Printed: 09/27/2024
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235495	A. Building B. Wing	07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Marshall	879 East Michigan Ave Marshall, MI 49068

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27446 This citation pertains to intake numbers MI00144590 and MI00144986. Based on interview and record review the facility failed to ensure for two out of three residents (Resident #1 and 3) accurate medical record documentation that reflected the care and services provided and the resident's condition. Findings Included: Resident #1 (R1) Review of R1's electronic medical record (EMR) revealed R1 had signed a Do Not Resuscitate (DNR) document and an Advanced Directive which revealed her wish to not receive resuscitation. Per R1's face sheet she was admitted to the facility on [DATE]. Review of R1's progress notes dated [DATE], revealed the Nurse Practitioner (NP) was notified via telehealth R1 was confused, short of breath, and pale in color. Review of another progress notes dated [DATE], documented by the same NP revealed R1 stated she did not feel right and wanted to go to the hospital. Vital signs were documented but there were no concerns, and R1 refused to wear her CPAP machine (worn on her mouth) at night. Review of another progress note dated [DATE] at 2:43 PM, revealed R1 stated something was not right. Vital signs were documented which were normal. Review of a progress note dated [DATE] at 5:43 PM, revealed R1 was at the nurses's station where she was observed to have irregular respirations, and pale shin. The note reveled the on call physician was notified and the nurse was waiting for follow up physician orders. Review of the progress notes dated [DATE] at 11:56 PM, revealed a progress that documented R1 had passed away at 7:22 PM. Further review of R1's EMR (Electronic Medical Records) revealed no additional documentation regarding the change in R1's condition. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235495	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Marshall	879 East Michigan Ave Marshall, MI 49068

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on [DATE] at 11:37 AM, Registered Nurse (RN) C stated she was called down to R1's room via a walkie talkie, and was told R1 was not breathing. RN C said she called a code and began CPR, and said the crash cart was also brought to the room, and an ambu bag (a blue plastic bag connected to oxygen and place on a person's mouth and squeezed to create artificial breathing) was used which continued for approximately 4 minutes then she stopped because a staff member brought the binder from the nurse's station and showed her R1's signed DNR paperwork. RN C was asked if the code was documented on any other forms, and RN C said no she never documented anything in regards to the code event, but stated that she should have. Complete review of R1's progress note documentation revealed that beginning with the NP note on , d+[DATE]//2024 at 12:00 AM through the progress note dated [DATE] at 11:56 PM, there was no documentation about R1 coding, and having CPR performed, then stopped when code statues was obtained. Resident #3 (R3): Per R3's EMR R3 was admitted to the facility on [DATE]. Review of R3's progress notes revealed that on [DATE] the Physician's Assistant (PA) via telehealth made a notation that nursing had reported to her R3 was being sent to the hospital per family request. Vitals stable, cool and clammy, lethargic (sleepy) but responds. The note revealed R3's wife wanted him sent to the hospital because R3 did not look right and was not acting like himself. There were no other progress notes regarding R3's transfer to the hospital, there was no documentation about R3's condition at the time of transfer, no vital signs were documented, no time R3 was picked up and left the facility. A progress note dated [DATE] at 9:09 AM revealed, Note Text: notified at 9:00 sent out to hospital. That was the only other note made. Review of a Transfer Notice revealed it was dated [DATE] as the dated R3 was transferred to the hospital. In a phone interview on [DATE] at 2:02 PM, RN D stated that she was the nurse who cared for R3 on [DATE]. RN D said for R3's significant change in status she would have documented in the progress notes. However, RN D was made aware there were no notes regarding nursing sending R3 out to the hospital, and no notes regarding R3 condition at the time of transferring D stated that she did not document any notes on R3's transfer then. RN D said she was not aware that she was supposed to have filled out an SBAR (situation, background, assessment, and recommendation) change in condition form, a Transfer V2 form, and was supposed to put R3's emr records, SBAR, and transfer assessment into a green envelope, and check off the list of items that were required to be in the envelope and sent with the resident to the hospital.