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	06/24/2025

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. This citation pertains to intake: MI00153167 Based on interview and record review the facility failed to provide Activities of Daily Living (toileting and incontinence care) for one dependent resident (#1) of 3 residents reviewed. Findings Included: Resident #1 (R1) Review of the medical record revealed R1 was admitted to the facility 05/07/2025 with diagnoses that included chronic obstructive pulmonary disease (COPD), hypertension, contusion of left lower leg, morbid obesity, pulmonary fibrosis (chronic lung disease that occurs when lung tissue around air sacs becomes damage and scared), acute bronchitis (inflammation of the lining of bronchial tubes), emphysema (chronic lung disease that progressively damages the alveoli, or tiny air sacs in the lungs), cardiac murmur, hyperlipidemia (high fat content in blood), peripheral vascular disease (PVD), gastro-esophageal reflux disease, anemia (low red blood cells), congestive heart disease (CHF), rheumatoid arthritis (body's immune system attacks it own tissue, typically in the hands and feet), obstructive sleep apnea, and spondylosis (general term for age-related war and tear of the spinal disks). The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/13/2025, revealed R1's Brief Interview of Mental Status (BIMS) was 15 (cognitively intact) out of 15. R1's medical record revealed she was discharged from the facility 05/13/2025. Complaint was received 05/19/2025 at 04:52 p.m. which explained that R1 had been left in a wet brief for an extended period during R1's stay at the facility. Review of R1's Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/13/2025, section GG-Functional Abilities revealed that R1 was totally dependent for toileting hygiene. Review of R1's plan of care revealed that she needed 1 person assist with toileting. Review of R1's Documentation Survey Report V2 for 7-day bladder patterning (documentation entered by care givers every two hours to identify toileting patterns) revealed no documentation on 05/08/2025 at 12:00 a.m., 02:00 a.m., 04:00 a.m., 06:00 a.m., 5/09/2025 at 06:00 a.m., 08:00 p.m., 10:00 p.m., 5/12/2025 at 02:00 a.m., 04:00 a.m., and 06:00 a.m. (continued on next page)

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

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R1's Documentation Survey Report V2 for bowel elimination (documentation entered by care givers at least each shift to monitor bowel elimination) revealed no documentation for 05/09/2025 evening shift (03:00 p.m. -11:00 p.m.), 5/11/2025 day shift (07:00 a.m.-03:00 p.m.), and 05/11/2025 night shift (11:00 p.m. -07:00 a.m.). During an interview on 06/24/2025 at 09:56 a.m. Director of Nursing (DON) B explained that it is the expectation that Certified Nursing Aides (CNA) offer toileting to residents every two hours. DON B explained that it is the facility practice to conduct two-hour bladder pattering for a period of 7 days on all newly admitted residents. DON B explained that the bladder patterning is documented every two hours in the medical record. DON B also explained that the bladder pattering documentation would demonstrate that the staff was toileting the resident every two hours. DON B also explained that bowel documentation was to be completed once per shift. DON B reviewed R1's bowel documentation and bladder pattering and confirmed that documentation was not present as listed previously. DON B was asked if there would be any other documentation that demonstrated that R1 was assisted with toileting every two hours and offered bowel elimination once a shift. DON B explained that there was no other documentation that would demonstrate toileting of R1. DON B could not explain why R1's medical record did not demonstrate documentation of toileting every two hours and documentation of bowel movements once per shift.

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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. This citation pertains to intake: MI00153167 Based on interview and record review the facility failed to implement physician orders for the administration of pain medication for one resident (#1) of three residents reviewed. Findings Included: Resident #1 (R1) Review of the medical record revealed R1 was admitted to the facility 05/07/2025 with diagnoses that included chronic obstructive pulmonary disease (COPD), hypertension, contusion of left lower leg, morbid obesity, pulmonary fibrosis (chronic lung disease that occurs when lung tissue around air sacs becomes damage and scared), acute bronchitis (inflammation of the lining of bronchial tubes), emphysema (chronic lung disease that progressively damages the alveoli, or tiny air sacs in the lungs), cardiac murmur, hyperlipidemia (high fat content in blood), peripheral vascular disease (PVD), gastro-esophageal reflux disease, anemia (low red blood cells), congestive heart disease (CHF), rheumatoid arthritis (body's immune system attacks it own tissue, typically in the hands and feet), obstructive sleep apnea, and spondylosis (general term for age-related war and tear of the spinal disks). The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/13/2025, revealed R1's Brief Interview of Mental Status (BIMS) was 15 (cognitively intact) out of 15. R1's medical record revealed she was discharged from the facility 05/13/2025. Complaint was received on 05/19/2025 at 04:52 p.m. which explained that R1 had not received her pain medication every 4 hours as directed by the physician orders. Review of R1's physician orders demonstrated, Hydrocodone-Acetaminophen oral tablet 7.5-325mg (milligrams) give one tablet orally every 6 hours for pain related to rheumatoid arthritis. The order was written 05/07/2025 and discontinued 05/08/2025. R1's medical record also demonstrated a physician order which stated, Hydrocodone-Acetaminophen oral tablet 7.5-325mg give one tablet orally every 4 hours for pain related to rheumatoid arthritis. The order was written 05/08/2025 and discontinued 05/09/2025. R1's medical record also demonstrated a physician order which stated, hydrocodone-acetaminophen oral tablet 7. 5-325mg give two tablet by mouth every 4 hours for chronic pain. The order was written 05/09/2025 and was active until time of R1's discharge. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R1's Medical Administration Record (MAR) for the month of May demonstrated that Hydrocodone-Acetaminophen oral tablet 7.5-325mg (milligrams) give one tablet orally every 4 hours for pain related to rheumatoid arthritis was not documented as given. R1's MAR for the month of May also demonstrate that hydrocodone-acetaminophen oral tablet 7.5-325mg give two tablet by mouth every 4 hours for chronic pain was documented as 9 -(see progress notes) for the date of 5/13/2025 at 08:00 a.m. and 12:00 a.m. Review of progress notes revealed entry that stated , 5/13/2025 10:25 Orders - Administration Note Text: Hydrocodone-Acetaminophen Tablet 7.5-325 MG Give 2 tablet by mouth every 4 hours for Chronic pain requested delivery, script verified with technician at pharmacy, EDK entry x 2 attempts with no response, called pharmacy 3 times to get this pharmacy shipped to facility or a code given for retrieval from EDK. Technician is discussing with pharmacist. UM aware this has been an ongoing concern per report given this morning and 5/13/2025 13:24 Orders - Administration Note Text: Hydrocodone-Acetaminophen Tablet 7.5-325 MG Give 2 tablet by mouth every 4 hours for Chronic pain EDK will not accept request x 3 times by 3 different nurse. UM is on phone with pharmacy after delivery was not met at 4 am or noon today as verified. Resident requested to have family bring from home. Then given on 5/13/25 at 1600. During an interview on 06/23/2025 at 03:02 p.m. Director of Nursing (DON) B explained that she was aware of R1 not receiving her pain medication as ordered by the physician. DON B explained that R1 had used all the Hydrocodone-Acetaminophen Tablet 7.5-325mg (milligrams) and therefore a new order was needed so that pharmacy could provide the medication or approve that the medication could be taken from the facilities back-up. DON B also explained that it was her expectation that a new physician order for Hydrocodone-Acetaminophen Tablet 7.5-325 MG should have been re-ordered prior to R1 running out of medication. DON B could not explain why the nursing staff did not re-order the pain medication prior to Hydrocodone-Acetaminophen Tablet 7.5-325 MG not being available.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on observation, interview, and record review the facility failed to accurately assess and monitor pressure ulcers for one resident (#7) of three residents reviewed. Findings Included: Resident #7 (R7) Review of the medical record revealed R7 was admitted to the facility 02/24/2025 with diagnoses that included chronic obstructive pulmonary disease (COPD), repeated falls, enlarged prostate, pseudobulbar affect (inappropriate involuntary laughing and crying due to a nervous system disorder), adjustment disorder, dyspnea (difficult or labored breathing), dementia with agitation, constipation, hypertension, obstructive sleep apnea, and atherosclerotic heart disease (damage or disease of hearts major blood vessels). The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 06/13/2025, revealed R7's Brief Interview of Mental Status (BIMS) was 7 (severe cognitive impairment) out of 15. Review of R7's medical record revealed a document entitled Skin and Wound Evaluation V7.0, completed 05/26/2025, revealed a deep tissue pressure injury (persistent non blanchable deep red, maroon or purple discoloration) to his left gluteus. The same document revealed a measurement of 0.8cm2 (centimeters squared) in area, a length of 5.0 cm (centimeters), a width of 08.cm, and less than 0.1cm in depth. Review of the picture taken, of the wound, demonstrated one wound to the left gluteus and one wound to the coccyx. The measurements of the wounds appeared to have been included together but the wounds were not connected. Review of R7's medical record revealed a document entitled Skin and Wound Evaluation V7.0, completed 06/02/25, revealed a deep tissue pressure injury to his left gluteus. The same document revealed a measurement of 7.1 cm2, length of 8.5cm, width of 1.9cm and a depth not applicable. Review of the picture taken, of the wound, demonstrated one wound to the left gluteus (which appeared to be deep tissue injury) and one wound to the coccyx (which appeared to be stage 2). The measurements of the wound appeared to have been included together but the wound was not connected. Review of R7's medial record revealed a document entitled Skin and Wound Evaluation V7.0, completed 06/09/2025, revealed an unstageable (obscured full-thickness skin and tissue loss) pressure ulcer to his left gluteus. The same document revealed a measurement of 4.6cm2, length of 6.7cm, width of 2.2cm, and depth that was non applicable. Review of the picture taken of the wound demonstrated one wound to the coccyx and his left gluteus was not visible. Review of R7's medical record revealed a document entitled Skin and Wound Evaluation V7.0, completed 06/16/2025, revealed an unstageable pressure ulcer to his left gluteus. The same document revealed measurements of 0.8cm2 surface area, 1.7cm in length, 0.7cm in width, and 0.2cm in depth. Review of the picture taken of the wound demonstrated one wound to the coccyx. Review of R7's medical record revealed a document entitled Skin and Wound Evaluation V7.0, completed 06/23/2025, revealed an unstageable pressure ulcer to his left gluteus. The same document revealed measurements of 2.5cm2 surface area, 2.8cm in length, 1.3cm in width, and nonapplicable in depth. Review of the picture take of the wound demonstrate one wound to the coccyx. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R7's plan of care revealed the problem statement Resident has impaired skin integrity as evidence by right and left heel boggy redness to groin, and deep tissue injury to left gluteus. During observation and interview on 06/24/2025 at 08:47 a.m. R7 was observed lying down in bed and an alternating mattress was placed on the bed. R7 could not answer if he had a wound on his left gluteus or his coccyx. In an interview on 06/24/2025 at 09:26 a.m. Wound Nurse (WN) I explained that she was responsible for evaluating resident wounds. WN I explained that she would conduct an assessment, which included: measurements of the wounds, classification of the wounds, location of the wounds, measurements of the wounds, description of the wounds, and would take pictures of the wounds. WN I explained that all preceding information would be record on a document entitled Skin and Wound Evaluation V7.0. WN I also explained that it was her responsibility to update the residents plan of care. WN I was asked to review R7's Skin and Wound Evaluation V7.0s, dated 05/26/2025 and 06/02/2025. WN I could not explain why the documents listed R7's wounds as one wound. WN I confirmed that the picture demonstrated two wounds, one deep tissue injury to left gluteal and one unstageable pressure ulcer to R7's coccyx. WN I could not explain why the assessment was not completed accurately for R7's wounds and could not explain why the measurements for the wounds had not been measured individually. WN I was asked to review R7's Skin and Wound Evaluation V7.0, dated 06/16/2025. WN I was asked to explain why it was documented as a left gluteal wound when the picture was only of a coccyx wound. WN I explained that the left gluteal wound must be healed and offered no other explanation. During an interview on 06/24/2025 at 09:36 a.m. Director of Nursing (DON) B explained that Wound Nurse (WN) I was responsible for the assessments of resident wounds on a weekly basis. DON B explained that WN I was also responsible for updating the residents plan of care. DON B was asked to review all of R7's Skin and Wound Evaluation V7.0 documentation and his plan of care. After review of those documents DON B confirmed that R7's Skin and Wound Evaluations V7.0 did not contain accurate measurements or classification of wounds that were pictured. DON B was asked to review R7's plan of care. DON B confirmed that R7's plan of care was not accurate as it did not list both pressure ulcers and identify that the left gluteal pressure ulcer had been healed. DON B could not explain why R7's plan of care and wound assessments had not been completed accurately. During observation on 06/24/2025 at 10:21 a.m. it was observed that R7 was lying down in bed. Wound Nurse (WN) I was observed performing a dressing change, according to physician orders, to R7. R7 was rolled to his right side with the assistance of Director of Nursing (DON) B. WN I removed R7's dressing to his coccyx. An unstageable wound to the coccyx was observed. WN I measured the coccyx wound and pictures were obtained. The wound bed could not be visualized because of slough tissue. The edges of R7s coccyx wound had granulations present. R7's left gluteal appeared to be intact and no pressure ulcer was present. WN I was observed to perform the treatment to the coccyx wound as physician order and dressing was re-applied. Review of R7's Skin and Wound Evaluation V7.0 completed 06/24/2025 at 10:31 a.m. revealed documentation that R7 had an unstageable pressure wound to his coccyx, with an origination date of 05/26/2025. Measurements of the unstageable pressure wound to his coccyx was recorded as 0.9cm2, 2. 0cm in length, 0.6cm in width, and a depth of 0.2cm.