

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 01/09/2025
NAME OF PROVIDER OR SUPPLIER Medilodge of Marshall		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0557</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions.</p> <p>46954</p> <p>Based on observation, interview and record review, the facility failed to knock prior to entering resident rooms and failed to ensure a resident was treated with respect and dignity for one (Resident #13) of three reviewed for dignity. Findings include:</p> <p>On 1/8/25 at 10:16 am, a staff member was observed entering a resident room without knocking.</p> <p>On 1/8/25 at 10:19 AM, a staff member was observed entering a resident room without knocking.</p> <p>On 1/8/25 at 12:34 PM, a staff member was observed entering a resident room without knocking.</p> <p>On 1/8/25 at approximately 12:45 PM, Resident 13 (R13) was observed at the dining room table without a lunch meal in front of her. Certified Nursing Assistant (CNA) P was observed entering the dining room and noticed R13 did not have a lunch. CNA P approached the dietary staff and requested a lunch tray for [resident first name whatever, whatever.</p> <p>In an interview on 1/9/25 at approximately 1:30 PM, R13 was observed in her room rummaging through her personal belongings. R13 was conversant, understood questions and answered appropriately. R13 stated that she was newer to the facility and had only been a at the facility for just over a week. R13 overheard being referred to as whatever, whatever and felt disrespected by the comment, however, chose to ignore it.</p> <p>On 1/9/24 at 1:40 PM, a staff member was observed opening the door of a resident's room and entering without knocking.</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 235495
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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** 46954</p> <p>Based on observation, interview, and record review the facility failed to obtain an x-ray in a timely manner for 1 (Resident #8) of 3 reviewed for delay of care. Finding include:</p> <p>Review of the electronic medical record revealed R8 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnosis which included hemiplegia and hemiparalysis following nontraumatic intracerebral hemorrhage affecting left non-dominant side (stroke causing weakness and/or paralysis on the left side of the body). Review of the Quarterly Minimum Data Set, dated dated dated [DATE], R8 scored a 13 out of 15 on the Brief interview for mental status indicated R13 was cognitively intact.</p> <p>In an observation on 1/8/25 at 1:32 pm, R8 was observed laying in bed watching television. R8 had a Geri-sleeve on his left wrist and arm. When queried about the Geri-sleeve, R8 stated that he had been dealing with some pain and swelling on his arm. R8 stated that he had an x-ray to his hand to rule out any injury, however, someone must have forgot the x-ray because it took a while.</p> <p>Review of a Provider Note dated 10/1/24 revealed Rehab brought to my attention that patient has had left thumb pain for the last 3 days. Patient states that they woke up 1 (one) morning and it was in pain. Rates pain as 10 out of 10. Resident is seeking x-ray.</p> <p>Review of the Physician Order's revealed an Order for a left hand x-ray initiated on 10/1/24.</p> <p>Review of a Provider Note dated 10/7/24 revealed X-ray of left hand was ordered on October 1, 2024, spoke with unit manager, states that x-ray was not completed despite being ordered. Spoke with patient, states that hand continues to be painful and swollen, patient pointed to medial side of hand injury line up to his wrist. States this has been going on for couple of weeks and has not gotten any better. States the pain is a solid 6 out of 10 and is worse with therapy. Nothing seems to make the pain better at this time .</p> <p>Review of the results tab on the electronic medical record revealed that an X-ray of R8 left hand was not completed until 10/12/24.</p> <p>In an interview on 1/10/25 9:12 AM Licensed Practical Nurse (LPN) stated that there had been some delay in obtaining x-rays due to an imaging company issue, however, the expectation would be that the x-ray should have been completed within a day or two after being ordered.</p> <p>In an interview on 1/10/25 at 9:36 AM stated that the expectation for x-rays being completed would be the same day or the day after at the latest.</p> <p>In an interview on 1/10/25 at 11:29 AM, Director of Nursing (DON) B stated that the order for R8's was put in incorrectly by the Physician and a lack of communication with the staff caused the delay in the x-ray being completed timely.</p>		