

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235421	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/02/2024
NAME OF PROVIDER OR SUPPLIER Medilodge of Port Huron		STREET ADDRESS, CITY, STATE, ZIP CODE 5635 Lakeshore Fort Gratiot, MI 48059	

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 0584</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 safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49102</p> <p>Based on observation, interview, and record review, the facility failed to ensure a clean environment affecting three residents (R51, R7, and R26) of six residents reviewed for environmental concerns. Findings include:</p> <p>R51</p> <p>On 04/30/24 at 9:10 AM, R 51 was observed lying in bed in their room. R51's bed was observed adjacent to the wall, with a patch of peeling paint/cracks approximately the size of a basketball.</p> <p>On 05/01/24 at 9:09 AM, R51 was observed lying in bed and was asked about the peeling paint on the wall. R51 stated, Don't like it.</p> <p>A record review of R51's medical record revealed, R51 was admitted on [DATE] with diagnoses of Dementia, Schizophrenia, and Unspecified Intellectual Disabilities. A review of the most recent Minimum Data Set (MDS) assessment dated [DATE] noted, R51's Brief Interview for Mental Status (BIMS) score of 11, which indicates mild cognitive impairment.</p> <p>R7</p> <p>On 04/30/24 at 9:25 AM, R7 was observed lying in bed in their room watching television. There was an area behind the head of the bed which had deep scrapes in the wall and the paint was peeling.</p> <p>On 05/01/24 at 10:00 AM, R7 was observed sitting up in their wheelchair. R7 was asked about the peeling paint in their room. R7 stated, I think my wall should be fixed and painted.</p> <p>A record review of R7's medical record revealed, R7 was admitted on [DATE] with diagnoses of Vascular Dementia, Mood Disorder and Hemiplegia. A review of the most recent MDS assessment dated [DATE], revealed R7 with a BIMS score of 12 which indicates mild cognitive impairment.</p> <p>R26</p> <p>On 04/30/24 at 9:30 AM, R26 was observed lying in bed in their room watching television. There was a large area behind the head of the bed which had several deep scrapes in the wall and several smaller areas of peeling paint.</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 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 05/01/24 at 10:05 AM, R26 was observed sitting up in wheelchair near the door. R26 was asked about the peeling paint on their wall. R26 stated, I think my wall should be fixed and painted. Not nice looking.</p> <p>A record review of R26's medical record revealed, R26 was admitted on [DATE] with diagnosis of Alzheimer's Disease. A review of the most recent MDS assessment dated [DATE], revealed R26 with a BIMS score of 11 which indicates mild cognitive impairment.</p> <p>On 05/02/24 at 8:55 AM, a tour of the rooms was conducted with the Maintenance Director. The Maintenance Director was asked about the observations of the peeling paint/damaged walls in the resident's room. The Maintenance Director stated, This wing is one of the oldest parts of the building. I have been trying to work with admissions to fix rooms when they are empty. I can't fix a wall if the resident is in the room. The Maintenance Director was asked the facility's expectations for the walls in the resident's room and explained the expectation is for all rooms to be in good repair.</p> <p>A review of the facility's policy titled Safe and Homelike Environment with a revised date of 1/01/2022 revealed, In accordance with residents' rights, the facility will provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risks .</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44750</p> <p>Based on observation, interview, and record review, the facility failed to provide showers per preference and schedule for one resident (R70) out of three reviewed for showers. Findings Include:</p> <p>On 5/2/2024 at 11:04 AM, R70 was observed sitting in their wheelchair. R70 was interviewed regarding receiving showers per schedule and when requested. R70 stated they do not always receive their showers as scheduled and when they do, the staff rush through them.</p> <p>A review of the medical record revealed that R70 admitted into the facility on [DATE] with the following diagnoses, Pruritus and Anxiety Disorder. Further review of the Minimum Data Set assessment revealed a Brief Interview of Mental status score of 7/15 indicating an impaired cognition. R70 also required assistance with bed mobility and transfers.</p> <p>Further review of R70's shower documentation for March 2024 and April 2024 revealed that R70 did not receive a shower on the following days; 3/2, 3/6, 3/9, 3/13, 3/16, 3/20, 3/23, 3/27, 3/30, 4/4, 4/9, 4/16, 4/19, 4/23, 4/26, and 4/30/24. Documentation on these days revealed, Response not required. R70 received a total of seven showers within the 60-day period.</p> <p>On 5/2/2024 at 11:18 AM, an interview was conducted with the Director of Nursing (DON). The DON stated they did find one refusal in the progress notes related to R70's showers. The DON stated that they know R70 does have refusals, but the nurses should put in a progress note each time R70 refuses a shower.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44750</p> <p>Based on observation, interview, and record review, the facility failed to label and date a (wound) dressing for one resident (R2) out of one reviewed for skin conditions. Finding include:</p> <p>On 4/30/2024 at 9:30 AM, R2 was observed sitting in their wheelchair. R2 was noted to have a dressing on their lower left leg. The dressing was not dated. R2 stated they have problems with their legs and the nurse's put dressings on them. R2 stated they have sores on their legs sometimes and they bleed. R2 was also noted to have cream on their feet and paper towels in their shoes.</p> <p>On 5/1/2024 at 10:05 AM and at 5/2/2024 at 9:07 AM, R2 was observed with an undated dressing to their lower left leg. The dressing appeared to be soiled. R2 stated the dressing has not been changed since I spoke to them on 4/30/2024. R2 stated they do not remember when it was last changed or when it was put on.</p> <p>A review of the medical record revealed that R2 admitted into the facility on [DATE] with the following diagnoses, Cerebral Infarction and [NAME] Insufficiency. Further review of the Minimum Data Assessment set revealed Brief Interview for Mental Status score of 7/17 indicating an impaired cognition. R2 also required assistance with bed mobility and transfers.</p> <p>Further review of the physician orders did not show an order for the dressing use.</p> <p>On 5/2/2024 at 11:21 AM, an interview was conducted with the Director of Nursing (DON). The DON stated their expectation related to dressings is they are completed safely and properly. The DON stated they expect all dressings to be dated and a progress note as to why they put a dressing on.</p> <p>A review of a facility policy titled, Wound Treatment Management noted the following, .2. In the absence of treatment orders, the licensed nurse will notify physician to obtain treatment orders. This may be the treatment nurse, or the assigned licensed nurse in the absence of the treatment nurse.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for 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** 34851</p> <p>This citation has two deficient practice statements.</p> <p>Deficient practice statement one.</p> <p>Based on observation, interview, and record review the facility failed to secure an oxygen tank for one sampled resident (R46) of seven, reviewed for accidents.</p> <p>On 4/30/24 at 9:22 AM, R46's room was observed with an oxygen tank, that stood free on the floor, inside of a black bag (that clips to the wheelchair), and not in a secured carrier.</p> <p>On 5/01/24 at 9:25 AM, R46's room was observed with an oxygen tank, that was behind a positioning wedge. The tank was leaning against the wall inside of the black bag, and not in a secured carrier.</p> <p>On 5/02/24 at 9:22 AM, R46 was observed in their room and was not able to provide information regarding the oxygen tank due to cognitive impairment. R46's room was observed with the oxygen tank, that was behind a positioning wedge. The tank was leaning against the wall inside of the black bag, and not in a secured carrier.</p> <p>On 5/02/24 at 9:23 AM, Unit Manager A was asked and alerted about the oxygen tank free standing in R46's room. Unit Manager A explained that the tank was not to be in R46's room without a secure carrier and explained that the tank could fall and explode, fire hazard, or too much oxygen could fill the room if leaking.</p> <p>A review of R46's medical record revealed, R46 was admitted to the facility on [DATE] and readmitted [DATE] with diagnosis of Myocardial Infarction, Obstructive Sleep Apnea.</p> <p>Further review of R46's medical record noted, Order: Oxygen: RUN @ [2]L/MIN VIA [X] N/C [X] PRN (as needed) to maintain SPO2 greater than 90%. every shift related to NON-ST ELEVATION. MYOCARDIAL INFARCTION, OBSTRUCTIVE SLEEP APNEA.</p> <p>A review of R46's care plan noted, Focus: Resident is at risk for impaired respiratory status related to SOB (shortness of breath) d/t (due to) anxiety, pain</p> <p>Date Initiated: 03/29/2024. Goal: Resident will have reduced complications related to their altered pulmonary/respiratory status through next review. Date Initiated: 03/29/2024. Interventions: Observe vital signs and pulse oximetry as needed Date Initiated: 03/29/2024. Oxygen as ordered Date Initiated: 03/29/2024.</p> <p>On 5/02/24 at 11:27 AM, the Director of Nursing (DON) was asked the facility's expectation for oxygen storage. The DON explained the expectation is for the oxygen to be on a cart.</p> <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of the facility's policy titled, Oxygen Safety dated, 1/01/2022, reveal, It is the policy of this facility to provide a safe environment for residents, staff, and the public. This policy addresses the use and storage of oxygen and oxygen equipment . 4. Oxygen Storage c. Cylinders will be properly chained or supported in racks or other fastenings (i.e. sturdyportable carts, approved stands) to secure all cylinders from falling, whether connected, unconnected, full, or empty .</p> <p>49102</p> <p>Deficient practice statement two.</p> <p>Based on observation, interview, and record review the facility failed to secure an electronic cigarette and to provide supervision for one resident (R99) of seven, reviewed for accidents. Findings include:</p> <p>On 5/01/24 at 11:47 AM, an observation was made of R99 exhaling smoke from an electronic cigarette while lying in their bed. R99 was observed to quickly place device under the blanket.</p> <p>On 5/01/24 at 3:05 PM, Nurse C was asked about the observation of R99 smoking in their room. Nurse C stated, Residents should not have any smoking paraphernalia in the room.</p> <p>A review of R99's medical record revealed, R99 was admitted on [DATE] with diagnoses of Bipolar Disorder, History of Traumatic Brain Injury, and Acquired Absence of Left Leg above the Knee. A review of the most recent Minimum Data Set assessment dated [DATE] noted, R99 with a Brief Interview for Mental Status (BIMS) score of 12 indicating mild cognitive impairment.</p> <p>On 5/01/24 at 3:05 PM, the Director of Nursing (DON) was asked about the facility's expectation regarding residents smoking in their rooms. The DON stated, It is my expectation that residents will follow the protocol of no smoking.</p> <p>A review of the facility's policy titled, Smoking Policy Non-Smoking Campus-Residents dated 1/01/22 revealed, It is the policy of this facility to establish and maintain safe resident smoking practices for a non-smoking campus . Policy Explanation and Compliance Guidelines: Smoking Area: 1. Prior to, or upon admission, residents shall be informed that smoking is not permitted inside of facility or outside the facility on any facility property. This includes Electronic cigarettes .</p>		

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail.</p> <p>44750</p> <p>Based on observation, interview, and record review, the facility failed to assess and obtain consent for bed rails for one resident (R315) out of one reviewed for bed rails. Findings Include:</p> <p>On 4/30/2024 at 1:43 PM, R315 was observed laying in bed. R315 was noted to have full bed rails installed. R315 stated they do not use the bed rails for turning and repositioning.</p> <p>A review of the medical record revealed that R315 admitted into the facility with the following diagnoses, Lobar Pneumonia and Dementia. A review of the Minimum Data Set assessment revealed a Brief Interview for Mental Status assessment of 9/15 indicating an impaired cognition. R315 also required assistance with bed mobility and transfers.</p> <p>Further review of the medical records did not reveal a consent or assessment for the used of the bed rails.</p> <p>On 5/2/2024 at 9:04 AM, an interview was conducted with the Registered Nurse (RN) D. RN D stated that when someone gets bed rails, they complete three assessments, and they obtain a consent. RN D stated R315 was not supposed to have bed rails and they had not been assessed for them. RN D stated R315 was in a bed that a previous resident was in.</p> <p>On 5/2/2024 at 11:24 AM, an interview was conducted with the Director of Nursing (DON). The DON stated when a resident comes in the facility they will be evaluated by therapy and the nurses. The DON stated they then complete a risk versus benefits to see if the bed rails are beneficial and then obtain consent.</p> <p>A review of a facility policy titled, Side Rails noted the following, . c. Obtain informed consent from the resident, or the resident representative for the use of bed rails, prior to installation/use. d. Determine whether the side/bed rail is a restraint. Side/bed rails will be considered a physical restraint when they limit the resident's freedom of movement and cannot be removed easily by the resident. In such cases, the facility shall follow procedures related to physical restraints. Document the medical diagnosis, condition, symptom, or functional reason for the use of the side/bed rail. f. Obtain physician orders for the use of side/bed rails.</p>		

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<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** 44750</p> <p>Based on observation, interview, and record review, the facility failed to maintain infection control practices (handling medication, proper storage of nebulizer mask, and wearing personal protective equipment [PPE] for contact isolation rooms) for two residents (R315 and R60) from a total sample of 35. Findings include:</p> <p>On 5/1/2024 at 6:32 AM, medication administration was completed with Licensed Practical Nurse (LPN) F. LPN F was observed taking a pill out of the medication cup with their hands without first performing hand hygiene or wearing gloves.</p> <p>On 5/2/2024 at 9:25 AM, medication administration was completed with Licensed Practical Nurse (LPN) G. LPN G was observed breaking a pill in half with their hands without first performing hand hygiene or wearing gloves.</p> <p>On 5/1/2024 at 11:00 AM, an interview was conducted with the Infection Control Preventionist (ICP). ICP stated the nurses should absolutely complete hand hygiene and should not handle anything going in someone's mouth without gloves.</p> <p>R315</p> <p>On 4/30/2024 at 9:29 AM, a nebulizer mask was observed laying on the dresser next to the bed. The tubing was not dated, and the mask was not in a bag.</p> <p>On 5/1/2024 at 7:36 AM, a nebulizer mask was observed in the drawer. The mask was undated and was not in a bag. R315 was queried as to whether they used the nebulizer. R315 stated they used the nebulizer since being in the facility.</p> <p>A review of the medical record revealed that R315 admitted into the facility with the following diagnoses, Lobar Pneumonia and Dementia. A review of the Minimum Data Set assessment revealed a Brief Interview for Mental Status assessment of 9/15 indicating an impaired cognition. R315 also required assistance with bed mobility and transfers.</p> <p>R60</p> <p>On 4/30/2024 at 1:45 PM, 9:37 AM, and 5/1/2024 at 6:56 AM, a nebulizer mask was observed laying on the dresser. The tubing was not dated, and the mask was not in a bag.</p> <p>A review of the medical record revealed R60 admitted into the facility on [DATE] with the following diagnoses, Dysphagia and Sepsis. Further review of the Minimum Data Set assessment revealed a Brief Interview for Mental status score of 99 indicating that R60 was unable to complete a cognition assessment. R60 also required assistance with bed mobility and transfers.</p> <p>Further review of the physician orders revealed an order for nebulizer use, every six hours.</p> <p>(continued on next page)</p>		

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