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	11/15/2024

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49103 This citation pertains to intake MI00147601 Based on interview and record review, the facility failed to develop a comprehensive care plan for 1 (R201) of 1 resident reviewed which would include interventions as safeguards against swallowing non-food items resulting in the potential for reoccurrence of the behavior. Findings include: On 11/13/24 at 10:15 AM R201 was observed in his wheelchair out in the main area of the facility talking and interacting with staff members. On 11/13/24 at 1:10 PM R201 during observation and interview was eating lunch in his room and said things were good. According to Electronic Medical Record (EMS) review R201 had an original admitted [DATE] and a recent admitted [DATE]. R201 had pertinent diagnoses of Unspecified Intellectual Disabilities and Generalized Anxiety Disorder and Schizophrenia (a mental disorder characterized by delusions and disordered thinking). The Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/16/24 revealed R201 scored 3 out of 15 indicating severe cognitive impairment on the Brief Interview for Mental Status (BIMS-a cognitive screening tool). Review of the EMR revealed that R201 had two episodes of swallowing non-food items and hospitalization s: EMR review revealed that on 10/20/24 at 10:08 PM R201 reported to Registered Nurse (RN) C that R201 had swallowed 2 quarters. Further record review revealed that R201 had expressed that he wanted to go to the hospital and expressed feeling suicidal. R201 was sent on that day to the hospital for psychiatric evaluation. EMR review of a hospital discharge record dated 10/7/24 revealed documentation by Medical Doctor (M.D.) L that R201 had been admitted [DATE] after he presented to the emergency room (ER) after ingesting 2 AAA batteries in an attempt to commit suicide. The batteries were removed by esophagogastroduodenoscopy (EGD) and R201 was seen by psychiatry. (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 11/15/2024

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R201's care plan showed a focus item dated 10/17/24 and updated 10/30/24 addressing R201's behavior of swallowing non-food items with interventions listed such as approaching in a calm manner and communicating with R201 and observing mental status and situational stressors. The care plan did not include interventions addressing safeguards against picking up and swallowing non-food items. On 11/14/24 at 2:55 PM during interview with the Nursing Home Administrator (NHA) A and Director of Nursing (DON) B and Regional Nurse Consultant E there was discussion about the care plan and the lack of specific interventions to safeguard the resident. The discussion resulted in the DON saying there would be more review of the plan and information forthcoming. On 11/15/24 the care plan focus item mentioned above (in printed form) was presented by administration. Prior to exit conference there was no further information presented by administration. Review of an article published by the Joint Commission in 2020 states in part, Comprehensive care plans are dynamic documents maintained by an interdisciplinary team that contain specific, actionable information for clinicians and staff across multiple care settings. And according to an article published by NurseJournal.org in 2024 states in part, Nursing care plans are individualized and ensure consistency for nursing care of the patient, document patient needs and potential risks, and help patients and nurses work collaboratively toward optimal outcomes.

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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 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49103 This citation pertains to intake MI00147874 Based on interview and record review the facility failed to provide Cardiopulmonary Resuscitation (CPR) for 1 resident (R200) of 4 residents reviewed who was a full code resulting in Immediate Jeopardy when CPR efforts were not performed at the time resident R200 was found to have no pulse or respirations and this deficient practice has the potential for 44 facility residents not having there full code status wishes honored. Findings include: Review of the electronic medical record (EMR) revealed that on [DATE] R200 was found unresponsive and with no pulse. According to a nurse progress note created [DATE] at 7:32:02 AM with an effective time of 4:50 AM by Licensed Practical Nurse (LPN) M, the nurse, LPN M, had been notified by Certified Nurse Assistant G that R200 wasn't breathing. LPN M documented that she went to R200's room and found that he was . pale and yellow and lips were blue, skin was cold, no response from resident. LPN M further documented that she checked the code status while the other nurse (LPN D) got the crash cart (a cart with emergency medical equipment) and LPN M called 911. According to LPN M's note the staff placed a backboard underneath the resident and when Emergency Medical Services (EMS) arrived chest compressions (CPR) began and rescue breathing through an ambu bag. (An ambu bag is a hand-held device used to provide positive pressure ventilation to patients who are not breathing). According to EMR review, R200 had an admitted [DATE] and pertinent diagnoses of Obstructive Sleep Apnea (a sleep related breathing disorder) and Morbid Obesity. The Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of [DATE] revealed R200 scored 15 out of 15 indicating intact cognition on the Brief Interview for Mental Status (BIMS-a cognitive screening tool). EMR review also revealed that Nurse Practitioner (NP) E had written an order stating Full Resuscitate dated [DATE]. On [DATE] at 3:19 PM LPN M was interviewed and explained the exact time R200 was found with no pulse or respirations was not clear in her memory. Go by my notes LPN M said. When asked what the documented time of 4:50 AM reflected said, That must have been when it happened. LPN M said that when R200 was found to be deceased I had the laptop and checked his code status on my laptop; I grabbed it. I had to call 911. No, we hadn't started CPR; we had gotten the backboard under him but hadn't started CPR. LPN M said that compressions and rescue breathing did not begin until Emergency Medical Services (EMS) arrived. When asked how long that period was from the time R200 was found and to the point EMS arrived LPN M estimated it to be about 5 minutes. When queried as to why CPR did not begin before EMS arrived LPN M responded, I can't say. When queried about CPR training LPN M responded, I was trained in CPR and have done it many times. It was difficult getting the backboard under him because of his size. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 3:50 PM LPN D was interviewed about the occurrence on [DATE] when LPN D was called to the room shortly after R200 was found with no pulse or respirations. LPN D said, I think she (LPN M) was on the phone with 911 before I came down with the crash cart. She was in the hall. When asked about the amount of time before EMS arrived LPN D stated, I think it was within 10 minutes of when it all started; the whole process from when I walked out and she said he coded and when EMS arrived was about a 10 minute period. LPN D said that CPR was not in progress prior to the arrival of EMS. When questioned as to why CPR had not been started, LPN D stated, I did everything I could to get it started and explained that LPN M had been standing back rather than . participating. LPN D said the Certified Nurse Assistant (CNA) G had helped LPN D get the backboard underneath R200. LPN D also said the usual process is that a CNA would be the one to call 911. When queried about CPR training LPN D said she had been trained in CPR. When asked if the certification was current LPN D answered that it had not been up to date. I took the class yesterday; ([DATE]) it's probably been a few months overdue. On [DATE] at 10:46 AM after review of the EMS Run Sheet (a medical record for ambulance services) the Director of EMS H was interviewed and verified the timeline of events: EMS received the emergency call on [DATE] at 4:49:29 AM and arrived on scene at 04:52:48. He said someone from the Fire Department was on scene and had started CPR. According to the documentation on the Run Sheet CPR was discontinued at 5:24 AM and R200 was pronounced deceased by Physician C. On [DATE] at 11:18 AM the township Fire Department Chief I was interviewed and said that a fire department member had arrived at 4:51 AM and had initiated CPR which had not been in progress by facility staff. At the time of survey 44 residents were identified as having a full code status and being at risk of an adverse outcome with code status not being honored in the event of cardiac or respiratory arrest. On [DATE] at 11:45 AM CNA G was interviewed about the occurrence of R200's death on [DATE]. Pretty much when I did my last round I walked in and it was around 4:25 or 4:30 AM and I saw he was not breathing CNA G stated. CNA G said at that point I ran out of the room to find the nurse, and grabbed the walkie talkie to establish contact with nurses and that no one responded to the call for a nurse. I ran down A hall CNA G said, explaining that LPN M had been working both A hall and D hall. CNA G said as she ran back to the front desk LPN M was seen coming in the front door. CNA G said, altogether, it had taken a few minutes - probably about 2 to 3 minutes to find the nurse (LPN M) who had been outside on break. CNA G said LPN M then came immediately to the room and upon seeing R200 made the statement that R200 was gone. CNA G said at this point LPN D was in the room and said to LPN M that CPR needed to be done. CNA G said, We rolled him over to get the board under him as LPN C called 911. On [DATE] at 12:55 PM during interview with LPN J the process of Code Blue was asked about: LPN J stated, We call code blue; someone gets the crash cart; someone gets the chart to see if they are CPR; we start CPR right away once we get the backboard or put them on the floor and we have someone at desk calling 911. And added, We do CPR until EMS arrives or we will continue to assist, and we document. We keep track of each thing happening during the code. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 2:00 PM during subsequent interview with the NHA and DON the process of Code Blue was discussed: The DON stated, If I find a resident unresponsive, check airway breathing, circulation, check code status; start CPR immediately and have a timeline being documented and someone delegated to call 911. Review of documents submitted by the facility: LPN D's CPR certification expired [DATE] and was renewed [DATE]. Review of the facility policy with a revision date of [DATE] and titled Cardiopulmonary Resuscitation (CPR) and Basic Life Support (BLS) with a revision date of [DATE] states in part, If a resident experiences cardiac arrest or respiratory arrest and the resident does not show obvious clinical signs of irreversible death (rigor mortis, dependent lividity, decapitation, transection, or decompositon) facility staff must provide basic life support, including CPR prior to the arrival of emergency medical services. On [DATE] at 2:34 PM a meeting was held with Nursing Home Administrator A, Director of Nursing B and Regional Nurse Consultant F and were notified of Immediate Jeopardy IJ that was identified as beginning [DATE] and caused a serious adverse outcome of R200 due to failure of staff to provide CPR on a full code resident. R200 had been prounced dead by Physician C on [DATE] at 5:24 AM. The facility submitted a removal plan to remove the Immediate Jeopardy: Documentation of the amount of residents at risk. -On [DATE], the facility identified CPR was not initiated immediately. -On [DATE], the Director of Nursing and/or designee began education of facility staff on initiating CPR immediately to include: checking of code status utilizing the electronic medical record on the laptop or kiosk or utilizing the paper chart; the timeline and steps for assessing pulse and respirations when a resident is found unresponsive and initiating CPR immediately to include placing on floor if needed. Initiating CPR includes checking airway, breathing, circulation and beginning compressions while someone verifies the code status and 911 is called. Identify a team leader to assign duties and scribe. Ensure crash cart is with patient and AED is applied. Compressions will continue until EMS arrives and verbalizes they will take over. -The facility has 26 Licensed Nurses. As of [DATE] at 9:00am, the facility has educated 25 of the 26 Licensed Nurses. -Any staff not educated will not be permitted to work a shift until education has been completed. -The facility Medical Director was notified on [DATE]. -The Director of Nursing and/or designee completed a chart audit on 85 charts and verified the advanced directives to the physician order for accuracy on [DATE]. -On [DATE] an audit was completed of Licensed Nurses to ensure CPR certifications were up to date. The identified nurse was recertified [DATE]. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-The QAPI committee has reviewed the Cardiopulmonary Resuscitation (CPR) and Basic Life Support (BLS) policy and has deemed them appropriate on [DATE]. -The facility had an Adhoc QAPI meeting including the Medical Director on [DATE] and deemed this removal plan appropriate. -The Director of Nursing is responsible for continued compliance. The Immediate Jeopardy removal plan was verified and IJ was removed on [DATE] when the facility implemented the approved plan. However, the deficient practice continued at scope and severity of isolated with no actual harm with potential for more than minimal harm that is not immediate jeopardy due to sustained compliance that could not be verified by the state agency.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49103 Based on interview and record review, the facility failed to provide ongoing clinical assessments (neurological assessments) for 1 (R203) of 1 resident reviewed for neurological assessments resulting in the potential for lack of recognition of brain injury. Findings include: Electronic Medical Record (EMR) review revealed that R203 admitted was [DATE]. R203 had pertinent diagnoses of Cerebral Atherosclerosis (a disease that occurs when the arteries in the brain become hard, thick, and narrow), Legal Blindness and Dementia (a group of symptoms affecting memory, thinking and social abilities). Further record review revealed a Visit Type: Acute note entered [DATE] by Nurse Practitioner (NP) E documenting a fall R203 had on [DATE] and stated in part, Spoke with nursing staff, note redness to right hand, right shoulder, and red mark on forehead. NP E documented that R203 was seen sleeping in bed. In the assessments and plans portion of the note NP E documented a plan to discuss care with hospice. Further review of the EMR revealed that the next progress note was entered by nursing on [DATE] and documented that R203 was sleeping soundly and showing signs of impending death. A note following that entered by nursing on [DATE] documented that during skin care R203 had become combative. A note following that entered by nursing on [DATE] documented that wound care could not be done due to pain. A note following that entered by nursing on [DATE] addressed oxygen care followed by a note entered by nursing [DATE] regarding Ativan administration and resident assessment of sleeping soundly with no s/s of pain or discomfort. On [DATE] a note was entered by nursing documenting that R203 had died that morning. On [DATE] at 11:00 AM during interview with the Nursing Home Administrator (NHA) A Director of Nursing (DON) B and Regional Nurse Consultant E the documented fall and follow-up care was discussed. Specifically, the question was asked about the lack of neurological assessment charting in progress notes. The administration provided Fall Follow-up records for review. Upon review there were 4 forms, 1 for each day - dated [DATE] - [DATE]. There was discussion about the vital sign portion of the form which showed that on [DATE] and [DATE] the vital signs were listed as those from [DATE]. The DON explained that unless the nurse edits this portion the previous vital signs flow in and automatically fill in the form. When asked if the nurse should edit the forms to reflect the current assessment the DON answered yes. When asked if the situation reflected any cause for concern about the validity of the neurological assessment portion the DON said it would not because that portion does not flow into the form. The assessment has to be entered each time the form is opened. On [DATE] at 12:10 PM a Neurological Assessment policy was requested. The DON said the facility did not have a Neurological Assessment policy but did have a Fall Policy and would submit it and would also submit the incident report. Review of the fall report (incident report) dated [DATE] recorded that R203 was found with abrasion to the top of the scalp and a bruise to the right hand. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 2:00 PM during subsequent interview with the NHA A and DON B the question was asked if nursing standard of care had been followed for neuro checks. The DON responded, I believe it was followed. They did a neuro check each day. The DON said if there had been a change from baseline an order would have been obtained from the doctor to do the checks more frequently. Review of the facility policy titled Falls-Clinical Protocol with a date of review of [DATE] states in part, Residents who have fallen and been witnessed to hit their head, suspected to have hit their head, and all un-witnessed falls regardless of resident's cognitive status should have neuro checks per MD order or protocol. Review of an article published online by the Agency for Healthcare Research and Quality titled Preventing Falls in Hospitals; Tool 3 N: Post Fall Assessment, Clinical Review. The article states in part, Record vital signs and neurologic observations at least hourly for 4 hours and then review. Continue observations at least every 4 hours for 24 hours, then as required. Notify treating medical provider immediately if any change in observations. Review of an article published online by The American Association of Post-Acute Care Nursing titled Post-Fall Assessments and dated 2021 states in part, It is not always immediately obvious that a resident has sustained a serious, or even life-threatening, injury, as in the case of a subdural hematoma. Therefore, nurses must take great care to complete thorough follow up-assessments.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49103 This citation pertains to intake MI00147874 Based on interview and record review the facility failed to reassess the respiratory status of 1 (R200) of 4 residents reviewed resulting in the potential for respiratory failure as cause of death. Findings include: According to Electronic Medical Record (EMR) review, R200 had an admitted [DATE] and pertinent diagnoses of Obstructive Sleep Apnea (a sleep related breathing disorder) and Morbid Obesity. The Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of [DATE] revealed R201 scored 15 out of 15 indicating intact cognition on the Brief Interview for Mental Status (BIMS-a cognitive screening tool). According to discharge paperwork from the hospital prior to R200's admission to the facility during hospital stay R200 was using a CPAP during sleep. (A CPAP is a machine that treats obstructive apnea). EMR review revealed a CPAP was not documented as being in use during the facility stay. According to documentation by Licensed Practical Nurse (LPN) K entered on [DATE] at 6:08 PM R200 was found to be in a supine position (lying flat) and appearing hypoxic (low oxygen in the body tissues) and cyanotic (a blueish discoloration of skin). LPN K started oxygen by nasal cannula and raised the head of the bed. According to the documentation R200's oxygenation rose quickly to 96%. Further review of the EMR revealed no further nursing progress notes were entered until [DATE] at 7:32:02 AM with an effective time of 4:50 AM by Licensed Practical Nurse (LPN) M. LPN M documented that R200 had been seen last at 12:30 AM and had been sleeping with the head of bed elevated, with oxygen on, and . snoring loudly. The note further documented that the next time LPN M came to the room was when notified by Certified Nurse Assistant (CNA) D that R200 wasn't breathing. LPN M documented that she went to R200's room and found that he was . pale and yellow and lips were blue, skin was cold, no response from resident. EMR review further revealed that resident was pronounced dead after Cardiopulmonary Resuscitation (CPR) efforts by Emergency Rescue Services EMS. On [DATE] at 3:19 PM LPN M was interviewed and verified R200 had been seen sleeping around midnight on [DATE]. He was doing fine LPN M stated. The next time LPN M saw R200 was at the time CNA G had called LPN M to his room. The note in the chart indicates a time of 4:50 AM. LPN M said she was uncertain about the time frame of events. I would say go by my notes LPN M said adding that the situation had been upsetting. On [DATE] at 2:00 PM during interview with Nursing Home Administrator (NHA) A, Director of Nursing (DON)B and Regional Nurse Consultant F respiratory assessments were discussed. The question was asked if follow-up nursing respiratory assessments would have been expected to be done after R200 had an episode of hypoxia and cyanosis on [DATE]. In response the DON said, If there is a change you would be expected to go in and check more frequently. If the nurse assessed and doesn't document how does anyone know you assessed? It looks like someone didn't assess if it wasn't documented. When asked about CPAP and if that had ever been ordered or used the DON said that information was not known but would be checked into and reported back. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prior to the end of the survey the facility had not provided added information about CPAP. According to an article published by Respiratory Care in 2020, Monitoring respiratory values such as breathing frequency, minute ventilation, breathing effort and dyspnea are common in acute care. There is evidence that accurate monitoring and interpretation of these values leads to early identification and treatment of impending respiratory failure.