/24 following a fall with injury.</p> <p>A review of R64's progress notes revealed the following:</p> <p>10/20/24: Called by CNA [certified nursing assistant] to come quick resident was on the floor in front of her wheelchair laying on her right side with right arm behind her . had significant noted skin tear to forehead, left outer eye and left wrist .order to transfer to emergency room obtained .taken to [acute care hospital] .</p> <p>A review of the EMR revealed no evidence of a written bed hold notice provided to R64 or a Resident Representative.</p> <p>On 10/24/24 at 9:01 AM, an interview was conducted with the Nursing Home Administrator (NHA) who verified bed hold notifications were not being completed. The NHA stated, I didn't realize it wasn't getting done.</p> <p>Review of facility policy titled, Bed Hold Upon Transfer revised 2/1/22, read, in part:</p> <p>(continued on next page)</p>		

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<p>F 0625</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>.Before a resident is transferred to the hospital or goes on therapeutic leave, the facility will provide to the resident and/or the resident representative written information that specifies: a. The duration of the bed hold policy . b. The reserve bed payment policy in the state plan policy . c. The facility policies regarding bed-hold periods to include allowing a resident to return to the next available bed . d. Conditions upon which the resident would return to the facility . The facility will keep a signed and dated copy of the bed-hold notice information given to the resident and/or resident representative in the resident's file.</p>		

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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49302</p> <p>This deficiency pertains to Complaint Intake MI00146981.</p> <p>Based on observation, interview, and record review, the facility failed to provide necessary treatment and services to prevent the development and promote the healing of pressure injuries for three Residents (#29, #22, and #36) of three residents reviewed for wounds. This deficient practice resulted in the deterioration of a left heel pressure injury in one Resident (#29) resulting in gangrene, sepsis, and the need for surgical amputation.</p> <p>Findings include:</p> <p>Resident #29 (R29):</p> <p>Review of R29's electronic medical record (EMR) revealed initial admission to the facility on [DATE] with diagnoses including vascular dementia and type two diabetes. Review of R29's most recent Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 6, indicative of severe cognitive impairment.</p> <p>On 10/22/24 at 10:25 AM, R29 was observed sitting at the nurses' station in a wheelchair. R29 was observed with a compression sleeve on her left lower limb which appeared to be amputated at approximately mid-shin down.</p> <p>Review of R29's weekly Skin Assessments revealed a new abnormal skin area located the second digit of the right foot on 10/23/23.</p> <p>Review of progress note dated 10/27/23 at 7:30 AM, read, in part:</p> <p>.called to room by CNA [certified nursing assistant] for report of pressure injury to left heel. Back of heel open with loss of first layer of skin, purple area to center of wound, skin around wound intact, small amount of clear liquid drainage mixed with scant amount of blood .</p> <p>The next documentation of R29's left heel wound was recorded on 3/21/24, labeled as an existing abnormal skin area, nearly 5 months after the initial identification of the skin impairment.</p> <p>Review of R29's initial Wound Evaluation, dated 10/27/24, read:</p> <p>Deep Tissue Injury .left heel . in-house acquired . area 16.61 cm2 [centimeters] .</p> <p>Review of Wound Care Clinic progress notes revealed the following orders:</p> <p>-1/24/24: Keep weight off of affected area/limb at all times . offload heels - wear pillow boot at all times .</p> <p>-3/11/24: Keep weight off of affected area/limb at all times . offload heels - wear pillow boot at all times .</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>-4/24/24: Keep weight off of affected area/limb at all times . offload heels - wear pillow boot at all times .</p> <p>Review of R29's physician orders read, Blue boots to bilateral feet while in bed, initiated 3/19/24.</p> <p>Review of R29's Plan of Care revealed a Focus that read, Resident is at risk for impaired skin integrity . with the following intervention initiated 1/12/24: Apply offloading heel protectors in bed as resident tolerates.</p> <p>On 10/23/24 at 3:56 PM, an interview was conducted with Assistant Director of Nursing (ADON) I who stated R29's pressure reducing interventions included turning and repositioning, a specialty mattress, and an offloading padded boot. When asked the frequency in which the offloading boot should have been applied, ADON I stated, all the time. When asked why the care plan specified the heel protectors should be worn in bed only, ADON I stated the care plan was never revised to reflect updated interventions. ADON I verified the CNAs were not provided with the correct interventions.</p> <p>On 10/23/24 at 12:45 PM, an interview was conducted with CNA U who recollected R29 had a blue boot to protect her heel. When asked how often R29 was required to wear the boot, CNA U could not confirm R29 wore it at all times stating, I tried to make sure it was on during my shift, but we're often short staffed. Stuff like that can get missed</p> <p>Review of R29's Wound Evaluations, revealed the following:</p> <p>-5/21/24: Progress: Deteriorating . Wound shows signs of deterioration at this time including macerated skin to periwound [area surrounding wound], increased erythema [redness], increased purulent drainage at time of assessment .</p> <p>-5/28/24: Progress: Deteriorating . Wound continues to deteriorate. Noted increased purulent drainage, odor to wound after cleaning, macerated tissues to periwound. Provider updated and wound culture obtained. Results back and provider ordered new antibiotic .</p> <p>-7/15/24: Progress: Deteriorating . Wound noted with discoloration to wound bed. Wound itself shows no signs/symptoms of infection at this time. Consulted with wound clinic related to declining wound .</p> <p>-7/30/24: Progress: Deteriorating . Wound shows deterioration this week with increased slough to wound bed. Periwound red but blanchable. No warmth to touch. Resident states occasional pain to area .</p> <p>-8/12/24: Progress: Deteriorating . Wound measurement shows nominal change but visible deterioration this week with brown eschar forming over 70% of the wound bed. PCP [primary care physician] was informed and witnessed. Standing order to send resident to ER [emergency room] for evaluation if wound worsens .</p> <p>Review of R29's EMR revealed the following progress note:</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>8/19/24 at 10:40 AM: Wound to left heel has progressively worsened showing majority necrotic tissue with small area of bone showing . S/Sx [signs/symptoms] of localized infection present. Resident was sent to hospital for evaluation .</p> <p>Review of R29's plan of care revealed no updated care plan interventions since 1/12/24.</p> <p>Review of R29's ER History and Physical, dated, 8/20/24, read, in part:</p> <p>This patient presents with left foot diabetic gangrene with associated sepsis and is at increased risk of septic shock and death .</p> <p>Review of R29's hospital discharge summary, dated 9/6/24, read, in part:</p> <p>.female .was admitted to our hospital on 8/20/24 with left calcaneal [heel] diabetic ulcer . patient given surgery here, it was felt that she will unlikely heal the left wound. Left below-knee amputation was recommended. She was taken to the OR [operating room] on 8/28/24 and underwent left below knee-amputation .</p> <p>On 10/24/24 at 9:01 AM, an interview was conducted with the Nursing Home Administrator (NHA) and Director of Nursing (DON) regarding R29's left heel pressure injury and subsequent amputation. The NHA and DON were unsure why the order for heel protection at all times was never reflected in R29's plan of care nor why updated interventions were not added despite deterioration of the wound. The DON could not explain R29's left heel injury was not documented on a skin assessment until 3/21/24 after initial identification on 10/27/23. The NHA stated, That's a big problem.</p> <p>Review of facility policy titled, Pressure Ulcer/Skin Breakdown - Clinical Protocol, reviewed 3/20/24, read, in part:</p> <p>.Because a resident at risk can develop a pressure ulcer/pressure injury (PU/PI) within hours of the onset of pressure, the at-risk resident needs to be identified and have interventions implemented promptly to attempt to prevent PU/PI .</p> <p>45123</p> <p>Resident #22 (R22)</p> <p>Review of R22's admission minimum data set (MDS), dated [DATE], revealed R22 did not have any open areas or impairments to their skin integrity, was at risk for developing pressure ulcers, and rejection of care.</p> <p>Review of R22's significant change MDS, dated [DATE], revealed R22 had developed one unstageable pressure ulcer and did not have any rejection of care.</p> <p>Review of R22's significant change MDS, dated [DATE], revealed R22 had developed a stage four pressure (severe skin tissue damage) ulcer.</p> <p>Review of R22's quarterly MDS, dated [DATE], revealed R22 had an existing stage four pressure ulcer and lacked any rejection of cares.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 10/21/24 at 1:16 PM, an observation was made of R22 lying in their bed. R22 had a wound vac device on their nightstand with a clear plastic tubing connected to the wound vac device. The plastic tubing was not connected to the other end of the wound dressing and was turned off. R22 was asked how long the wound vac had been turned off and replied, Since last night.</p> <p>On 10/21/24 at 1:30 PM, an interview was conducted with License Practical Nurse (LPN) M and was asked why R22 has wound care solution in their room that belongs to a different resident and replied, That is an excellent question. LPN M was asked why R22's wound vac is off and replied, The night shift nurse turned it off because it was alarming. All nurses have been educated on how to change R22's dressing and use the wound vac. I just don't trust them all to change R22's dressing and I just haven't gotten to it yet today. LPN M was asked what time they arrived at the facility today and replied, Eight o'clock this morning. Typically, we try and change them first thing in the morning. I found some supplies in the other storage room. I will change the dressing next. R22's wound vac dressing change was completed at 2:00 PM on 10/21/24 by LPN M.</p> <p>On 10/23/24 at 12:30 PM, an observation was made of R22 in their room sitting on the side of their bed eating lunch. R22 was asked if his wound vac was working properly today and replied, No, I shut it off because it was alarming.</p> <p>On 10/23/24 at 12:45 PM, an interview was conducted with LPN K and was asked if they were aware that R22's wound vac was turned off and replied, Yes, but I haven't had a chance to change the wound vac dressing. LPN K was asked if LPN M was aware so they could assist with the dressing change and replied, No. LPN M completed the dressing at 2:05 PM on 10/23/24 for R22 that was turned off at 10:00 AM.</p> <p>Review of R22's physician order, dated 8/27/24, read in part, NPWT (negative pressure wound therapy) [A treatment that uses a wound vac to help wounds heal] for coccyx: Change every Mon (Monday), Wed (Wednesday), Fri (Friday) days. Cleanse wound with wound cleanser, pat dry, apply skin sealant (skin prep) to peri wound, fill dead space with black foam, cover with sealant cover film and apply to NPWT tubing .</p> <p>Review of R22's physician order, dated 8/28/24, read in part, PRN (as needed); Coccyx. When Wound Vac fails or is not available. Wash gently with wound cleansing solution, pat dry. Apply calcium alginate to wound bed cover with ABD (abdominal) pad. Secure in place with tape . R22's as needed dressing change for their coccyx wound was not signed out on the treatment administration record (TAR) when the wound vac was turned off that evening.</p> <p>On 10/24/24 at 10:30 AM, an interview was conducted with the Director of Nursing (DON), and was asked what kind of dressing R22 had on when their wound vac had been turned off the night of 10/20/24 and replied, The night nurse did not apply the as needed dressing change. The nurse just took off the wound vac dressing, left the foam in place, covered the coccyx wound with an ABD pad, and secured the dressing with tape. The nurse did not do it correctly.</p> <p>Resident #36 (R36)</p> <p>Review of R36's quarterly MDS, dated [DATE], revealed no impairments to their skin or open areas.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of R36's quarterly MDS, dated [DATE], revealed one unstageable open area of the skin and at risk for developing open areas or impairments of the skin.</p> <p>Review of R36's quarterly MDS, dated [DATE], revealed on stage three pressure ulcer of the skin, not present on admission, and lack any rejection of cares.</p> <p>On 10/21/24 at 12:35 PM, an interview was conducted with R36 in their room. R36 was lying in bed with the head of the bed up to approximately 80 degrees and was slouched down in an appearing uncomfortable position. R36 was asked if they had any open areas and replied, maybe so. R36 lacked any pillow behind her head during this observation.</p> <p>On 10/22/24 at 11:15 AM, an observation was made of R36 lying in their bed with the head of the bed at approximately a 70 to 80 degrees and was slouched down and hunched over asleep.</p> <p>On 10/24/24 at 8:45 AM, an observation was made of R36 lying in their bed with the head of the bed at approximately a 70 to 80 degrees and was slouched down and hunched over watching TV. R36 was asked if staff reposition them or remind them to reposition and replied, No. R36 was asked if they use a pillow behind their back to help offload and replied, I don't have a pillow behind my back. Should I have one?</p> <p>Review of R36's care plan, dated 8/29/24, read in part, .Focus: Resident has impaired skin integrity as evidence by: Stage 3 pressure ulcer (full thickness tissue loss) to upper spine .Interventions: Encourage resident to offload presure (sic) by repositioning self. Resident prefers to sit with head of bed at 30 - 45 degrees per .preference .Offer turn and Reposition, side to side (limit time on .back .) using pillows/wedge to prop behind back PRN (as needed)</p> <p>Review of R36's wound evaluation, dated 3/24/24, revealed an unstageable pressure ulcer that was six hours old, in house acquired, located on their spine, and measured 2.27 centimeters (cm) in length by 1.18 cm in width.</p> <p>Review of physical therapy consult note, dated 3/25/24, read in part, .Reason for screen: new ulcer to upper spine. Findings: PT (physical therapy) screen only. Pt. (patient) does not want therapy and is at baseline with functional mobility. Pt. does sit on EOB (edge of bed) frequently and rarely lays on .back per nurse .</p> <p>Review of R36's physician progress note, dated 4/4/24, revealed the lack of acknowledgement that R36 had any open areas or skin impairments, and the skin section of the progress note was blank.</p> <p>Review of R36's physician progress note, dated 4/18/24, read in part, .Asked to see patient for wound midback .wound midback approximately 2 cm x 0.5 cm, stage 2, minimal surrounding erythema (redness) .1. Wound care consult .</p> <p>Review of R36's wound clinic consult discharge instructions, dated 5/13/24, read in part, .Turn every 2 hours. Avoid position directing pressure to Wound site. Limit side lying to 30 degrees tilt. Limit HOB (head of bed) elevation to 30 degrees in bed .</p> <p>Review of R36's wound evaluation, dated 5/30/24, revealed a stage three pressure ulcer, in house acquired, located on their spine, and measured 0.83 cm length by 0.44 cm width by 0.2 cm depth.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of R36's wound clinic consult note, dated 6/10/24, read in part, .Sharp debridement performed . Recheck in 1 month.</p> <p>Review of R36's wound clinic consult note, dated 8/6/24, read in part, .The wound is again covered with rather adherent slough. Sharp debridement performed .Recheck in 3 weeks.</p> <p>Review of R36's wound clinic consult note, dated 9/4/24, read in part, .She was placed on 10 days of doxycycline (antibiotic) at the nursing home for concern for wound infection. The wound had been improving the first 2 months of treatment, but then started to increase in size .claims .is not lying on it or pressing against it when seated. I would like staff to ensure this is the case .If .is leaning against it when seated, flat memory foam pillow should be used to offload pressure. Wound sharply debrided . return in 2 weeks for a recheck</p> <p>Review of R36's wound clinic consult note, dated 9/18/24, read in part, .measuring larger .continues to report .is not lying on it .Remainder of the wound sharply debrided .Ensure pressure is completely offloaded . Recheck in 1 month .</p> <p>Review of R36's wound evaluation, dated 10/21/24, revealed a stage 3 pressure ulcer to their spine, facility acquired, and measured 1.79 cm length by 1.65 cm width by 1.0 cm depth.</p> <p>On 10/24/24 at 9:21 AM, an interview was conducted with the Assistant Director of Nursing (ADON) / Registered Nurse (RN) I and was asked how R36's had developed a stage 3 pressure ulcer and replied, I am not sure. We identified there was an increase in pressure wounds around March and so we did a skin sweep and identified residents that had impaired skin or were at risk for breakdown. We added interventions for them at the time. That is when I believe R36's skin impairment was first identified. Interventions for turning and repositioning were added. We got rid of all the heavy absorbant pads because we felt they were adding extra moisture to the skin. The ADON / RN I was asked when the physician is made aware of newly identified open areas to residents' skin and replied, I would get the physician involved if a resident had a reddened skin area that was blanchable after the first few days it had not improved. The ADON / RN I was asked about wound vacs and staff training and replied, All nursing staff are trained on how to use and should be competent to do wound vac dressing changes. Wound vacs are a hit and miss for working.</p> <p>On 10/24/24 at 11:00 AM, an interview was conducted with the Director of Nursing (DON) and was asked if there were any added interventions to R36's care plan now that they were lying on their back more frequently and replied, No. I guess we need to have her evaluate by physical therapy again and see if they have any suggestions that would help with offloading. The DON confirmed R22's wound vac should not have been turned off for more than the amount of time to redress a new wound vac dressing and staff should be assessing proper function of the wound vac with every encounter with R22 and at a minimum of every two hours.</p> <p>Review of policy titled, Pressure Ulcer/Skin Breakdown - Clinical Protocol, dated 3/20/24, 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 unless the individual's clinical condition demonstrates that they were unavoidable; and a resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice to promote healing, prevent infection, and prevent new ulcers from developing .</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49302</p> <p>This Deficient Practice Statement (DPS) has two parts: A and B.</p> <p>DPS A:</p> <p>Based on observation, interview, and record review, the facility failed to provide adequate supervision resulting in a fall with major injury for one Resident (#64) of five residents reviewed for accident hazards and supervision. This deficient practice resulted in serious bodily injury including a head laceration and a cervical (neck) fracture for Resident #64.</p> <p>Findings include:</p> <p>Resident #64 (R64):</p> <p>Review of R64's electronic medical record (EMR) revealed initial admission to the facility on [DATE] with diagnoses including osteoporosis, repeated falls, a stroke affecting the right dominant side, and toxic encephalopathy (a brain condition often resulting in changes in cognitive function). Review of R64's most recent Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 8, indicative of moderate cognitive impairment.</p> <p>Review of R64's EMR revealed the following Nurse's Note:</p> <p>10/20/24 at 2:15 PM: Resident had unwitnessed fall from wheelchair in front of 300 hall nurse desk, had large skin tear to forehead, left eye and left wrist .transferred per EMS [Emergency Medical Services] to emergency room for tx [treatment] and evaluation.</p> <p>On 10/23/24 at 11:50 AM, R64 was observed laying in bed with a large hematoma (bruise) to her left eye and a laceration across her forehead that had been secured with sutures (stiches).</p> <p>On 10/23/24 at 10:29 AM, an interview was conducted with Certified Nursing Assistant (CNA) E who verified she was familiar with R64's level of care. CNA E recalled responding to a fall code on 10/20/24 where she witnessed R64 on the floor with a bleeding laceration on her forehead. When asked R64's level of mobility, CNA E stated R64 for dependent for mobility and could not propel herself in a wheelchair. CNA E stated, Somebody placed her at the nurse's station for better supervision . I think this fall was after lunch, and residents are often placed at the nurse's station after lunch because there is only one care assistant [CNA] on the hall and the other is helping in the dining room.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 10/23/24 at 11:24 AM, a telephone interview was conducted with Registered Nurse (RN) O who verified she responded to the fall code for R64 on 10/20/24. RN O stated in previous days, R64 started trying to get out of bed and had sustained falls from bed, so she was brought to the nurses' station after lunch for increased supervision by the staff who were charting. RN O stated prior to the fall, she responded to a call light in a private resident room with the only CNA on duty on R64's unit. In the process of assisting in the private room, other RN O stated other staff must have left the nurses' station which left R64 unattended. RN O stated, We were spread too thin that day [in regard to staffing levels]. When asked if resident supervision is lacking when staffing level are short, RN O responded, Yes, definitely.</p> <p>On 10/23/24 at 2:18 PM, a phone interview was conducted with RN P who verified she was working on the hall adjacent to the nurses' desk by which R64 was stationed. RN P recollected responding to hearing a loud crash while in a nearby resident room and observing R64 laying on the floor. When asked about contributing factors to R64's fall, RN P stated, There was only one nursing aide on the hall that day Staffing has been challenging.</p> <p>Review of R64's EMR revealed the following entries:</p> <p>1. Nurses' Notes on 10/22/2024 at 17:09 [5:09 PM]: Resident returned from hospital via EMS on comfort care .Resident with large, sutured laceration of the forehead, Scattered skin tears of the L [left] wrist . Resident mostly non-responsive but did open eyes with painful stimuli. Per MD [medical doctor] at hospital, resident has remained NPO [nothing by mouth] and is unable to swallow pills, food or drinks .</p> <p>2. Pertinent Charting-Change in Condition note on 10/22/2024 at 20:59 [8:59 PM]: Change identified: decline with mental status and ADL [activities of daily living], unresponsive .</p> <p>3. Pertinent Charting-Change in Condition note on 10/23/2024 at 9:49 AM [8:59 PM]: Originally identified change: Fall with change in mental status. Resident spent time in hospital following fall with head injury. Resident has returned to facility on comfort care with several skin issues, new C2 [second cervical (neck) vertebrae] fracture, change [in] LOC [level of consciousness] and new comfort care order for EOL [end-of-life] care.</p> <p>On 10/24/24 at 9:01 AM, an interview was conducted with the Nursing Home Administrator (NHA) and the Director of Nursing (DON) who confirmed low staffing levels and subsequent inadequate supervision has been an ongoing issue at the facility.</p> <p>Review of facility policy titled, Accidents and Supervision, revised 12/27/23, read, in part:</p> <p>.Supervision is an intervention and a means of mitigating accident risk. The facility provides adequate supervision to prevent accidents .</p> <p>DPS B:</p> <p>Based on observation, interview, and record review, the facility ensure supervision during smoke for one Resident (#15) of five residents reviewed for accident hazards and supervision.</p> <p>Findings include:</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Resident #15 (R15)</p> <p>Review of R15's electronic medical record (EMR) revealed initial admission to the facility on [DATE] with diagnoses including tobacco use, history of falling, chronic obstructive pulmonary disease (COPD), and vascular dementia.</p> <p>On 10/22/24 at 3:02 PM, R15 was observed sitting on a four-wheeled walker outside the main facility entrance smoking a cigarette unsupervised.</p> <p>On 10/23/44 at 4:45 PM, R15 was again observed sitting on a four-wheeled walker outside the main facility entrance smoking a cigarette unsupervised.</p> <p>On 10/23/24 at approximately 4:50 PM, facility management was made aware of R15's whereabouts and lack of supervision. Assistant Administrator R stated, That's [R15], he's allowed to smoke by himself. When asked about R15's smoking plan of care, Assistant Administrator R was unsure of R15's interventions.</p> <p>Review of R15's Plan of Care revealed the following Goal, initiated 8/12/24: Resident will smoke safely at the designated area(s) at scheduled times through the next review. An intervention, initiated 8/12/24 read, Observe the resident's safety during smoking.</p> <p>Review of facility policy titled, Smoking Policy Smoking Campus-Residents, reviewed 5/31/23, read, in part:</p> <p>It is the policy of this facility to establish and maintain safe resident smoking practices . Any restrictions placed on smoking privileges shall be noted on the care plan so that all personnel may be alert[ed] to smoking restrictions . Any resident with smoking privileges shall not be permitted to smoke without direct supervision of a responsible staff member, family member, visitor or volunteer worker and direct supervision must be provided throughout the entire smoking period . All smoking privileges shall be so noted on the care plan .</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49397</p> <p>Based on observation, interview, and record review, the facility failed to assess two residents (Resident #18, Resident #274) of two residents reviewed for the clinical need for urinary catheterization (a tube placed into the bladder to facilitate bladder drainage), leading to inappropriate or potentially unnecessary catheter usage.</p> <p>Findings include:</p> <p>Resident #18 (R18)</p> <p>A review of R18's Electronic Medical Record (EMR) indicated diagnoses of complex regional pain syndrome (chronic condition that causes severe pain dis-proportionate to the injury), morbid obesity (body mass index of 40 or higher), essential hypertension (high blood pressure not caused by medical conditions), fibromyalgia (chronic condition that causes widespread pain, fatigue, and sleep issues), osteoarthritis (degenerative joint disease), irritable bowel syndrome (chronic digestive disorder of the large intestine), sarcopenia (muscle mass, strength, and performance compromised by age), muscle weakness, rheumatoid arthritis(autoimmune disease of the joints causing loss of function), venous insufficiency (condition where veins in legs have trouble returning blood to the heart), depression. R18 was noted to have a BIMS (Brief Interview for Mental Status) of 15/15 identifying intact cognition.</p> <p>During a review of R18's orders it was noted R18 had an order placed on 7/12/24 to change indwelling catheter (Specify size: 16fr (French); balloon:10cc (cubic centimeter) r/t (related to) urinary retention. On 8/16/24 an order was placed for a urology consult per resident request for indwelling catheter and enlarged scrotum.</p> <p>A review of R18's clinical documentation does not indicate a referral has been made to a urologist.</p> <p>A review of R18's care plan indicated the indwelling catheter was placed due to urinary retention. There was not a diagnosis of urinary retention in R18's chart.</p> <p>While conducting an interview with R18 on 10/23/24 at 12:26 PM, R18 stated the catheter was placed after shoulder surgery on 6/3/24. R18 stated the catheter was in place due to urinary urgency, the need to get out of bed quickly, while being unable to get out of bed without help. R18 stated help from staff was not always quick enough, so the facility kept the indwelling catheter in place to help with dignity of not wetting himself or to have peri-care as many times in a day.</p> <p>Resident #274 (R274)</p> <p>(continued on next page)</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of R274 EMR indicated R274 was admitted to the facility on [DATE], with diagnoses including cellulitis (skin infection) of right lower limb, lymphedema (swelling in the body due to build up of lymph fluid), chronic diastolic heart failure (heart is not able to pump enough blood to meet body's needs), paroxysmal atrial fibrillation (upper chambers of heart beat irregularly), morbid obesity (body mass index of 40 or higher), obstructive sleep apnea (throat muscles relax and narrow the airway during sleep, interrupting breathing), essential hypertension (high blood pressure not caused by medical conditions), osteoarthritis (degenerative joint disease), and history of falls.</p> <p>R274 Nursing Admission Evaluation Part 2 completed on 10/17/24 indicated that R274 had an indwelling catheter in place at this time.</p> <p>A review of R274's orders indicated an order placed 10/16/24 change catheter bag as needed</p> <p>A review of R274's care plan shows no indication that R274 has a catheter, or how to care for it.</p> <p>While conducting an interview with the Assistant Director of Nursing (ADON), the ADON stated they were not aware of R274 having an indwelling catheter.</p> <p>On 10/23/24 at 1:33 PM, R274 stated she had her catheter when she came from the hospital. R274 stated the catheter was placed due R274's inability to make it to the bathroom in time not to have a urinary accident.</p> <p>During an interview conducted on 10/23/24 at 3:00 PM, the NHA stated they did not have a policy regarding catheter usage, only catheter care procedures. This indicated no standardized process to evaluate residents for medical need of a catheter or to explore alternative continence management strategies.</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40383</p> <p>Based on observation, interview and record review, the facility failed to ensure ongoing assessment and monitoring for weight fluctuations for two Residents (R61 and R124) of four residents reviewed for nutritional needs. This deficient practice resulted in the potential for inaccurate assessments, continued weight loss or gain, and physical decline. Findings include:</p> <p>Resident 61 (R61)</p> <p>During an interview on 10/22/24 at 7:51 AM, R61 stated he was eating well but not always getting what I want. When asked about his weight R61 stated, They are not weighing me as much as the hospital did, and was unsure of his current weight.</p> <p>The medical record for R61 revealed an admitted [DATE] with diagnoses which included pressure ulcer of the sacral region, diabetes (T2DM), heart failure (CHF), kidney disease (CKD), high blood pressure (HTN) and gastro-esophageal reflux disease (GERD).</p> <p>On 9/17/24 a Minimum Data Set (MDS) assessment was completed. Section K of this document revealed a weight for R61 as 175 pounds. A corresponding initial assessment was completed in the medical record indicating a hospital weight of 79.4 kilograms (or 174.68 pounds).</p> <p>The care plan for R61 initiated on 9/16/24 included a focus of: Resident is at risk for altered nutritional status related to T2DM with/neuropathy, chronic sacral wound, GERD, HTN, CHF, . Date Initiated: 09/16/2024 Interventions for this risk included: Periodically obtain resident's weight, evaluate, and report to Dietitian, Physician/NP (Nurse Practitioner) /PA (Physician's Assistant) and responsible party of significant weight changes. Date Initiated: 09/16/2024</p> <p>No initial weights taken in the facility were found in the medical record.</p> <p>On 9/30/2024 the Registered Dietitian (RD) B completed a Dietary Progress Note which read in part: Note Text: RD requests weight is acquired as resident is receptive, as resident does not have admission weight and admitted on ,d+[DATE]. Resident's appetite is fair to good, but varies, and likely affected by recent COVID infection. Noted that he tested negative on 9/28. Resident receiving wound care on pressure wounds to sacrum and R (right) heel present (on) admission .</p> <p>On 10/1/24 a weight of 149 pounds was recorded in the medical record for R61. No other weights were found despite the last known weight from the hospital that had been used to calculate R61's nutritional needs by RD B was 175 pounds.</p> <p>Resident 124 (R124)</p> <p>On 10/21/24 at 12:37 PM, R124 was observed in the main dining room feeding herself. She did not finish her meal.</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The medical record for R124 revealed an admitted [DATE] with diagnoses which included protein-calorie malnutrition, difficulty swallowing (dysphagia) following a stroke. On 10/4/24 a weight for R124 was recorded as 187 pounds.</p> <p>On 10/6/24, R124 was sent out to the hospital due to unresponsiveness and was returned/readmitted to the facility on [DATE] with additional diagnoses including, aspiration pneumonia due to inhalation of food and vomit.</p> <p>No weight was obtained upon readmission.</p> <p>On 10/20/2024, a nurse note documented Note Text: Resident vomited overnight and produced black, granular vomit all over her bed . R124 was sent out to the hospital after discussion with the on-call physician. R124 was readmitted on the same day.</p> <p>No weight was obtained upon readmission.</p> <p>On 10/21/24 the RD assessment for R124 included, Resident readmitted to facility after re-hospitalization . Reported issues with chewing and swallowing . Needs updated weight x (due to) readmission . RD recommends diet order update .Recommend magic cup order stay in place to provide additional kcal (calorie)/protein at meals RT (related to) malnutrition diagnosis . This assessment listed the weight for R124 as 187 pounds taken on 10/4/24. This weight was the only weight recorded in the medical record. This weight was obtained prior to the two hospital admissions and was the basis for the calculation of R124's nutritional needs.</p> <p>The care plan for R124 included a focus of: Resident is at risk for altered nutritional status related to hx (history) of aspiration pneumonia . pro-cal (calorie) malnutrition ; Interventions for this focus included: Periodically obtain resident's weight, evaluate, and report to Dietitian, Physician/NP/PA and responsible party of significant weight changes. Goals for this focus included: Resident will not have a significant weight loss through next review.</p> <p>During an interview on 10/23/24 at 12:15 PM, the Nursing Home Administrator (NHA) stated resident weights should be taken at least monthly, but weekly for those with pressure areas, and other issues.</p> <p>During a telephone interview on 10/24/24 at 8:33 AM, RD B stated she did have difficulty obtaining the resident's weights to complete assessments and track weight variations.</p> <p>The facility policy titled, Weight Monitoring and dated as last reviewed/revised on 10/26/23 read in part: .5. A weight monitoring schedule will be developed upon admission for all residents:</p> <ul style="list-style-type: none"> a. Weights should be recorded at the time obtained. b. newly admitted residents - monitor weight weekly for 4 weeks. c. Residents with weight loss - monitor weight weekly . 		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49302</p> <p>This deficiency pertains to Complaint Intake MI00146981.</p> <p>Based on observation, interview, and record review, the facility failed to provide sufficient staffing to address the care, needs, and safety of the entire facility population. This deficient practice resulted in unmet care needs and the potential for serious safety issues for all 65 residents of the facility.</p> <p>Findings include:</p> <p>Review of Complaint Intake MI00146981 submitted to the State Agency (SA) read, in part:</p> <p>Complainant is a staff member at [Facility Name]. Complainant states residents are being neglected by being left laying in wet and soiled beds, resident[s] are also not getting showers due to the facility not having enough staffing to keep up and handle the workload .</p> <p>Resident #42 (R42):</p> <p>Review of R42's electronic medical record (EMR) revealed initial admission to the facility on [DATE] with diagnoses including congestive heart failure and need for assistance with personal care. Review of R42's most recent Minimum Data Set (MDS) assessment, dated 9/13/24, revealed a Brief Interview for Mental Status (BIMS) score of 15, indicative of intact cognition. Review of MDS Section H, Bowel and Bladder, revealed always continent was selected for both urinary and bowel continence. Review of MDS Section F, Preferences for Customary Routine and Activities indicated how important is it to you to choose between a tub bath, shower, bed bath, or sponge bath as very important.</p> <p>On 10/23/24 at 10:52 AM, an interview was conducted with R42 who vocalized staffing concerns that impacted her daily cares and preferences. R42 stated on several occasions she has pushed her call button for toileting assistance only to endure a 40-60-minute response time. R42 stated, .I eventually just urinated in my brief. I just can't wait that long to use the bathroom. Another time, I had to resort to defecating in my brief . I feel like a barnyard animal. When asked if the floor staff provide a reason for the delay in response time, R42 responded, When the CNAs (certified nursing assistants) come in [the room], they usually apologize and tell me they're the only one [care assistant] on the hall, or they were helping somebody else, or they were helping a CNA on another hall because a resident requires 2 aides . R42 stated low staffing levels have also led to forfeiting a shower for a bed bath. R42 stated, I a lift [requires a mechanical lift to transfer]. So, I require two people [to operate the lift]. The facility is short-staffed, so I often get bed baths instead of going to the shower. When asked if she preferred showered, R42 stated, Yes.</p> <p>Review of R42's Plan of Care revealed a Focus which read, Resident has an ADL [activities of daily living] self-care deficit . with the following interventions:</p> <p>BATHING: 2-person assist, prefers showers 2x per week .</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>TOILETING: 1 person assist</p> <p>TRANSFERS: 2-person assist, mechanical lift .</p> <p>Review of the Shower Task revealed R42 was given 4 bed baths out of 10 opportunities in a 30-day look back period.</p> <p>Resident #15 (R15)</p> <p>Review of R15's EMR revealed initial admission to the facility on [DATE] with diagnoses including vascular dementia, pressure ulcer of the sacral region, and history of falling. Review of R15's most recent MDS assessment, dated 8/18/24, revealed a BIMS score of 15, indicative of intact cognition. Review of MDS Section F, Preferences for Customary Routine and Activities indicated how important is it to you to choose between a tub bath, shower, bed bath, or sponge bath as very important.</p> <p>On 10/21/24 at 12:35 PM, R15 was observed in his room, sitting at the edge of the bed. R15 was wearing a sweater and sweatpants, both of which appeared to be soiled with food debris. R15 stated, It's really hard to get a shower around here. When asked about his last shower, R15 was unable to recall the exact date but recalled, Last time they asked [if R15 wanted a shower], I was watching a show I really like, which they know, so I think it was a ploy. R15 stated facility mark his shower opportunity as refused instead of offering an alternative time.</p> <p>Review of R15's Plan of Care revealed a Focus which read, Resident has an ADL self-care deficit . with the following interventions:</p> <p>BATHING: 1 person assist, prefers showers 2x per week .</p> <p>Review of the Shower Task revealed options Resident refused or not applicable was selected on 5 of the previous 12 shower opportunities.</p> <p>Resident #61 (R61)</p> <p>Review of R61's EMR revealed initial admission to the facility on [DATE] with diagnoses including pressure ulcers of the sacrum and right heel. Review of R61's most recent MDS assessment, dated 9/17/24, revealed a BIMS score of 15, indicative of intact cognition.</p> <p>On 10/23/24 at 12:54 PM an interview was conducted with R61 who stated he is supposed to receive help repositioning in bed every 2 hours to aid with pressure relief. R61 said, I will go for 5 hours on one side .it's just too long. It starts to get painful. I will put my call light on to remind them, but a CNA will come in sometimes and say 'I can't do it by myself, I need help from somebody else but she is the only one working on the hallway . They need more staff.</p> <p>Review of R61's Plan of Care revealed a Focus which read, Resident has an ADL [activities of daily living] self-care deficit . with the following intervention:</p> <p>BED MOBILITY: 2-person assist.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>An additional Plan of Care Focus read, Resident has impaired skin integrity as evidenced by: MASD [moisture-associated skin damage] to the sacrum, unstageable pressure injury to the right heel with the following intervention:</p> <p>Encourage/assist with turning and repositioning every 2 hours .</p> <p>Review of the Turning and Repositioning Task in a 2-week look back period between the hours of 8:00 PM - 8:00 AM revealed frequencies of repositioning (out of 6 possible care-planned opportunities):</p> <p>10/10/24: 3</p> <p>10/11/24: 2</p> <p>10/12/24: 0</p> <p>10/13/24: 1</p> <p>10/14/24: 2</p> <p>10/15/24: 0</p> <p>10/16/24: 2</p> <p>10/17/24: 1</p> <p>10/18/24: 2</p> <p>10/19/24: 1</p> <p>10/20/24: 3</p> <p>10/21/24: 2</p> <p>10/22/24: 2</p> <p>10/23/24: 1</p> <p>On 10/23/24 at 10:13 AM, an interview was conducted with CNA Q who stated, Staffing is a nightmare. When asked how staffing shortages impact the facility residents, CNA Q stated, I'll work through my lunches and breaks and still not see everybody [residents] . I know for a fact residents are laying in wet briefs for long periods of time . I just don't have time to get to them. Showers are getting put off . and I know [R61] doesn't get repositioned as often as he should .</p> <p>Resident #64 (R64):</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Review of R64's EMR revealed initial admission to the facility on [DATE] with diagnoses including osteoporosis, repeated falls, a stroke affecting the right dominant side, and toxic encephalopathy (a brain condition often resulting in changes in cognitive function). Review of R64's most recent MDS assessment dated [DATE], revealed a BIMS score of 8, indicative of moderate cognitive impairment.</p> <p>Review of R64's EMR revealed the following Nurse's Note:</p> <p>10/20/24 at 2:15 PM: Resident had unwitnessed fall from wheelchair in front of 300 hall nurse desk, had large skin tear to forehead, left eye and left wrist .transferred per EMS [Emergency Medical Services] to emergency room for tx [treatment] and evaluation.</p> <p>On 10/23/24 at 11:50 AM, R64 was observed laying in bed with a large hematoma (bruise) to her left eye and a laceration across her forehead that had been secured with sutures.</p> <p>On 10/23/24 at 10:29 AM, an interview was conducted with Certified Nursing Assistant (CNA) E who verified she was familiar with R64's level of care. CNA E recalled responding to a fall code on 10/20/24 where she witnessed R64 on the floor with a bleeding laceration on her forehead. When asked R64's level of mobility, CNA E stated R64 for dependent for mobility and could not propel herself in a wheelchair. CNA E stated, Somebody placed her at the nurse's station for better supervision . I think this fall was after lunch, and residents are often placed at the nurse's station after lunch because there is only one care assistant [CNA] on the hall and the other is helping in the dining room.</p> <p>On 10/23/24 at 11:24 AM, a telephone interview was conducted with Registered Nurse (RN) O who verified she responded to the fall code for R64 on 10/20/24. RN O stated in previous days, R64 started trying to get out of bed and had sustained falls from bed, so she was brought to the nurses' station after lunch for increased supervision by the staff who were charting. RN O stated prior to the fall, she responded to a call light in a private resident room with the only CNA on duty on R64's unit. In the process of assisting in the private room, other RN O stated other staff must have left the nurses' station which left R64 unattended. RN O stated, We were spread too thin that day [in regard to staffing levels]. When asked if resident supervision is lacking when staffing level are short, RN O responded, Yes, definitely.</p> <p>On 10/23/24 at 2:18 PM, a phone interview was conducted with RN P who verified she was working on the hall adjacent to the nurses' desk by which R64 was stationed. RN P recollected responding to hearing a loud crash while in a nearby resident room and observing R64 laying on the floor. When asked about contributing factors to R64's fall, RN P stated, There was only one nursing aide on the hall that day Staffing has been challenging.</p> <p>On 10/24/24 at 9:01 AM, an interview was conducted with the Nursing Home Administrator (NHA) and the Director of Nursing (DON) who verified low staffing levels has been an ongoing issue at the facility.</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45123</p> <p>Based on observation, interview, record review, the facility failed to destroy discontinued schedule two medications in a timely manner for three medications carts reviewed of four medication carts for medication storage and used another resident's medication on a different resident.</p> <p>On [DATE] at 1:16 PM, an observation was made of Resident #22 (R22) in their room. R22 was asked if it was alright to look around for their wound care supplies and replied, Yeah, sure go right ahead. In R22's closet an observation was made of another residents acetic acid 1000 milliliters solution. R22 was asked if the facility staff was using the solution on them and replied, Yes, they use that on my lower legs when they wrap them.</p> <p>Review of R22's physician order, dated [DATE], read in part, Acetic Acid Irrigation Solution 0.25% .Apply to BLE (bilateral lower extremities) topically in the afternoon every Tue (Tuesday), Fri (Friday) for edematous state .</p> <p>On [DATE] at 1:30 PM, an interview was conducted with Licensed Practical Nurse (LPN) M, and was asked why another resident's wound care supplies were in R22's room and being used on R22, and replied, That is an excellent question. It should not be in the room and should be stored in the wound care cart. R22 should have their own supplies.</p> <p>On [DATE] at 11:25 AM, a review of the medication cart for 100 hall was conducted. The narcotic sign put sheet was reviewed for as needed antipsychotic medications and was found to have a sign out sheet for Resident #19 (R19). The sign out sheet was for lorazepam 0.5 milligrams (mg), give 1 tablet by mouth every 24 hours as needed for anxiety.</p> <p>Review of R19's EMR, physician order dated [DATE], revealed the following, lorazepam 0.5 mg, give 1 tablet by mouth every 24 hours as needed for anxiety and with an end date of [DATE]. R19's lorazepam physician order was expired and had not been reordered.</p> <p>On [DATE] at 11:25 AM, a review of the medication cart for 300 hall was conducted. The narcotic sign put sheet was reviewed for as needed antipsychotic medications and was found to have a sign out sheet for Resident #49 (R49). The sign out sheet was for lorazepam 1 mg, give 1 tablet by mouth every 8 hours as needed for anxiety.</p> <p>Review of R49's EMR, physician order dated [DATE], revealed the following, lorazepam 1 mg, give 1 mg by mouth every 8 hours as needed for anxiety for 14 days, and end date [DATE]. R49's lorazepam physician order was expired and had not been reordered.</p> <p>On [DATE] at 11:25 AM, a review of the medication cart for 400 hall was conducted. The narcotic sign put sheet was reviewed for as needed antipsychotic medications and was found to have a sign out sheet for Resident #37 (R37) and Resident #66 (R66). The sign out sheets for R37 was for lorazepam 0.5 mg, give 1 tablet by mouth every 12 hours as needed for anxiety. The sign out sheets for R66 was for lorazepam 0.5 mg, give 1 tablet by mouth every 24 hours as needed for anxiety.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of R37's EMR, physician order dated [DATE], revealed the following, lorazepam 0.5 mg, give 0.5 mg by mouth every 12 hours as needed for anxiety for 14 days, and end date [DATE]. R37's lorazepam physician order was expired and had not been reordered.</p> <p>Review of R66's EMR, physician order dated [DATE], revealed the following, lorazepam 0.5 mg, give 0.5 mg by mouth every 24 hours as needed for anxiety for 14 days, and end date [DATE]. R66's lorazepam physician order was expired and had not been reordered.</p> <p>Review of policy titled, Discontinued Medications, undated, read in part, Policy: When medications are discontinued by the prescriber or the resident is discharged and medications are not sent with the resident, the medications are stored in a secure and separate area from the active medications .Procedures: 1. The nurse documents the order to discontinued the medication in the resident's paper or electronic record. 2. Medications are removed from the medication cart or active supply immediately upon receipt of an order to discontinue (to avoid inadvertent administration) .</p> <p>Review of facility policy titled, Medication Administration, dated [DATE], read in part, Policy: Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection. Policy Explanation and Compliance Guidelines .10. Review MAR to identify medication to be administered. 11. Compare medication source with MAR to verify resident name, medication name, form, dose, route, and time of administration .</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45123</p> <p>This deficient practice has two different DPS's. DPS A and DPS B.</p> <p>DPS A:</p> <p>Based on interview and record review the facility failed to obtain informed consent and obtain physician orders for psychotropic medication for Residents (R19 and R49) of four residents reviewed for unnecessary psychotropic medications.</p> <p>Resident #19 (R19)</p> <p>Review of the Minimum Data Set (MDS) assessment, dated 5/24/24, revealed R19 was admitted to the facility on [DATE] with a primary diagnosis of contact with and suspected exposure to Covid-19.</p> <p>On 10/23/24 at 4:36 PM, review of R19's electronic medical records (EMR) revealed R19 had a physician order for lorazepam 0.5 mg (milligram), give 0.5 mg by mouth every 8 hours as needed for anxiety related to generalized anxiety disorder for 2 weeks, start date 5/9/24 and stop date 5/23/24.</p> <p>Review of R19's EMR, physician order dated 7/18/24, revealed the following, lorazepam 0.5 mg, give 1 tablet by mouth every 24 hours as needed for anxiety and with an end date of 9/12/24. R19's order recap had a discontinued reason listed as: Needs to be reordered every 14 days.</p> <p>Review of R19's physician progress note, dated 7/18/24, lacked any documentation regarding the use of lorazepam and the need to continue therapy or how R19 was affected by the medication.</p> <p>Review of R19's pharmacy monthly review, dated 8/5/24, read in part, .This patient is on prn (as needed) lorazepam. Per CMS all prn psych meds have stop dates after 14 days. Please add stop date and revisit order every 14 days . Physician responded on 9/1/24 and verified a prn with continued renew every 14 days.</p> <p>Review of R19's controlled substance record sheets, dated 8/15/24 through 10/17/24, revealed that R19 received lorazepam 0.5 mg on 9/30/24 at 7:00 PM, 10/1/24 at 7:00PM, 10/3/24 at 7:00 PM, 10/8/24 at 7:00 PM, 10/9/24 at 7:00 PM, 10/10/24 at 7:00 PM, 10/14/24 at 7:20 PM, 10/15/24 at 7:25 Pm, and 10/17/24 at 7:00 PM. R19 received nine doses of lorazepam without a physician order.</p> <p>Review of R19's EMR, physician order dated 9/12/24, revealed the following, lorazepam 0.5 mg, give 1 tablet by mouth every 24 hours as needed for anxiety and with an end date of 9/26/24.</p> <p>Review of R19's consent to use psychotropic medication therapy, dated 5/17/23, revealed the lack of a dose as indicated on the consent sheet and was over a year old. The psychotropic medication lorazepam had been started and stopped several times without a renewed or updated consent in R19's EMR.</p> <p>Resident #49 (R49)</p> <p>(continued on next page)</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the MDS assessment, dated 5/8/23, revealed R49 was admitted to the facility on [DATE] with a primary diagnosis of contact with and suspected exposure to Covid-19.</p> <p>On 10/23/24 at 4:30 PM, review of R49's EMR revealed R49 had a physician order for lorazepam 1 mg, give 1 mg by mouth every 8 hours as needed for anxiety, start date 2/20/24 and end date 5/5/24.</p> <p>Review of R49's EMR, physician order dated 5/7/24, revealed the following, lorazepam 1 mg, give 1 mg by mouth every 8 hours as needed for anxiety for 14 days, and end date 5/21/24.</p> <p>Review of R49's EMR, physician order dated 5/22/24, revealed the following, lorazepam 1 mg, give 1 mg by mouth every 8 hours as needed for anxiety, and end date 6/19/24.</p> <p>Review of R49's pharmacy monthly review, dated 6/11/24, read in part, .This patient is on prn lorazepam. Per CMS all prn psych meds have stop dates after 14 days. Please add stop date and revisit order every 14 days . Physician responded on 6/19/24 and verified ok to make changes as above.</p> <p>Review of R49's EMR, physician order dated 6/19/24, revealed the following, lorazepam 1 mg, give 1 mg by mouth every 8 hours as needed for anxiety for 14 days, and end date 7/3/24.</p> <p>Review of R49's EMR, physician order dated 6/19/24, revealed the following, lorazepam 1 mg, give 1 mg by mouth every 8 hours as needed for anxiety for 14 days, and end date 7/3/24.</p> <p>Review of R49's EMR, physician order dated 7/16/24, revealed the following, lorazepam 1 mg, give 1 mg by mouth every 8 hours as needed for anxiety for 14 days, and end date 7/30/24.</p> <p>Review of R49's EMR, physician order dated 8/19/24, revealed the following, lorazepam 1 mg, give 1 mg by mouth every 8 hours as needed for anxiety for 14 days, and end date 9/2/24.</p> <p>Review of R49's controlled substance record sheets, dated 4/23/24 through 10/1/24, revealed that R49 received lorazepam 1 mg on 7/8/24 at 8:15 PM, 7/9/24 at 6:00PM, 7/11/24 at 7:00 PM, 8/13/24 at 12:50 PM, and 8/13/24 at 7:54 PM. R49 received five doses of lorazepam without a physician order.</p> <p>On 10/22/24 at 3:15 PM, an interview was conducted with the Nursing Home Administrator (NHA), and was asked if nurses should be administering medication without a physicians order, and replied, No. Medications that are administered all need a physicians order to be given.</p> <p>Review of facility policy titled, Medication Administration, dated 1/17/23, read in part, Policy: Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection. Policy Explanation and Compliance Guidelines .10. Review MAR to identify medication to be administered. 11. Compare medication source with MAR to verify resident name, medication name, form, dose, route, and time of administration .</p> <p>Review of facility policy titled, Medication - Psychotropic, dated 10/30/23, read in part, Policy: Residents are not given psychotropic drugs unless the medication is necessary to treat a specific condition, as diagnosed and documented in the clinical record, and the medication is beneficial to the resident, as demonstrated by monitoring and documentation of the resident's response to the medication(s) .</p> <p>(continued on next page)</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>49302</p> <p>DPS B:</p> <p>Based on interview and record review, the facility failed to conduct a timely gradual dose reduction (GDR) for psychotropic and anti-anxiety medications per physician recommendations for one Resident (#29) of five residents reviewed for unnecessary medications. This deficient practice resulted in the potential for adverse side effects and use for an excessive duration.</p> <p>Findings include:</p> <p>Resident #29 (R29):</p> <p>Review of R29's electronic medical record (EMR) revealed initial admission to the facility on [DATE] with diagnoses including vascular dementia, anxiety disorder, mood disorder, adjustment disorder, major depressive disorder, and post-traumatic stress disorder (PTSD). Review of R29's most recent Minimum Data Set (MDS) assessment, dated 9/10/24, revealed a Brief Interview for Mental Status (BIMS) score of 6, indicative of severe cognitive impairment.</p> <p>Review of R29's active medication list revealed:</p> <ol style="list-style-type: none"> 1. Paxil Tablet, 40mg, one time per day, initiated November 2022, for major depressive order. 2. Abilify, 10mg, one time per day, initiated January 2023, for anxiety. <p>Review of R29's behavioral health notes revealed the following recommendations:</p> <ol style="list-style-type: none"> 1. 2/8/24: No recent adjustments in psychiatric medications are noted in review of EMR . Assessment & Plan . due for GDR Paxil . 2. 3/29/24: No recent adjustments in psychiatric medications are noted in review of EMR . Assessment & Plan . due for GDR Abilify . 3. 5/10/24: No recent adjustments in psychiatric medications are noted in review of EMR . Assessment & Plan . due for GDR Abilify . <p>Review of the provider progress notes revealed R29 was seen by the facility physician on 2/22/24 and 4/19/24 without follow-up on GDR recommendations made by the behavioral health provider. On 5/16/24, the facility physician made a note stating No GDR @ [at] this time, pt [patient] stable . which was 98 and 48 days following the initial GDR recommendations for Paxil and Abilify, respectively.</p> <p>On 10/24/24 at 9:01 AM, an interview was conducted with the Nursing Home Administrator (NHA) and the Director of Nursing (DON) regarding timeliness of GDR recommendations. The NHA stated, The process was broken. The NHA stated the DON at the time was supposed to review documentation from behavioral health services then relay those recommendations to the facility physician who was then supposed to accept or decline the recommendations. The NHA went on to say there was a breakdown in this process. Both the NHA and DON verified a delay in response time in regard to GDR recommendations.</p> <p>(continued on next page)</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of facility policy titled, Gradual Dose Reduction of Psychotropic Drugs, reviewed 10/26/23, read, in part:</p> <p>.Residents who use psychotropic drugs receive gradual dose reductions and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs . Opportunities during the care process to consider whether medications should be continued, reduced, discontinued, or otherwise modified include: .when the physician or prescribing practitioner evaluations the resident's progress .</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>13791</p> <p>Based on observation, interview and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety. This deficient practice has the potential to result in food borne illness among any and all 65 residents of the facility. Findings include:</p> <p>On 10/21/24 at approximately 12:20 PM during noon meal service, small bowl servings of potato salad were observed on a tray, at room temperature adjacent to the steam table serving line. The temperature of the potato salad was measured with a metal stem probe thermometer and found to be ranging from 46 F to 49 F. Eight small bowls of cottage cheese were observed being held next to the steam table waiting to be placed on residents' trays. The temperature of the cottage cheese was measured to be 47 F. Dietary [NAME] (DC) C was asked to take the temperature of the potato salad and cottage cheese with a facility thermometer. The potato salad was reported to be in the same range of 46-49 F and cottage cheese reported to be 45 F by [NAME] C. An interview with Kitchen Manager (KM) A was conducted regarding this issue. KM A stated the products would be disposed and proper holding had not been done.</p> <p>The FDA Food Code 2017 states: 3-501.16 Time/Temperature Control for Safety Food, Hot and Cold Holding.</p> <p>(A) Except during preparation, cooking, or cooling, or when time is used as the public health control as specified under S3-501.19, and except as specified under (B) and in (C) of this section, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD shall be maintained:</p> <p>(1) At 57 C (135 F) or above, except that roasts cooked to a temperature and for a time specified in 3-401.11(B) or reheated as specified in 3-403.11(E) may be held at a temperature of 54 C (130 F) or above; or</p> <p>(2) At 5 C (41 F) or less.</p> <p>On 10/21/24 at approximately 1:15 PM the refrigerator in the 200/300 halls' nourishment room was observed to have a package of Great Value rotisserie slice chicken. No identifying information was found on the package, including the resident it belonged to, the date it was placed in the refrigerator or any expiration or use by date. In the same refrigerator a bottle of pure maple syrup was observed in the door shelf and had an expiration date of 5/02/24. On 10/22/24 at approximately 07:16 AM an interview was conducted with KM A and Registered Dietitian (RD) B. Both were asked who was responsible for checking the nourishment refrigerators on the units. Both stated it was a shared duty between the dietary department and nursing. When asked when the last time the nourishment refrigerators were checked, KM A stated that the current morning they had. At approximately 7:35 AM RD B was observed in the 200/300 nourishment room disposing of the Great Value rotisserie chicken. When asked about the disposal, RD B stated she was unable to find an expiration date. When asked if any other products had been identified, RD B stated No. RD B was then directed to the container of syrup at which time, the expiration date was acknowledged and then the product was disposed.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>The FDA Food Code 2017 states: 3-501.17 Ready-to-Eat, Time/Temperature Control for Safety Food, Date Marking.</p> <p>(A) Except when PACKAGING FOOD using a REDUCED OXYGEN PACKAGING method as specified under S 3-502.12, and except as specified in (E) and (F) of this section, refrigerated, READY-TOEAT, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD prepared and held in a FOOD ESTABLISHMENT for more than 24 hours shall be clearly marked to indicate the date or day by which the FOOD shall be consumed on the PREMISES, sold, or discarded when held at a temperature of 5 C (41 F) or less for a maximum of 7 days. The day of preparation shall be counted as Day 1.</p> <p>(B) Except as specified in (E) -(G) of this section, refrigerated, READY-TO-EAT TIME/TEMPERATURE CONTROL FOR SAFETY FOOD prepared and PACKAGED by a FOOD PROCESSING PLANT shall be clearly marked, at the time the original container is opened in a FOOD ESTABLISHMENT and if the FOOD is held for more than 24 hours, to indicate the date or day by which the FOOD shall be consumed on the PREMISES, sold, or discarded, based on the temperature and time combinations specified in (A) of this section and: Pf</p> <p>(1) The day the original container is opened in the FOOD ESTABLISHMENT shall be counted as Day 1; Pf and</p> <p>(2) The day or date marked by the FOOD ESTABLISHMENT may not exceed a manufacturer's use-by date if the manufacturer determined the use-by date based on FOOD safety. Pf</p> <p>(C) A refrigerated, READY-TO-EAT TIME/TEMPERATURE CONTROL FOR SAFETY FOOD ingredient or a portion of a refrigerated, READY-TO-EAT, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD that is subsequently combined with additional ingredients or portions of FOOD shall retain the date marking of the earliest-prepared or first-prepared ingredient.</p> <p>On 10/22/24 at approximately 11:25 AM, [NAME] C placed a pan of roast beef in the steam table. After measuring the temperature [NAME] C placed the pan back into the steamer, stating it was not hot enough. At approximately 11:40 AM [NAME] C removed the pan from the steamer and placed it in the steam table. [NAME] C then placed a thermometer in the product and asked Is 159 degrees okay?. An interview was then initiated with [NAME] C asking her if the product was being reheated and what she understood was required for proper reheating temperature. [NAME] C stated that the roast beef was being reheated but stated she did not know what the proper reheating temperature was supposed to be. When instructed that the product was to be reheated to at least 165 F for 15 seconds, [NAME] C placed the pan back in the steamer. At approximately 11:50 AM [NAME] C removed the pan from the steamer placed a thermometer in the product and transferred it to the steam table. When asked what temperature she had measured, [NAME] C replied 166 degrees. The product was then measured by this writer with a metal stem probe thermometer and found the range of the temperature for the entire pan was between 126 F and 146 F. No temperature of any part of the product was at or above 165 F. [NAME] C was asked to again measure the product with a facility thermometer and was found that no part of the product was at or above 165 F.</p> <p>The FDA Food Code 2017 states: 3-403.11 Reheating for Hot Holding.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>(A) Except as specified under (B) and (C) and in (E) of this section, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD that is cooked, cooled, and reheated for hot holding shall be reheated so that all parts of the FOOD reach a temperature of at least 74 C (165 F) for 15 seconds</p> <p>On 10/23/24 at approximately 8:15 AM, the 3/4 copper drain line from the ice machine bin was traced from the bottom of the machine to a floor drain. The elbowed end of the drain line was observed to be submerged over 1 into the stand pipe of the floor drain and covered with black mold like substance. An interview with KM A was conducted at this time and asked if she was aware that the drain line from the ice machine was not appropriate. KM A stated she had previously discussed it with the maintenance director (MD) G and was planning to fix it soon. On 10/23/24 at approximately 10:10 AM an interview was conducted with MD G who stated that he had just been made aware of the drain line issue that morning, and the information had come after it had been brought to the attention of KM A.</p> <p>The FDA Food Code 2017 states: 5-205.12 Prohibiting a Cross Connection.</p> <p>(A) A PERSON may not create a cross connection system by connecting a pipe or conduit between the DRINKING WATER system and a nonDRINKING WATER system or a water system of unknown quality.</p>		

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<p>F 0867</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action.</p> <p>49397</p> <p>Based on interview and record review, the facility failed to implement an effective Quality Assurance & Performance Improvement (QAPI) program that included development, monitoring, and evaluation of adverse events to correct quality deficiencies and maintain sustained compliance. This deficient practice had the potential to affect all 65 residents in the facility.</p> <p>Findings Include:</p> <p>On 10/24/24 at 9:47 AM, an interview was conducted with the Nursing Home Administrator (NHA) who verified that the QAPI meetings were held monthly. When asked if they monitor adverse events, the NHA asked what did I mean? The NHA stated that she receives emails from the regional clinical nurse and the Director of Nursing. The NHA stated that the regional clinical nurse tells her what happened and what they should be doing. The NHA was unable to explain how medical errors or adverse resident events were identified, analyzed, corrected, or monitored to ensure desired outcomes through the QAPI process.</p> <p>Review of the facility policy titled, QAPI Plan, reviewed/ revised 10/24/22 read, in part:</p> <p>It is the policy of this facility to systematically collect data as part of the QAPI program to ensure the care and services it delivers meet acceptable standards of quality in accordance with recognized standards of practice . Medical errors and adverse events are routinely tracked. Facility staff monitor residents for medical errors and adverse events in accordance with established procedures for the type of adverse event. An investigation will be conducted on each identified medical error or adverse event to analyze causes. Preventative actions and mechanisms will be implemented to prevent medical errors and adverse events, including feedback and education. Monitoring will be conducted to ensure desired outcomes are achieved and sustained .</p>		

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 10/24/2024
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 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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49397</p> <p>Based on observation, record review, and interview the facility failed to implement enhanced barrier precautions (EBP) for 1 of 3 residents reviewed for EBP. This deficient practice has the potential for development and transmission of Multidrug Resistant Organism (MDRO) infections.</p> <p>Findings Include:</p> <p>On 10/22/24, at 9:49 AM it was noted that there was no EBP outside of room [ROOM NUMBER] for bed A. Bed A was assigned to Resident 274 (R274).</p> <p>A review of records indicated R274 was admitted to the facility on [DATE], with diagnosis of cellulitis (skin infection) of right lower limb, lymphedema (swelling in the body due to build up of lymph fluid), chronic diastolic heart failure (heart is not able to pump enough blood to meet body's needs), paroxysmal atrial fibrillation (upper chambers of heart beat irregularly), morbid obesity (body mass index of 40 or higher), obstructive sleep apnea (throat muscles relax and narrow the airway during sleep, interrupting breathing), essential hypertension (high blood pressure not caused by medical conditions), osteoarthritis (degenerative joint disease), and history of falls.</p> <p>R274 Nursing Admission Evaluation Part 2 completed on 10/17/24 indicated that R274 had an indwelling catheter in place at this time.</p> <p>A review of R274's care plan indicated that there was no care plan for EBP for her catheter per standards of care.</p> <p>On 10/23/24 at 7:35 AM it was noted that there was no EBP outside of room [ROOM NUMBER].</p> <p>On 10/23/24 at 8:00 AM it was noted that there was no EBP outside of room [ROOM NUMBER].</p> <p>On 10/23/24 at 8:05 AM while conducting an interview with the Infection Preventionist (IP) nurse I stated, R274 should have EBP if R274 had an indwelling catheter.</p> <p>Lack of EBP put R274 at risk for 6 days for an MDRO infection during her catheter care.</p>		

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 10/24/2024
NAME OF PROVIDER OR SUPPLIER Medilodge of Munising		STREET ADDRESS, CITY, STATE, ZIP CODE 300 W City Park Dr Munising, MI 49862	
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0947</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention.</p> <p>49302</p> <p>Based on interview and record review, the facility failed to ensure dementia training was completed by four of four Certified Nursing Assistants (CNAs) reviewed for annual training requirements. This deficient practice resulted in the potential for unmet care needs and the potential to affect all residents with dementia in a current facility census of 65 residents.</p> <p>Findings include:</p> <p>Review of CNA in-service training logs were conducted for CNAs F, V, U, and E. The training transcripts of CNAs F, V, and U read: Dementia Care: Normal Aging vs. Alzheimer's/Dementia listed as incomplete with a due date of 9/30/24. CNA E's training transcript did not list any dementia training.</p> <p>On 10/24/24 at 10:53 AM, an interview was conducted with the Assistant Director of Nursing (ADON) I who stated there was no specific dementia training for nurse aides as it was included in a training course called, Challenging Behaviors. When asked about the course listed on the transcript titled, Dementia Care: Normal Aging vs. Alzheimer's/Dementia, ADON I stated he was unaware of the course and verified it was overdue for CNAs F, V, U, and E.</p> <p>Review of the Challenging Behaviors training transcript did not reveal education regarding dementia care.</p> <p>Review of the most recent Facility Assessment Tool, dated 7/2023 - 6/2024, read, in part:</p> <p>.Required in-service training for nurse aides. In service training must: include dementia management training and resident abuse prevention training .</p>		