STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235399	A. BUILDING _____ B. WING _____	07/02/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MEDILODGE OF PORTAGE	**7855 CURRIER DR PORTAGE, MI 49002**

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

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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.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake # MI 844 Based on observation, interview and record review, the facility failed to provide preventative care, consistent with professional standards of practice for 1 out of 7 residents (Resident #104) reviewed for the risk for the development of pressure injuries, resulting in the development of an avoidable pressure ulcer and the potential for infection and overall deterioration in health status. Findings include: Review of the facility policy Pressure Ulcers/Pressure Injury Prevention and Treatment-Clinical Protocol last revised 11/28/2017 revealed, The facility should have a turning and repositioning program which allows staff to know resident's individual intervention and monitoring. The following is but one example of such a program: i. Yellow Dot-Residents who are at high risk for the development of PU/PI (Pressure Ulcer/Pressure Injury) .1. Plain yellow dot-Turned and repositioned every 2 hours . Review of a Face Sheet revealed Resident #104 was a [AGE] year-old male, originally admitted to the facility on [DATE], with pertinent [DIAGNOSES REDACTED]. Review of a Minimum Data Set (MDS) assessment for Resident #104, with a reference date of 5/1/20 revealed a Brief Interview for Mental Status (BIMS) score of 11, out of a total possible score of 15, which indicated Resident #104 was moderately cognitively impaired. Review of the Functional Status revealed that Resident #104 required extensive 2 person assistance with bed mobility and transferring. Review of the Skin Condition revealed no documentation of a Pressure Injury. Review of Resident #104's Care Plan revealed, The Resident needs activities of daily living assistance related to alcoholic liver [MEDICAL CONDITION] with malignant ascites CAD ([MEDICAL CONDITION]), HF (heart failure), Type 2 DM (diabetes), generalized weakness, pain, incontinence. Date Initiated: 04/25/2020 .The resident uses bilateral grab bars & one staff assistance with turning and repositioning in bed. Date Initiated: 04/27/2020 .The Resident admitted to (facility) with blanchable redness to his coccyx and bilateral buttocks, excoriation to the groin .Encourage and assist Resident to float heels when in bed .Yellow Dot Program: encourage and assist Resident to turn and reposition when in bed q. (every) 2-3h and PRN (as needed). During an observation on 06/30/2020 at 9:40 A.M., Resident #104 was in his bed on his back. He did not have any positioning device under his left side, right side, or under his legs. During an observation on 06/30/2020 at 11:50 A.M., Resident #104 was in his bed on his back. He did not have any positioning device under his left side, right side, or under his legs. During an observation on 06/30/2020 at 1:56 P.M., Resident #104 was in his bed on his back. He did not have any positioning device under his left side, right side, or under his legs. During an observation on 06/30/2020 at 3:23 P.M., Resident #104 was in his bed on his back. He did not have any positioning device under his left side, right side, or under his legs. During an observation and interview on 07/01/2020 at 10:00 A.M., Resident #104 was in his bed on his back. He did not have any positioning device under his left side, right side, or under his legs. Resident #104 reported that staff do not assist him with repositioning or offsetting pressure. Resident #104 reported his buttocks becomes sore from the amount of time he spends on his back. During an observation on 07/01/2020 at 12:23 P.M., Resident #104 was in his bed on his back. He did not have any positioning device under his left side, right side, or under his legs. Review of Resident #104's Norton Plus Pressure Ulcer Scale dated 4/25/20 revealed, High Risk for pressure ulcers. Review of Resident #104's Nursing Admission Evaluation dated 6/13/20 revealed, Buttocks .red/blanchable indicating blood flow to the area. Review of Resident #104's physician progress notes [REDACTED]. Indicating no pressure ulcer or open area to Resident #104's skin. During an observation on 07/02/2020 at 8:46 A.M., Resident #104's buttocks was observed. There was a bright red, open, non-blanchable area on Resident #104's right inner buttock approximately the size of the diameter of a AAA battery. Review of Resident #104's Skin assessment dated [DATE] revealed, right buttock .shearing 0.8 (cm) x 1(cm) x 0.05 (cm) (depth) indicating a Stage II Pressure Ulcer. Review of Resident #104's Skin Assessment's revealed no weekly skin assessments completed from 6/13/20 to 7/2/20. Review of Resident #104's Daily Skin Observations from 6/3/20 to 7/2/20 revealed no documentation of an Open Area on Resident #104's skin. Review of Resident #104's Behavior Logs for June/July 2020 revealed no documentation of refusal of care for bed mobility. During an interview on 07/02/2020 at 10:30 A.M., Certified Nursing Assistant (CNA) F reported that residents that require assistance with bed mobility should be repositioned every hour. During an interview on 07/02/2020 at 10:40 A.M., Licensed Practical Nurse (LPN) M reported that complete Skin Assessments are completed weekly for every resident. LPN M reported that any change in skin condition is documented and reported to the physician. During an interview on 07/02/2020 at 10:50 A.M., CNA G reported that residents that require assistance with bed mobility should be repositioned every 1-2 hours or more if needed.
F 0689 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake # MI 976 Based on observation, interview, and record review, the facility failed to 1.) failed to properly transfer a resident at discharge for 3 of 7 residents (Resident #102, #105, and #107) reviewed for accidents and hazards and, 2.) utilize wheelchair footrests (footplate's), resulting in a fall and the potential for serious injury. Findings include: Review of the facility Policy Preparing a Resident for Transfer or Discharge last revised 12/2016 revealed, Policy Statement Our facility shall prepare a resident for a transfer or discharge .2. Nursing Services will be responsible for .b. Packing and collecting personal possessions .d. Escorting the resident to transportation . Review of Mosby's Textbook for Long-Term Care Nursing Assistants by Claire Kostelnick, 6th Edition 2014 revealed on page 135 wheelchair safety were to Position the person's feet on the footplate's (foot pedals), Make sure the person's feet are on the foot plates before moving the chair (wheelchair). Never push a person in a wheelchair without feet resting on footplates. Resident #102 Review of a Face Sheet revealed Resident #102 was a [AGE] year-old male, originally admitted to the facility on [DATE], with pertinent [DIAGNOSES REDACTED]. Review of a Minimum Data Set (MDS) assessment for Resident # 102, with a reference date of 2/15/20 revealed a Brief Interview for Mental Status (BIMS) score of 15, out of a total possible score of 15, which indicated Resident #102 was cognitively intact. Review of the Functional Status revealed that Resident #102 required extensive 2 person assistance in transferring. Review of Resident #102's Incident Report dated 3/10/20 at 5:20 P.M. revealed, Resident was just discharged and wife was pushing resident down walk and the wheel went over the curb and resident fell out of wc (wheelchair) .No apparent injury .Resident (complains of) pain to neck. Review of Resident #102's Statement of Witness written by Family Member (FM) H and dated 3/10/20 revealed, Lady was wheeling a man out and started going down handicap ramp but didn't have the wc (wheelchair) wheels flat and the front right wheel went over curb and resident feel (sic) out of wc. He had all his belongings in his lap and that might have made him lean forward. During an interview on 07/02/2020 at 12:06 P.M. FM H reported that she witnessed Resident #102's fall in the parking lot. FM H reported a female was pushing Resident #102 and he had a lap full of different things. FM H reported that Resident #102 was being wheeled down the left ramp and one wheel of the wheelchair went up on the curb and the other wheel

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

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.

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F 0689 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) got stuck down into the little crease. FM H stated, I really believe it was the divot in the connection between the sidewalk and parking lot. FM H reported that no facility staff were present during Resident #102's fall. During an interview on 07/01/2020 at 3:21 P.M., Licensed Practical Nurse (LPN) I reported that she was the nurse on duty at the time of Resident #102's fall. LPN I reported that Resident #102's wife was escorting him to the car without staff assistance. LPN I reported that staff members should be present when a resident is being discharged and assist with transferring into the vehicle. LPN I stated, She (Resident #102's wife) hit cement that stopped her abruptly and then he tipped. LPN I reported that she did not observe the fall. During an interview on 06/30/2020 at 2:39 P.M., FM J reported that on 3/10/20 Resident #102 was discharged from the facility. FM J was bringing him to their car with his belongings on his lap. FM J reported she brought him down the left ramp next to the Pick Up Only parking space. FM J reported that the front wheelchair wheels stopped abruptly in the divot and Resident #102 fell out of the wheelchair. FM J reported the space connecting the ramp to the parking lot was not flush. FM J reported that Resident #102 immediately reported loss of feeling in his legs and severe pain in his back and neck. FM J reported that Resident # 102 was transported to the hospital via ambulance where he remained until April 17th, 2020. Review of Resident #102's Hospital Medical Records revealed, Patient (Resident #102) was discharged from rehab on 3/10/2020 but unfortunately as he was being wheeled out in a wheelchair, the wheelchair hit a rock and he fell . Patient was complaining of severe neck and back pain .His wife was wheeling him outside of the rehab facility today when the wheelchair hit a bump and he tipped over. The patient fall (sic) forward to the ground and had immediate pain in his neck, back and knee. He reports severe pain still in his neck and mid back .His wife reports that he has been unable to bear weight since this fall, and was previously able to stand and walk with assistance and a walker at rehab this morning .He was unable to stand, and legs collapsed underneath him when he tried to stand up with a walker. Multiple staff members supported the patient to prevent him from falling, and assisted him back to bed. Given this acute change and concern for new weakness, MRI of his cervical, [MEDICATION NAME] and lumbar spine was performed. [MEDICATION NAME] spine imaging was concerning for new fluid collection in T4 to T6 ([MEDICATION NAME] spine area) area causing [MEDICAL CONDITION] and compression of the spinal cord .1. Acute fluid collection in the postoperative bed from T4 to T6 causing moderate spinal canal narrowing, decreased size of the previously seen syrinx (fluid-filled cavity within the spinal cord) on 11/16/2019 and small focal area of myelomalacia (softening of the spinal cord) at the dorsal (upper side) aspect of the spinal cord at T6. Neuro surgical consultation is recommended . Resident # 105 Review of a Face Sheet revealed Resident #105 was a [AGE] year-old male, originally admitted to the facility on [DATE], with pertinent [DIAGNOSES REDACTED]. Review of a Minimum Data Set (MDS) assessment for Resident #105, with a reference date of 6/24/20 revealed a Brief Interview for Mental Status (BIMS) score of 3, out of a total possible score of 15, which indicated Resident #105 was severely cognitively impaired. Review of the Functional Status .Mobility Devices revealed that Resident #105 normally used a wheelchair. During an observation on 06/30/2020 at 12:06 P.M., Certified Nursing Assistant (CNA) C pushed Resident # 105 through the hallway and dining room (greater than 25 feet) without foot pedals on his wheelchair. During an observation on 06/30/2020 at 12:21 P.M., CNA D pushed Resident #105 through the dining room (greater than 25 feet) without foot pedals on his wheelchair. Resident #107 Review of a Face Sheet revealed Resident #107 was an [AGE] year-old female, originally admitted to the facility on [DATE], with pertinent [DIAGNOSES REDACTED]. Review of a Minimum Data Set (MDS) assessment for Resident #107, with a reference date of 6/1/20 revealed a Brief Interview for Mental Status (BIMS) score of 8, out of a total possible score of 15, which indicated Resident #107 was cognitively impaired. Review of the Functional Status .Mobility Devices revealed that Resident #107 normally used a wheelchair. During an observation on 07/01/2020 at 12:03 P.M., CNA E pushed Resident #107 through the dining room (greater than 25 feet) without foot pedals on her wheelchair. During an interview on 07/02/2020 at 10:30 A.M., CNA F reported that there must be foot pedals on wheelchairs while pushing residents. CNA F stated foot pedals are required for safety, so residents do not fall out of the wheelchair. During an interview on 07/02/2020 at 10:50 A.M., CNA G stated, Never push residents without foot pedals. CNA G reported foot pedals are used in order to prevent a fall from the wheelchair.
F 0921 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.** This citation pertains to intake #MI 976 Based on observation and interview, the facility failed to provide a safe and functional environment for residents, staff and the public as evidenced by the handicap entrance ramps being in a condition of disrepair resulting in the potential for falls and/or serious injury for residents, staff, and visitors. Findings include: During an observation on 06/ 0 at 1:58 P.M., the end of the ramp on the left side, which connected to the parking lot, had a divot that was greater than a half inch but less than an inch deep. The length of the area was greater than 12 inches long. During an interview on 07/01/2020 at 3:50 P.M., Ambulance Employee (AE) K reported that the ramp that goes to left causes concerns when she wheels residents down the ramp. AE K reported that the divot at the bottom of the ramp can cause the wheels on wheelchairs to hook and throw them out if they are not strapped into the wheelchair. AE K reported that because of the divot it is best to wheel them (residents) backwards. During an interview on 07/01/2020 at 12:46 P.M., Maintenance Employee (ME) L reported that he was not notified of work that needed to be done to the ramps/sidewalk. ME L reported that no repairs to the ramps have been completed since March 10, 2020. During an interview on 07/02/2020 at 10:55 A.M., ME L reported that he was repairing the ramps because there was too much of a deviation.