STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235630	A. Building B. Wing	08/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Wyoming	2786 56 Street, SW Wyoming, MI 49418

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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29073 Based on observation, interview and record review, the facility failed to honor resident choices and preferences based on the individualized plan of care for 1 resident (Resident #40) out of 16 residents reviewed for self-determination. Findings: Resident #40 (R40) Review of an Admission Record reflected R40 admitted to the facility with diagnoses that included muscle weakness, need for assistance with personal care, repeated falls, chronic post-traumatic stress disorder PTSD), dependence on enabling machines and devices and anxiety. Review of a quarterly Minimum Data Set (MDS) assessment dated [DATE] reflects R40 is cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) assessment score of 13/15. Review of a Care Plan initiated on 7/20/2023 reflected R40 required assistance with Activities of Daily Living (ADL) related to his diagnoses. Interventions included: Transfers: 2 person assist with Hoyer (mechanical) lift (added to the care plan on 6/14/2024); I like to sit up in my recliner after breakfast (added to the care plan 7/12/2024). Further review of the Care Plan indicated R40 was At risk for impaired mood related to depression, anxiety, insomnia and PTSD. The goal of the care plan focus was (R40) will remain free of signs and symptoms of distress, depression, anxiety, or sad mood. Interventions included Encourage participation from resident to make own decisions; Offer resident choices whenever possible to in order to promote a feeling of self-worth and control over the environment. (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

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 8/20/2024 beginning at 1:45 PM, R40 was seated in his wheelchair next to the nurse station on the unit where he lived. R40 reported he was waiting for staff to transfer him into his recliner chair because he was uncomfortable in his wheelchair. R40 explained that he often has to wait for a long time before 2 staff members can assist with a Hoyer transfer. R40 reported that sometimes he stays in bed longer than he would like to in the morning because he knows it will be a long time before staff will get him into his recliner again, and often staff will transfer him into bed rather than his recliner because staff don't want to transfer him any more than they have to. Certified Nursing Assistants were observed in the area and were aware R40 wanted to be transferred to his recliner and reported having other things to do and waters to pass. Registered Nurse (RN) A was seated at the nurse desk and was overheard instructing staff to transfer R40 into his recliner chair 3 times over the course of the observation. R40 said he was frustrated. RN B came to the nurse desk and agreed to assist Certified Nurse Aide (CNA) C with the two-person transfer. CNA C was overheard encouraging R40 to go to bed, rather than sit in his recliner and R40 said he preferred to sit in his recliner. R40 was transferred to his recliner at 2:25 PM, 40 minutes after the surveyor had become aware of R40's request. During an observation on 8/21/2024 at 11:30, R40 reported he was again wafting to be transferred into his recliner because his wheelchair was very uncomfortable. During a follow-up interview on 8/21/2024 at 3:51 PM, R40 said that he reports his concerns about how long it takes staff to transfer him to every staff who work with him.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37577 Based on observation, interview, and record review, the facility failed to follow professional standards regarding medication administration for 1 of 6 residents (Resident #57), reviewed for professional standards. Findings: Resident #57 (R57) Review of an Admission Record revealed R57 was a [AGE] year-old male, originally admitted to the facility on [DATE], with pertinent diagnoses of stroke, legal blindness, repeated falls, and anxiety disorder. During an observation on 08/21/24 at 10:15 AM, R57 laid in bed resting with his eyes open and a small plastic cup containing multiple pills sat on the overbed table. R57 stated that sometimes the nurse would leave his morning medications for him to take when he wakes up. R57 also reported that he does not take his medications independently, nor store any of his medications in his room. Review of the Electronic Health Record (EHR) for R57 revealed there was not an assessment nor a physician order for R57 to self-administer medications. During an interview on 08/23/24 at 8:08 AM, the Director of Nursing indicated that if a resident was able to self-administer medications, there would be an assessment and an order for such. Review of the facility policy Medication Administration last reviewed 01/17/23, reflected: (15) Observe resident consumption of medication.

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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** 31197 Based on interview, observation, and record review, the facility failed to ensure accurate skin assessments and timely responses to skin changes for 2 of 16 residents, (Resident #22 and Resident #54) reviewed for impaired skin. The deficient practice resulted in no follow-up assessments and treatment orders for identified skin conditions. Findings include: Resident #54 (R54) Review of the Face Sheet and Minimum Data Set (MDS) dated [DATE] revealed R54 admitted to the facility on [DATE] with diagnosis of (but not limited to) stoke, chronic pain syndrome, and heart failure. Brief Interview for Mental Status (BIMS) reflected a score of 12 out of 15 which represented R54 was cognitively intact. During an interview and observation on 8/20/24 at approximately 3:53 PM, R54 was asked if she had any wounds the staff was monitoring and R54 stated she had no wound dressings. R54 stated that she was told she needed surgery for a skin issue on her right breast. R54 pulled her shirt up and showed this Surveyor a darked, raised area of skin that was larger than a half dollar to the right breast. R54 said she'd had the skin issue for a long time. The August 2024 Treatment Administration Record (TAR) was reviewed on 8/20/24 after interviewing R54. There were no monitoring or treatment orders noted for the skin issue to the right breast. The skin assessments from 7/18/24 - 8/20/24 were reviewed on 8/20/24. The assessment dated [DATE] reflected that R54 had an existing abnormal skin area and documented in the comments box reflected, Mole on the right breast. The weekly skin assessments dated 7/25/24, 8/5/24, 8/8/24 and 8/15/24 were reviewed. These 4 most recent assessments all reflected that No was checked for Are there any existing abnormal skin areas? The assessments did not accurately reflect the skin issue to the right breast that R54 showed this Surveyor on 8/21/24. During an interview on 8/21/24 at approximately 12:15 PM, the Director of Nursing (DON) was advised that R54 told this Surveyor that she needed surgery to remove an abnormal skin lesion on her right breast but was unable to find anything about this in the electronic health record. The DON was advised of the weekly skin assessments that did not reflect any ongoing abnormal skin conditions. The DON stated she would look into this. At approximately 2:15 PM, the DON stated R54 was not scheduled for any procedures for the right breast skin issue and provided the following documents for review: -The admission assessment dated [DATE], R54 had a Mole to the right breast that measured 4.1 cm x 4.3 cm. -An updated weekly skin assessment dated [DATE] at 2:12 PM that reflected, Right breast mole measuring 4. 0 x 4.5. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-A verbal physician order to refer resident to dermatology to evaluate mole on right breast dated 8/21/24 at 2:06 PM. These actions were all taken after it was brought to the attention of facility. A request for the most recent physician assessment of the right breast skin issue was made on 8/21/24 at 2:39 PM and the DON provided a copy of the Physician Assistant's note 1/19/22 that reflected, Patient states she has a bunch of moles of her back and chest that are itching her .Several seborrheic keratosis (a skin condition that appears as a waxy, brown, black, or tan growth) noted throughout back and chest .3. Seborrheic keratosis. Advised to keep lesions moist with daily moisturizing . There was no measurement or order to monitor characteristics noted. The orders were reviewed again for updates on 8/22/24 and noted a new order dated 8/22/24 to Assess mole to right breast. Monitor characteristics, measure length and width and document in progress notes, in the evening every 3 month(s) starting on the 1st for 30 day(s) Note characteristics and measurements in progress note. And as needed for resident concerns, noted changes document in nursing notes. There was no evidence the abnormal skin issue to the right breast was being assessed and monitored prior to the onsite survey. Resident #22 (R22) Review of the Face Sheet and Minimum Data Set (MDS) dated [DATE] revealed R22 admitted to the facility on [DATE] with diagnosis of (but not limited to) peripheral vascular disease, heart failure, chronic kidney disease, diabetes, and pressure ulcer to the sacral area. Brief Interview for Mental Status (BIMS) reflected a score of 12 out of 15 which represented R22 was cognitively intact. During an interview and observation on 8/20/24 at 11:06 AM, R22 was observed resting on his bed with his feet on top of the blanket. The left great toe had a dressing with a date of 8/19/24 on it and a dressing to the top of his right foot that was dated 8/19/24. When asked about the wounds to the left toe and right foot, R22 could not recall how they happened but stated that he has poor circulation. The most recent weekly skin assessment dated [DATE] (11 days prior) reflected no new skin issues but reflected existing skin issues of right toes, right buttock and left buttock. No indication of a right foot wound to the top of the foot at the time of this assessment. The electronic progress notes from 8/1/24 - 8/21/24 were reviewed on 8/21/24 at approximately 11:30 AM and did not reveal any documentation of an open area to the right foot that required a dressing. The care plan for skin integrity in the electronic record was reviewed on 8/21/24 at 11:30 AM and did not reflect an issue to the right foot nor any interventions regarding it. The August 2024 TAR was reviewed on 8/21/24 at 11:30 AM and did not reflect a treatment order for the right foot. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview and record review on 8/21/24 at approximately 2:00 PM, the DON was advised of the presence of a dressing on R22's right foot that had the date of 8/19/24 documented on it. There was no indication of the skin issue documented in the progress notes, skin assessment nor the August TAR. The DON stated that Registered Nurse (RN) A does wound rounds every Monday and may have more information related to the right foot. During an interview on 8/22/24 at 10:45 AM, RN A stated that she was the first person to note a new skin tear to the top of the right foot. RN A stated normally she notifies the physician, obtains a treatment order, documents it in the progress notes and updates the care plan. RN A stated, There was a lot going on that day and I missed it.