STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235292	A. BUILDING _____ B. WING _____	09/23/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MEDILODGE OF SAULT STE MARIE	**1011 MERIDIAN RD SAULT SAINTE MARIE, MI 49783**

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 0578 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to review advance directives in a timely matter for one (Resident #57) of five residents reviewed for advance directives. This deficient practice resulted in the potential for residents not having the opportunity to express preferences for life saving measures. Findings include: A review of Resident #57's face sheet revealed an admission date of [DATE]. Resident #57's medical [DIAGNOSES REDACTED]. An advance directive was revealed in Resident #57's Electronic Medical Record (EMR) which was dated 1/11/19. The advance directive indicatted Resident #57 was to not be resuscitated in the event of an emergent life threatening situation. In an interview with Director of Social Services/Social Worker (SW) F on 09/17/20 at 4:10 p.m., SW F reported there was not a more recent advance directive for Resident #57. SW F agreed the advance directives should be reviewed on at least an annual basis. SW F was not able to voice what the policy was for reviewing advance directives. A copy of the facility's Advance Directives policy with the most recent revision date of 12/07/12 revealed the following information, .7. The Interdisciplinary Team will review annually with the resident his or her advance directives to ensure that such directives are still the wishes of the resident. Such reviews will be made during the annual assessment process and recorded in the resident medical record .
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** Based on observation, interview, and record review, the facility failed to ensure a fall care plan was in place for one Resident (#14) out of four Residents reviewed for falls. This deficient practice resulted in the potential for further falls and the potential for injury. Findings include: A review of Resident #14's record revealed admission to the facility on [DATE] with [DIAGNOSES REDACTED]. A review of a Brief Interview of Mental Status (BIMS) assessment revealed a score of 2/15, indicating severely impaired cognition. A review of a progress note dated 9/5/20 revealed, Resident observed lying on floor on right side of bed with head against night stand. Assessment: resident with triangular laceration to left side of forehead with moderate amt (amount) of bleeding. 2 large skin tears to left arm. injury. Mitigating Factors: bed not in low position. resident with baseline confusion. Environmental Factors: bed not in low position. Interventions: low bed . A review of a 9/5/20 progress note revealed, Resident returned from hospital for evaluation related to recent fall . has 8 sutures to right forehead. Skin tears to left arm are steri-stripped and covered, to be changed daily. Resident does not appear distressed and reports mild pain to left arm and shoulder with movement. Scheduled medications given without issues. Bed is in lowest position. Will cont (continue) to monitor. A review of Resident #14's Fall Risk Assessments revealed she scored the following: 3/6/20: 30, 6/3/20: 22, 9/3/20: 14, and 9/5/20: 20. All assessments revealed, Interventions Required. A review of Resident #14's care plan revealed that the fall care plan had not been initiated until 9/5/20.
F 0688 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the provision of range of motion (ROM) and restorative services for three Residents (Residents #6, #25, and #57) of three residents reviewed for ROM and contracture management. This deficient practice resulted in the potential for further decline, progression of contractures, and unnecessary pain. Findings include: Resident #6 Review of Resident #6's quarterly Minimum Data Set (MDS) assessment, reference date 6/17/20, revealed admission to the facility on [DATE], with [DIAGNOSES REDACTED]. Resident #6 was extensive two-person assistance for bed mobility, transfers, and toileting, and extensive one-person assistance for eating and dressing. The Brief Interview for Mental Status (BIMS) revealed a score of 15/15, which showed no cognitive impairment. During an interview on 9/15/20 at approximately 1:00 p.m., Resident #6 motioned towards her nightstand, and showed this Surveyor bilateral soft hand arthritis splints. Resident #6 was laying in supine (on her back) in her facility bed. Resident #6 reported, They are arthritis splints which go between my (hand) joints. The staff are not putting them on. Resident #6 next showed both of her hands, which each had flexion contractures (bent joints which cannot be straightened with ROM) at the smaller joints, and ulnar drift (bending towards the ulnar bone side) at the larger joints. Resident #6 also showed how it was difficult to hold a magazine which was on her bed. Resident #6 declined assistance, and with some extra time and effort did turn the pages. It was noted her right hand was contractured to nearly a fist, and her left hand was partly open but appeared deformed. Resident #6 stated she would like therapy or restorative ROM for her hands so she could us them more easily, such as to turn magazine pages or hold a cup. Resident #6 reported she was not getting any ROM for her hands or therapy recently. During an interview on 9/16/20 at 2:46 p.m., CNA Q, a full-time day shift CNA on Resident #6 and Resident #25's hall, was asked about ROM and mobility for these residents. CNA Q reported, We used to have a restorative aide, now we don't .I haven't done ROM with (Resident #6) for a long time. CNA Q stated she did not have time to complete ROM exercises with the residents on her hall, as she spent her time providing care to the residents. During an interview on 9/16/20 at 3:18 p.m., Resident #6 was again observed in her facility bed. Resident #6 was not wearing her bilateral hand splints. Resident #6 reported staff did put them on earlier today, and added, They've only been on about three times in the past month. Resident #6 reported staff did not provide any ROM to her arms or her legs, and reported she was getting stiffer. During a telephone interview on 9/17/20 at 9:43 a.m., CNA Q confirmed Resident #6 did use both of her hands to turn the pages of her magazines, hold a fork once placed in her right hand, and drink from a cup using her right hand when she was sitting up in her bed. CNA Q added, When she lies back (in bed which she prefers) she can't reach it then (the cup); she has some trouble lifting her arms. It's more her left arm then her right. Review of Resident #6's Look Back Report, Restorative Levels, received via email from the DON on 9/17/20 at 11:46 a.m., revealed 0 (no) entries for ROM (active), ROM (passive), and Splint/Brace, from 7/16/20 through 9/16/20. It was noted 0 minutes were spent on these activities, and no entries were noted. Review of Resident #6's last Occupational Therapy evaluation, provided by Rehabilitation Director/ Speech Language Pathologist (SLP) T on 9/16/20, dated 12/12/19, revealed, .Therapy necessary for joint protection .Without therapy patient at risk for pain and increased contractures .(goal) The caregiver demonstrates

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 0688 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) donning/doffing of B (bilateral) UE (upper extremity) ulnar drift splints . Review of Resident #6's current Care Plan revealed, (Resident #6) has limited physical mobility related to limited ROM, repaired rotary cuff, [MEDICAL CONDITION] (disease), and recent left knee surgery. Date initiated 4/25/18, revised 4/16/19 .Monitor .any s/s (signs or symptoms) of immobility, contractures forming, or worsening .Provide gentle range of motion as tolerated with daily care . Resident #25 Review of Resident #25's annual MDS assessment, reference date 7/03/20 , revealed admission to the facility on [DATE], with [DIAGNOSES REDACTED]. Resident #25 was total two-person assistance for bed mobility, transfers, and toileting, and extensive two-person assistance for dressing and eating. The BIMS revealed a score of 4/15, indicating severe cognitive impairment. On 9/15/20 at approximately 12:30 p.m., Resident #25 was observed in bed being fed by a nurse aide. Resident #25's hands and elbows appeared to be contractured (positioned in a flexed/curled position). During an interview on 9/16/20 at 2:54 p.m., Resident #25 was observed in bed on her right side wearing soft bilateral palmar cuff splints. Resident #25 was asked about her hands and her splints. Resident #25 stated, They (staff) aren't doing ROM right now as they don't have anyone to come and do the exercises . I have MS ([MEDICAL CONDITION]). I can't hold anything. It's been like that for two and a half years. I haven't had any ROM in a couple months . Resident #25's right wrist was also observed in a severe flexion contracture. A soft touch call light was at her right side of her head on her pillow; Resident #25 confirmed she used her head and neck rotation to activate her call light. During an interview on 9/16/20 at approximately 4:00 p.m., SLP T confirmed the last time Resident #25 was on therapy was 5/15/20, primarily for feeding and a splinting program. SLP T confirmed there was no restorative aide currently in the facility. During a telephone interview on 9/17/20 at 9:50 a.m., CNA Q was asked about Resident #25's functional status, and if she was providing any ROM to Resident #25. CNA Q responded, .Her hands don't work well enough to feed herself .(Resident #25) has to be fed We only get one aide . and there is just no time and you can't go in a room and do ROM and have resident lights on and waiting . During a telephone interview on 9/18/20 at 1:34 p.m., the Social Services Designee, Staff K was asked about Resident #25 BIMS score of 4, and the EMR (electronic medical record) showing Resident #25 was her own responsible party. Staff K confirmed Resident #25 is generally oriented, able to a hold conversation and participate in her own care planning, making decisions about her care. Staff K was asked if she had any concerns with Resident #25 being her own responsible party, and responded, No, I don't. During an interview on 9/16/20 at 4:31 p.m., the Director of Nursing (DON) was asked about the residents on (name of) hall who reported they were not receiving range of motion or restorative services. The DON responded, We had a full time restorative aide on the floor, and they would do a group pre-covid (before the COVID pandemic) .we have had a hard time pulling someone from the floor, and I am hiring for a part time shower aide and part time restorative aide and I just did some interviews . Review of Resident #25's occupational therapy daily note by Occupational Therapist (OT) U, dated 4/22/20, noted, PROM (passive range of motion) BUE (bilateral upper extremities) to decrease contractures, donned R palm roll and L resting hand splint . Review of Resident #25's, Look Back Report, Restorative Levels, received via email from the DON on 9/17/20 at 11:46 a.m., also revealed 0 (no) entries for ROM (active), ROM (passive), and Splint/Brace, from 7/16/20 through 9/16/20. Review of Resident #25's current Care Plan, revealed, Limited physical mobility r/t (related to) MS with paralysis, [MEDICAL CONDITION], and bilateral hand/arm contractures. Date initiated 10/19/2017, revised 11/30/2017 . Review of the policy, Restorative Nursing Program, revised 3/2019, provided by the DON on 9/16/20, revealed, .The following types of residents could benefit from a Restorative Program(s) but (sic) limited to: Contracture Prevention and/or Management . A review of Resident #57's face sheet revealed an admission date of [DATE]. Resident #57's medical [DIAGNOSES REDACTED]. On 9/16/20 at 7:30 a.m. Resident #57 was observed in ther bed. Their right side appeared to be flaccid. Resident #57 was unable to show any movement to either their right arm or leg. On 09/16/20 at 7:35 Certfied Nurse Aide (CNA) G reported Resident #57 did have right side flaccidness. CNA G was not aware of any restorative therapy Resident #57 at this time. During an interview with Registered Nurse (RN) E and CNA Ion 9/16/20 at 2:54 p.m., it was reported RN E had formerly been overseeing the restorative therapy program, but due to the loss of several staff members there is not a restorative therapy program in place currently. CNA I reported they used to be the restorative therapy aide, but is no longer functioning in this role. CNA I reported Resident #57 used to receive Passive Range of Motion (PROM) exercises to their right leg. In an interview with Licensed Practical Nurse (LPN) J on 9/16/20 at 3:14 p.m., LPN J reported there is not a dedicated restorative aid at this time. Currently LPN J receives restorative therapy recommendations from occupational and physical therapy for residents. LPN J then enters the the recommended restorative therapy exercises into the EMR. The CNAs should recieve these recommended restorative excercises as a task to perform with the residents. LPN J reviewed Resident #57's restorative therapy exercises with this Surveyor, A review of Resident #57's cardex (a care plan reference for CNA) revealed the following information, Level 3 Restorative Nursing: Range of Motion (passive) 2x5 PROM of RUE (Right Upper Extrmity) in all planes of motion. In a follow up interview on 09/16/20 at 5:02 PM, CNA G reported they looked at Resident #57's cardex and verfied there were not restorative exercises ordered for Resident #57 at this time. Further review of Resident #57's EMR revealed the Level 3 Restorative Nursing: Range of Motion (passive) 2X5 PROM (Passive Range of Motion) of RUE (Right Upper Extremity) in all planes of motion. was entered by RN E on 8/13/19. A review of completed tasks for Resident #57's completed tasks for the dates of 9/1/20 through 9/16/20 revealed PROM exercises did not occur for seven of the last 16 days.
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 contains two deficient practices: Deficient Practice #1 Based on observation, interview, and record review, the facility failed to ensure interventions were in place and consistently implemented to prevent falls for one Resident (#14) out of four Residents reviewed for falls, and failed to ensure wheelchair equipment safety for one Resident (#210) out of four Residents reviewed for wheelchair equipment safety. This deficient practice resulted in the potential for subsequent falls and the potential for injury. Findings include: A review of Resident #14's record revealed admission to the facility on [DATE] with [DIAGNOSES REDACTED]. A review of a Brief Interview of Mental Status (BIMS) assessment revealed a score of 2/15, indicating severely impaired cognition. A review of a progress note dated 9/5/20 revealed, Resident observed lying on floor on right side of bed with head against night stand. Assessment: resident with triangular laceration to left side of forehead with moderate amt (amount) of bleeding. 2 large skin tears to left arm. injury. Mitigating Factors: bed not in low position. resident with baseline confusion. Environmental Factors: bed not in low position. Interventions: low bed . A review of a 9/5/20 revealed, Resident returned from hospital for evaluation related to recent fall. She has 8 sutures to right forehead. Skin tears to left arm are steri-stripped and covered, to be changed daily. Resident does not appear distressed and reports mild pain to left arm and shoulder with movement. Scheduled medications given without issues. Bed is in lowest position. Will cont (continue) to monitor. A review of Resident #14's Fall Risk Assessments revealed the following scores: 3/6/20: 30, 6/3/20: 22, 9/3/20: 14, and 9/5/20: 20. All assessments revealed, Interventions Required. A review of Resident #14's care plan revealed the fall care plan had not been initiated until 9/5/20. This care plan included the intervention, Bed in lowest position when not providing care with an intervention date of 9/5/20. On 9/16/20 at 2:11 p.m., Resident #14 was observed sitting in bed drinking a supplement with the bed at medium height. At 2:40 p.m. Resident #14 was again observed sitting in bed, with the bed not in the lowest position. On 9/16/20 at 2:44 p.m., an interview was conducted with the Administrator. The Administrator confirmed that there had been no care plan in place for falls until after the incident on 9/5/20. On 9/16/20 at 3:10 p.m. Resident #14 was observed sitting in bed with the bed not in the lowest position. Registered Nurse (RN) S was observed to go in and close the door. At 3:11 p.m., RN S exited the room after repositioning the resident. The bed was then observed to be in the lowest position. When RN S was asked if the bed had been in the correct lowest position when she entered the room, RN S stated, I don't remember. A review of the facility policy titled, Falls - Clinical Protocol dated 6/2018 revealed, 1. As part of an initial and ongoing resident assessment, the staff will help identify individuals with a history of falls and risk factors for subsequent falling. This will be accomplished by the following task; a. The Falls Risk Evaluation is completed upon admission, quarterly, and with significant change in status. 1. Based on the assessment a care plan will be developed and implemented to address identified risk. This will be revised as necessary . During an observation on 9/15/20 at approximately 12:00 p.m., Resident #210 was observed in her room in bed with the lights

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F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) low. Her hemi-height (short) manual wheelchair was next to her bed. This Surveyor could see there were cracks on the fabric of the armrests. There was an open area about the size of a quarter where there was no black plastic over the right armrest, and a crack on the left armrest fabric The chair appeared older. Resident #210 reported she fell here and broke her hip, and that she had not received enough therapy. Resident #210 asked Surveyor to return as she was resting. During an interview on 9/16/20 at 3:20 p.m., Resident #210 was sitting in her manual wheelchair. Resident #210 appeared frustrated and showed this Surveyor she cannot manipulate her brakes, stating, It's not safe. I can't work it. Resident #210 demonstrated it was very difficult for her to operate both of her wheelchair brakes, the left brake specifically. Surveyor attempted to operate the brakes and found the right brake was tight, and the left brake was nearly impossible to engage to close without excessive painful effort. Surveyor noted neither metal brake was covered; with no padding or cover to prevent hand pain or injury and/or to improve ease of engaging the brake. There was no anti-rollback device observed on the wheelchair. Resident #210 then positioned her wheelchair for a transfer, showing this Surveyor she cannot lock the brakes for transfers. This Surveyor let Resident #210 know not to complete the transfer and understood she meant the brake does not work for her to lock before she transfers. Resident #210 indicated that was correct, that it was not safe during transfers. Resident #210 reported she was in therapy and when she was standing up or trying to transfer, It is dangerous. Surveyor also noted paint was chipped off on the sides of the wheels; the chair appeared old and in disrepair. Resident #210 reported she was frustrated as she had told both of her therapists that the wheelchair brakes were not working and it was not safe. There was no brake extender observed on either brake to possibly make it easier to engage. During an observation on 9/16/20 at 4:00 p.m., Resident #210 was observed leaving her room with Staff Y, who was assisting her to get a cup of coffee. Resident #210 was heard telling Staff Y her wheelchair brakes were not working, and she would like them repaired. During an observation on 9/16/20 at 4:38 p.m., the wheelchair was not repaired, the brakes remained uncovered. During a telephone interview with the Director of Nursing (DON) on 9/17/20 at 8:08 a.m , the DON was asked to describe Resident #210's wheelchair to this Surveyor. The DON reported, I did observe her armrests are wearing, and one of the brakes was very difficult to manipulate. I noticed the brakes didn't have the pads (covers); most of our wheelchairs do have the brake pads . The DON planned to follow up with therapy about this wheelchair. The DON called back at 8:59 a.m. and reported, They are looking into a new wheelchair .(Resident #210) said absolutely, we could order her a different chair. She seems to be deep in her chair with the arms, and is needing a new chair due to the armrest position. They put the brake pads on the chair this morning . During a telephone interview on 9/17/20 at approximately 8:25 a.m., Resident #210's Physical Therapist Assistant, PTA Z, was asked if she was aware Resident #210's concerns regarding her wheelchair. PTA Z paused, then reported, I don't have any concerns related to her wheelchair. When asked if Resident #210 had expressed difficulty operating her brakes, PTA Z denied any concerns were expressed, and would look into Resident #210's wheelchair today. When asked if manual wheelchairs should have brake covers PTA Z responded, Yes, I assume so. During a telephone interview on 9/17/20 at 8:47 a.m., the Environmental Service Director, Staff AA, was asked if he was aware Resident #210's wheelchair had any concerns reported. Staff AA reported he did receive an order yesterday evening to adjust a wheelchair brake, he assumed for Resident #210. During a telephone interview on 9/17/20 at 9:14 a.m. with Resident #210's Physical Therapist, PT BB, PT BB was asked about any concerns with Resident #210's wheelchair/brakes. PT BB paused, then denied awareness of any concerns with the wheelchair or brakes. He reported Resident #210's wheelchair had not changed recently; she has had the same wheelchair. PT BB acknowledged the wheelchair brakes should have padding, reporting, Normally they (the brakes) come with the pad. Sometimes we get an extender (to make it easier to operate the brakes). PT BB acknowledged this wheelchair should be changed if there were cracks in the pads, just for comfort. Surveyor also expressed infection control concerns with cracks on the armrest padding. Per his discussion with the therapy team this morning, PT BB reported the therapy staff are looking into getting Resident #210 a brake extension on the left brake, and a brake pad on the right brake. During a telephone interview on 9/17/20 at 3:24 p.m. with CNA G who was working down (Resident #210's) hall. CNA G reported she frequently provided care for Resident #210 on the day shift. CNA G was asked if there were any concerns related to Resident #210's wheelchair. CNA G responded, (Resident #210) had mentioned one of the brakes is hard to put on .one is pretty good, the other one is tough .I have mentioned it to therapy. When I mentioned it, we (the facility) didn't have any wheelchairs that were her size. They (the therapy department) had larger ones and she is a smaller lady. CNA G was asked when she mentioned it to therapy, responding, maybe a month ago; she is in the same chair as far as I have noticed. CNA G was asked to observe Resident #210's wheelchair and call this Surveyor back. CNA G reported back there were brake covers on the wheelchair, and noted there were still cracks on the armrests of the wheelchair. CNA G confirmed it appeared to be the same wheelchair she used daily. Review of Resident #210's current Physical Therapy notes showed Resident #210 was evaluated 8/25/20, and was still receiving therapy. Review of evaluation and goals showed therapy was working on transfer training with Resident #210. Review of Resident #210's fall reports showed Resident #210 had two falls from her wheelchair on 5/20/20 and 6/11/20. There was no injury on 5/20/20, and a small [MEDICAL CONDITION]/abrasion with a left hip hematoma on 6/11/20. Review of documents provided by Staff AA on 9/17/20, revealed evidence of regular general facility-wide wheelchair/equipment inspections by the facility, and an invoice for the purchase on this date for a wheelchair brake cover and a wheelchair brake extension for Resident #210's wheelchair, dated 9/17/20. Review of the policy, (Therapy Provider) Basic Guidelines for Treatment Policy - 103, received from the NHA on 9/22/2020, updated 6/2016, revealed, Purpose: To ensure proper care of patients and proper documentation procedures in accordance to state and federal laws and regulations. Policy: We are committed to providing quality care and acting with absolute integrity by the way we do work and conduct our daily business . The remainder of the policy referenced documentation, charting, and evaluation/treatment completion requirements. This was the only therapy policy received from the facility by the end of the survey.
F 0710 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Obtain a doctor's order to admit a resident and ensure the resident is under a doctor's care.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the Physician was assessing and documenting on the full status of a Resident's health regarding pressure ulcers for one Resident (#47) out of four Residents reviewed for pressure ulcers. This deficient practice resulted in the potential for lack of coordination of care with the physician. Findings include: A review of Resident #47's record revealed admission to the facility on [DATE] with [DIAGNOSES REDACTED]. A review of the 8/20/20 Minimum Data Set (MDS) assessment revealed a score of 1/15 on the Brief Interview of Mental Status (BIMS) assessment, indicating severely impaired cognition. On 9/15/20 at 12:05 p.m., Resident #47 was observed lying on their left side. A catheter bag in a privacy bag was observed to be hanging off the bed and making contact with the floormat beside the bed. A review of the physician orders [REDACTED].One time only for to promote wound healing until 09/14/20 . A review of the wound log for Resident #47 revealed the stage two pressure ulcer was discovered on the coccyx on 5/20/20. Per these notes, the wound started to show signs of tunneling on 9/8/20 at which point it was upstaged to a stage three pressure ulcer. A review of the physicians progress notes dated 8/30/20, 7/29/20, and 6/28/20 revealed no documentation regarding her pressure ulcer that developed on 5/20/20 or the indwelling catheter that was placed on 8/14/20. On 9/15/20 at 4:50 p.m., Registered Nurse (RN) E was interviewed regarding the wound and its care. When asked about the lack of documentation from the physician, RN E stated, I don't know why he wasn't documenting it, but he had to know about it because he was signing the orders (for the wound treatment and catheter).
F 0711 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the physician visit progress notes were placed in the medical record in a timely manner for eight Residents (#1, #16, #20, #30, #50, #54, #55, #210) of 20 residents reviewed for physician visits, and failed to ensure the resident's total program of care was reviewed during each physician visit, for one Resident (#201). These deficient practices resulted in the potential for a lack of coordination of care, and negative outcomes. Findings include: Resident #55 Review of Resident #55's admission Minimum Data Set (MDS) assessment, reference date 5/18/20, revealed admission to the facility on [DATE], with [DIAGNOSES REDACTED]. Resident #55 required one-person assistance for transfers, walking in room, dressing, toileting and hygiene. The Brief Interview for Mental Status (BIMS)

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F 0711

Level of harm - Minimal harm or potential for actual harm

Residents Affected - Few

(continued... from page 3)

revealed a score of 10/15, which showed moderate cognitive impairment. A review of Resident #55's physician progress notes [REDACTED].@ 17:55:00 (5:55 p.m.), Created date: 9/20/2020 @ 18:03:48 (6:30 p.m.) Effective date: 8/15/2020 @ 11:05:00 (11:05 a.m.), Created date: 9/20/2020 @ 18:09:51 (6:30 p.m.) Resident #210 Review of Resident #210's quarterly MDS assessment, reference date 7/31/20, revealed admission to the facility on [DATE], with [DIAGNOSES REDACTED]. Resident #210 required extensive two-person assistance for bed mobility, transfers, dressing, and toileting. The BIMS revealed a score of 9/15, which showed moderate cognitive impairment. A review of Resident #210's physician progress notes [REDACTED].@ 14:42:00 (2:42 p.m.), Created date: 9/20/20 @ 14:48:16 (2:48 p.m.) Effective date: 4/29/2020 @ 16:09:00 (4:09 p.m.), Created date: 5/17/20 @ 20:14:17 (8:00 p.m.) Effective date: 5/26/2020 @ 14:48:00 (2:48 p.m.), Created date: 9/20/20 @ 14:52:30 (2:52 p.m.) Effective date: 7/11/2020 @ 14:52:00 (2:52 p.m.), Created date: 9/20/20 @ 14:56:34 (2:56 p.m.) During a telephone interview on 9/22/20 at 4:07 p.m. with the Nursing Home Administrator (NHA) and the Senior DON, RN W, this Surveyor disclosed survey concerns related to physician services during the QAPI task interview. The NHA disclosed the facility had already implemented past noncompliance and reeducations with the physician team. The NHA and RN W shared they had met with the physicians and explained their role and expectations. There had been regular communication and ongoing efforts from the facility to ensure they (the physician team) worked towards compliance. The facility reported they had been making strides in this area. The NHA reported this area was a monthly QAPI for the facility. The NHA acknowledged the facility had identified concerns related to physician services similar to those discovered during this survey, and additionally related to physician visit timeliness, physician response to pharmacy recommendations, and timeliness of signing physician orders. During a telephone interview on 9/22/20 at 5:56 p.m., the facility Medical Director, Physician V, was asked about the late entries found during this survey for facility physician progress notes [REDACTED]. When asked what he had directed the physician team to do about this concern, Physician V stated, We try to encourage them to do timely visits and notes. This Surveyor shared Physician D notes were discovered at times to be one or more months late when entered into the EMR. Physician V denied being aware of these specific occurrences related to Physician D's physician notes . When asked what the expectation would be, Physician V stated, It (the physician progress notes [REDACTED]. It may be as long as 72 hours .I have no idea why that happened that way (in reference to the late entries by Physician D), adding, No, it's not acceptable. I will try to continue to encourage him to be more timely . When asked about timeliness of signing orders, Physician V responded he was aware this occurred in the past, and the facility asked the physician team to make sure the orders are signed weekly. Physician V acknowledged he was responsible for oversight of the physicians and physician services provided to the facility. Physician V reported facility physician services with his company are available to the facility 24 hours a day, 7 days a week. Review of the policy, Physician Services, revised 10/07/2010, provided by the NHA via email on 9/22/20 at 3:45 p.m., revealed, Physician orders [REDACTED].Physician visits, frequency of visits, emergency care of residents, etc. are provided in accordance with current OBRA regulations and facility policy. Additional clarification regarding physician services/visits and current OBRA regulations was requested during the survey, and not received by survey exit. Review of the facility document, Physician's Meeting, dated January 20, 2020, provided by the NHA via email on 9/23/20 at 8:39 a.m., revealed an Agenda which included, .7. physician progress notes [REDACTED]. Signing orders .Physician Visits - CMS Compliance .F 711 .Review of the resident's total program of care, including medications and treatments, at each visit .Write, sign and date progress notes at each visit, and .sign and date all orders with the exception of influenza and pneumococcal vaccines, which may be administered per physician-approved facility policy after an assessment of contraindications . Review of the document, Physician Services Letter, dated 4/29/20, provided by the NHA via email on 9/23/20 at 8:39 a.m., revealed, Physician Visits are not happening at this time in a timely fashion. It is expected, and required, for all new admissions to be seen by a physician within 72 hours of admitting to (name of facility) .With every visit, there should be a progress note entered into PCC. This is the only way to verify residents are being examined by a physician. It is imperative you leave documentation of putting your hands and eyes on our residents. It is essential physician orders [REDACTED].With returning pharmacy recommendations, not only is your signature required at times there are choices to be made concerning diagnosis, dose changes, etc. Please be mindful while completing pharmacy recommendations . There is a handwritten note at the bottom of page stating, Letter sent to all doctors 4/29/20 certified mail with attachments . Attachments include two documents, Medical Director Expectations, and Provider Expectations . Review of Resident #210's (Psychiatry Services Provider Name) Psychiatric behavioral care consult report, dated 8/13/20, revealed, Assessment and Plan: .[MEDICAL CONDITION] without behavioral disturbances .If not already trialed, I recommend beginning: 1. [MEDICATION NAME] (donepezil) at 5 mg HS (bedtime), 2. [MEDICATION NAME] (memantine) at 5 mg BID (twice daily) . Review of this Psychiatric behavioral care consult report further revealed, Mood disorder due to known physiological condition with mixed features .deteriorated .Patient describes sleep as very poor despite 15 mg [MEDICATION NAME] (common name [MEDICATION NAME]) every night. She has been taking this nightly > 90 days; the maximum recommended. She has likely developed tolerance. It will require a gradual taper which I would advise beginning now. Following is a suggested taper schedule. Weeks 1 & 2: [MEDICATION NAME] 15 mg tabs. Take 1 tab PO (by mouth) at HS M/W/F (Monday, Wednesday, and Friday). [MEDICATION NAME] 15 mg tabs. Take 0.5 mg PO at HS every S/T/T/S (Sunday, Tuesday, Thursday, and Saturday). Weeks 3 & 4. [MEDICATION NAME] 15 mg tabs. Take 0.5 mg PO Q (every) HS. Weeks 5 & 6. [MEDICATION NAME] 15 mg tabs. Take 0.5 mg tabs PO every S/T/T/S. Weeks 7 & 8. [MEDICATION NAME] 15 mg tabs. Take 0.5 mg tabs PO every M/W/F. Weeks 9: DISCONTINUE [MEDICATION NAME]. A therapeutic dose of [MEDICATION NAME] should help sleep as it helps mood but it may take 2 months. ADVISE STARTING [MEDICATION NAME] 7.5 mg PO Q HS . Review of Resident #210's nursing progress notes and physician progress notes [REDACTED]. The most recent physician note, dated 9/18/20, did not mention the Behavioral Care Solutions consult, or any medication recommendations or changes. Documentation of physician communication and/or evidence of a GDR (Gradual dose reduction) related to this consult was requested from the NHA on 9/22/20. An email received from the NHA on 9/22/20 revealed, We do not have a response from the doctor recorded. We do not have evidence of a GDR. It was noted in this same email the facility located the MRR from the pharmacist to the physician dated 8/10/20 regarding Resident #210 being eligible for the pneumococcal vaccine. There was no physician response noted on this pharmacy to physician communication as well. Review of the GDR policy, provided by the NHA on 9/23/20, titled, Antipsychotic Medication Use, updated November, 2017, revealed, .Gradual Dose Reduction/s. 1. Residents receiving antipsychotic medications will be reviewed quarterly and with condition change. Based on assessing the resident's symptoms and overall situation, the Physician will determine whether to continue, adjust, or stop existing antipsychotic medication. 2. Gradual dose reductions will be attempted according (sic) the CMS (Centers for Medicare and Medicaid Services) guidelines and recommendations by the physician, pharmacist, interdisciplinary team, and resident symptoms/improvements .

Resident #1 A review of Resident #1's Electronic Medical Record (EMR) revealed an admission date of [DATE]. Resident #1's physician progress notes [REDACTED].@15:37 (3:37 p.m.), Created date: 2/16/20 @ 23:13 (11:13 p.m.) Effective date: 3/14/2020 @ 17:43 (5:43 p.m.), Created date: 5/17/20 @ 17:51 (5:51 p.m.) Effective date: 7/11/20 @ 10:20 a.m., Created date: 9/20/20 @ 17:44 (5:44 p.m.) Resident #16 A review of Resident #16's EMR revealed an admission date of [DATE]. Resident #16's physician progress notes [REDACTED].@ 17:30 (5:30 p.m.), Created date: 9/20/20 @ 17:33 (5:33 p.m.) Resident #20 A review of Resident #20's EMR revealed an admission date of [DATE]. Resident #20's physician progress notes [REDACTED].@ 17:31 @ 10:56 a.m. Created date: 2/17/20 @ 00:00 (12:00 a.m.) Resident #30 A review of Resident #30s EMR revealed an admission date of [DATE]. Resident #30s physician progress notes [REDACTED].@ 20:21 (8:21 p.m.) Effective date: 7/11/20 @ 13:17 (1:17 p.m.), Created date: 9/20/20 @ 13:17 (1:17 p.m.) Effective date: 8/10/20 @ 13:17 (1:17 p.m.), Created date: 9/20/20 @ 13:25 (1:25 p.m.) Resident #50 A review of Resident #50's EMR revealed an admission date of [DATE]. Resident #50's physician progress notes [REDACTED].@ 17:06 (5:06 p.m.) Effective date: 6/22/19 @ 17:06 (5:06 p.m.), Created date: 9/22/19 @ 17:08 (5:08 p.m.) Effective date: 10/29/19 @ 14:22(2:22 p.m.), Created date: 2/16/20 @ 21:36 (9:36 p.m.) Effective date: 1/25/20 @ 13:36 (1:36 p.m.), Created date: 2/16/20 @ 21:42 (9:42 p.m.) Effective date: 3/14/20 @ 13:47 (1:37 p.m.)., Created date: 5/17/20 @ 18:51 (6:51 p.m.) Effective date: 7/11/20 @ 17:07 (5:07 p.m.), Created date: 9/20/20 @ 17:11 (5:11 p.m.) Resident #54 A review of Resident #54's EMR revealed an admission date of [DATE]. Resident #54's physician progress notes [REDACTED].@ 15:44 (3:44 p.m.)., Created date: 9/20/20 @ 15:47 (3:47 p.m.) Effective date: 5/23/20 @ 15:47 (3:47 p.m.), Created date: 9/20/20 @ 15:50 (3:50 p.m.) During an interview with the NHA on 09/22/20 at 3:11 p.m., the NHA reported some providers needed pressure to get their notes and visits dictated. The NHA stated they understood this could cause delays in communication regarding resident care. The facility's Physician Service policy with the most recent revision date of 10/7/10 included the following information, 3. Physician orders [REDACTED]. The facility did not provide this Surveyor a copy of the policy referenced and OBRA regulations despite it being requested.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235292	A. BUILDING _____ B. WING _____	09/23/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MEDILODGE OF SAULT STE MARIE	1011 MERIDIAN RD SAULT SAINTE MARIE, MI 49783

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 0711 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 4)
F 0713 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide or arrange emergency care by a doctor 24 hours a day.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure on-call physician emergency services were available for one (Resident #41) of 10 residents reviewed. This deficient practice resulted the Resident not receiving physician emergency services in a timely matter, therefore increasing the risk of serious health impairment due to a delay in receiving services. Findings include: A review of Resident #41's Electronic Medical Record (EMR} revealed an admission date of [DATE]. Resident #41 had medical [DIAGNOSES REDACTED]. A nurse's note written by Licensed Practical Nurse (LPN) P on 9/9/20 at 4:15 a.m. revealed the following information, Note Text: At start of shift resident was responsive and lethargic. Responded to verbal stimuli. Administered scheduled medications; resident reported to have consumed 5% of dinner meal and 240 mL{milliliters) of fluids. Following dinner resident was noted to be more lethargic. Resident responds to verbal stimuli, does not respond appropriately. VS {vital signs) obtained VS WNL (within normal limits) except elevated temp of 102; administered Tylenol supp (suppository) at this time with positive effect after follow up. Noted decreased respiratory staff increased respirations with use of accessory muscles. Bilateral rhonic (indicates secretions in lungs) noted in lung fields. Non-productive cough. Resident previously treated for [REDACTED]. Placed call to emergency contact wife was unable to connect. Continued to monitor residents status. Re-checked VS resident O2{oxygen) stats below 80% unable to increase stat to baseline supplemental O2 @ 2L (liters) for comfort. Called non emergent ambulance for transfer to (local) hospital. During an interview on 09/22/20 at 3:11 p.m. with the Nursing Home Administrator (NHA), the NHA reported they were not aware of the lack of availability of the on call physician on 9/9/20. The NHA reported they would have to follow up with the Director of Nursing (DON) to determine if they had any knowledge of the occurrence. The NHA agreed the on-call phsyician needed to be available and it was concerning that the physician did not respond to the call made by LPN P. Additional information (policy and/or procedure) pertaining to on-call providers was requested. The requested information was not provided by the end of this survey.
F 0756 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to facilitate a timely response to a pharmacy recommendation for one (Resident #54) of five residents reviewed. This deficient practice resulted in the potential for unsafe medication administration for residents as identified by the pharmacist. Findings include: A review of Resident #54 Electronic Medical Record (EMR) revealed an admission date of [DATE]. Resident #54 had medical [DIAGNOSES REDACTED]. A review of the monthly Medical Regiment Review (MRR) performed by the pharmacist revealed the following information: A consultant pharmacist recommendation to physician note written by pharmacist N to Physician O dated 3/17/20 contained the following information, Dear (Physician O), Patient (Resident #54) is currently taking [MEDICATION NAME] tablets. Please consider changing to not to exceed 3 gm/day from all sources. Physician O agreed to the recommendation on 6/15/20. A consultant pharmacist recommendation by pharmacist N to Physician O, dated 4/17/20, contained the following information: Dear (Physician O), Patient (Resident #54) is currently being treated for [REDACTED]. Please consider reducing to recommended dose of 15 mg BID for 21 days then 20 mg qd (daily). Physician O changed the dose to 20 mg daily on 6/15/20. During an interview on 09/18/20 at 2:11 p.m., Pharmacist N reported they were aware the facility has had problems with facilitating physician response to the pharmacist recommendations. Pharmacist N stated it seemed as though the requests from pharmacists seemed to fall through cracks and agreed the response to recommendations made for Resident #54 had been delayed excessively. A copy of the MEDICATION REGIMEN REVIEW iMRR, aMRR and MRR POLICY and PROCEDURE policy with the most recent revision date of 2/2020 revealed the following information, The consultant's comprehensive monthly report will be provided to the facility either electronically and/or in written hard copy within 5 business days of completion of monthly consulting rounds. If provided electronically, the Director of Nursing or designee shall print out the report to facilitate follow up and required notification of the Attending Physician(s) and Medical Director within a professional standard of timely response. Clinical justification will be documented on the recommendation response, which will remain as part of the in the clinical chart, if a recommendation is declined by the prescriber. Recommendations that are declined without clinical justification may be rewritten with a request for further clarification or required documentation.
F 0759 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure medication error rates are not 5 percent or greater.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain a medication administration error rate of 5% or less involving two Residents (#1 and #16). This deficient practice resulted in the potential for adverse effects resulting from the actual or potential for inaccurate medication dosage, when not following accepted standards of practice for administration. Findings include: On 09/16/20 at 8:24 a.m., Licensed Practical Nurse (LPN) F was observed preparing to adminster insulin via insulin pen to Resident #16. An air bubble was present in the syringe. LPN F was asked about the air bubble remaining in the syringe after priming the pen. LPN F shrugged their shoulders and replied, It (the air bubble) is always there. LPN F administered the insulin without further attempting to remove the air bubble. On 09/16/20 at 8:38 a.m., LPN F was observed drawing up Resident #1's [MEDICATION NAME] from a medication cup into a syringe. A small air bubble was present in the syringe. Verification of correct dose was not possible due to the presence of the air bubble. LPN F did not attempt to remove air bubble to facilitate verification of dose. During these observations, LPN F appeared to be very rushed. This Surveyor requested LPN F slow down several times. LPN F did not acknowledge this Surveyor's request. On 09/16/20 at 11:35 a.m., concerns regarding the medication administration were shared with the Director of Nursing (DON). The DON agreed medications should not be administered in a rushed pace because it could increase the risk of errors. The DON agreed air bubbles should be removed from insulin pens and syringes to eliminate the risk of potential medication errors. According to diabeteseducator.org, when administering insulin from a pen injector type device you should: Attach a fresh pen needle: Screw or click the needle securely in place according to the manufacturer's instructions. Remove the cap(s) from the pen needle to expose the needle. Prime the pen: Pointing the needle up in the air, dial one or two units on the pen and press the plunger fully with your thumb. Repeat until a drop appears. Dial your dose: Turn the dial on the pen to your prescribed dose. (Accessed 9/24/20 from: https://www.diabeteseducator.org/docs/default-source/legacy-docs/_resources/pdf/general/Insulin_Injection_How_To_AADE.pdf) The following information was obtained from diabetesselfmanagement.com, .Injecting air mixed with insulin won't physically hurt you, but you will inject less insulin than you think . (Accessed 9/24/20 from https://www.diabetesselfmanagement.com/managing-diabetes/treatment-approaches/common-insulin-pen-errors-diabetes-questions-answers/) The medication administration survey task revealed a medication error rate of 7.41%, based on 27 opportunities for error (observations), and 2 medication errors detected.
F 0761 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to properly label, store, and dispose of medications in two of three medication storage areas, and failed to properly store a medication for one (Resident #7) who was not assessed to administer their own medications. This deficient practice resulted in the potential for the entire population of residents in the facility to access or receive improper or expired medications. Findings include: On 09/16/20 at 10:54 a.m, during an inspection of the medication storage room refrigerator with Registered Nurse (RN) E, a multi dose vial of influenza quadrivalent (influenza vaccination) was identified with an expiration date of 5/22/20. RN E stated, This shouldn't be in here, we haven't given one (influenza vaccination) in ages. Four plastic vials with blank labels containing a clear liquid were inside a plastic bag. RN E reported they had no idea what the vials contained. On 09/16/20 at 11:10 a.m., an inspection of the A Hall medication cart with Licensed Practical Nurse (LPN) F revealed the following deficiencies: A foil blister pack containing tablets was found to be in the drawer of the cart, the blister pack was stored

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	235292	A. BUILDING _____ B. WING _____	09/23/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MEDILODGE OF SAULT STE MARIE	1011 MERIDIAN RD SAULT SAINTE MARIE, MI 49783

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 0761 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 5) inside of the packaging. There was no way of determining which resident the medication belonged to. LPN F reported the medication was a [MEDICATION NAME]. Resident #23's Ellipta inhaler was not labeled with the date it was opened. Resident #16's [MEDICATION NAME] (Humalog insulin) was opened on 8/11/20. LPN F reported insulin was good for 28 days. Resident # 19's [MEDICATION NAME] inhaler was not labeled with the date it was opened. Resident #10's Atrovent nasal spray was not labeled with the date it was opened. Resident #57 had a bottle [MEDICATION NAME] drops in the medication cart. LPN F reported the medication had been discontinued. Resident #15 had a bottle of latanoprost eye drops which had been opened on 07/19/20. LPN F reported the eye drops expired 28 days after opening. Resident #15 had an additional bottle of latanoprost eye drops which was not labeled with the date the bottle had been opened. Upon completion of the medication cart inspection, LPN F placed the expired insulin and eye drops and the discontinued ear drops into the garbage receptacle of the medication cart. The top of the garbage receptacle was not closed, and the medication was visible to passersby in the hall. In a follow up interview with LPN F on 09/16/20 at 11:25 A.M., LPN was asked what the policy pertaining to the disposal of expired or discontinued medication. LPN F pointed at the garbage receptacle on the medication cart and stated, I threw it (the expired and discontinued medications) in there (the garbage container on the medication cart). During an interview with the Director of Nursing (DON) 09/16/20 at 11:35 A.M., the DON reported it was not the policy to dispose of medications in the garbage receptacles of the medication carts because there was potential for residents to access the medications. A review of the facility's Discarding and Destroying Medications policy with the most recent revision date of 01/2020 revealed the following information, .2. Non-controlled and Scheduled V controlled drugs must be destroyed in the presence of two (2) licensed nurses .4. Ointments, creams, and other like substances may be discarded into the trash receptacle in the medication room. 5. Unless otherwise instructed, tables, capsules, liquids, and contents of vials and [MEDICATION NAME] in a sharps container with Kitty Litter or other agent such as a drug destroyer. 6. Whoever witnesses the destruction/disposal of mediations must sign and date the medication disposition record. Resident #7 On 9/16/20 at 2:12 p.m., Resident #7 was observed sitting in the hallway in her wheelchair. There was a rolling bedside table beside her in the hallway, and on it was a medicine cup with a circular red tablet in it. RN S was observed walking through the hallway. When asked what the tablet was, RN S said, It looks like a TUMS (chewable antacid tablet). When asked if the tablet should be sitting in hall way, RN S stated, No, it should not be there. RN S reported that Resident #7 had previously been found with Tums that her family had brought in. When asked if she was assessed to be safe to self administer medications, RN S stated, No, I don't think so. But I will check her room to see if she has any more. A review of Resident #7's medical record revealed she admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A review of the 6/19/20 Minimum Data Set (MDS) assessment revealed she scored 15/15 on the Brief Interview for Mental Status (BIMS) assessment indicating intact cognition. Review of the assessments for this Resident revealed no Self-Administration of Drugs Assessment to indicate the Resident was safe to self administer their own medications. Review of the orders revealed no order allowing the Resident to self-administer medications. On 9/16/20 at 3:50 p.m., RN S was asked if she had checked Resident #7's room for the Tums. RN S said she hadn't. RN S proceeded to go into Resident #7's room and found an unopened bottle of Tums in the bedside table. After further observing the rolling bedside table in the hallway beside Resident #7, two more red tablets were found in a little basket, accessible to any resident that was in the hallway. RN S reported that she would contact the family again to educate them not to bring medications in for Resident #7.
F 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.** Based on observation and interview, the facility failed to store, prepare, distribute and serve food in accordance with professional standards for food service safety as evidenced by: A. Failing to ensure potentially hazardous food stored in the steam table, awaiting to be served was maintained at proper temperatures (above 135F) B. Failing to ensure that a dispensed hand sanitizing product was approved for food service use. C. Failing to ensure one cook washed his hands before conducting food handling functions. D. Failing to ensure that potential contaminated back flow locations were properly protected with backflow protection devices. E. Failing to ensure proper dating procedures of potentially hazardous foods in the reach-in refrigerator was followed. F. Failing to provide proper lighting in two of two refrigerator units. This deficient practice has the potential to result in food borne illness among any or all the 58 residents in the facility. Findings include: A. On 9/16/2020 at 7:27 AM, observations of the morning meal service were made in the kitchen as the staff prepared food to be delivered to residents. Food had not begun to be served onto trays at this time. Temperatures of potentially hazardous foods (PHF) were measured on the steam table using a Super Fast Thermapen digital thermometer. A stainless steel container of yellow and red pureed food was measured to have an internal temperature of 115F. Staff Cook C was asked if temperatures had been measured on the temperatures of the food on the steam table, to which he replied Not yet. At 7:32 AM Staff C began measuring temperatures with a hand held digital thermometer. Once Staff C had completed his measurements, he was asked what the pureed food was in the small stainless steel container. Staff C replied It's pureed confetti eggs. Staff C was then asked what the temperature was when he measured the product, to which he stated 161F. At 7:35 AM Staff C was then requested to measure the same product while this surveyor observed the readings on his thermometer. As Staff C probed and stirred the product with his thermometer, the maximum temperature read by his thermometer was 115F. The product was measured using this surveyor's thermometer directly adjacent to Staff C's thermometer in the product and found both read 115F at the same time. When asked how the food's temperature had fallen from 161F to 115F in 3 minutes, Staff C replied I know it was 161F in there somewhere. The 2013 FDA Food Code states: 3-501.16 Time/Temperature Control for Safety Food, Hot and Cold Holding. (A) Except during preparation, cooking, or cooling, or when time is used as the public health control as specified under 3-501.19, and except as specified under (B) and in (C) of this section, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD shall be maintained: (1) At 57oC (135oF) or above, except that roasts cooked to a temperature and for a time specified in 3-401.11(B) or reheated as specified in 3-403.11(E) may be held at a temperature of 54oC (130oF) or above; B. On 9/15/20 at 11:45 AM observations of the kitchen began. An alcohol hand sanitizer dispenser was observed mounted on the wall near the entry door from the service corridor. Cook C was routinely observed going to the dispenser and dispensing hand sanitizer to his hands and returning to food preparation activities. These observations were made during the noon meal on 9/15/20, the morning meal on 9/16/20 (7:15 AM to 8:30 AM) and the noon meal preparation activities on 9/16/20 (11:05 AM to 11:30 AM). An interview with Dietary Manager DM) A was conducted on 9/16/20 at 11:10 Am while observing the sanitizer dispenser. DM A was asked if the sanitizer was a food grade product and approved from kitchen use. DM A removed the bag of sanitizer from the dispenser and read the information stamped on the bag. There was not any identification information stating it was approved for food service preparation locations. DM A then kept the bag removed from the dispenser. The 2013 FDA Food Code states: 2-301.16 Hand Antiseptics. (A) A hand antiseptic used as a topical application, a hand antiseptic solution used as a hand dip, or a hand antiseptic soap shall: (1) Comply with one of the following: (a) Be an APPROVED drug that is listed in the FDA publication Approved Drug Products with Therapeutic Equivalence Evaluations as an APPROVED drug based on safety and effectiveness; or (b) Have active antimicrobial ingredients that are listed in the FDA monograph for OTC Health-Care Antiseptic Drug Products as an antiseptic handwash, and (2) Consist only of components which the intended use of each complies with one of the following: (a) A threshold of regulation exemption under 21 CFR 170.39 - Threshold of regulation for substances used in FOOD-contact articles; or (b) 21 CFR 178 -Indirect FOOD Additives: Adjuvants, Production Aids, and Sanitizers as regulated for use as a FOOD ADDITIVE with conditions of safe use, or (c) A determination of generally recognized as safe (GRAS). Partial listings of substances with FOOD uses that are GRAS may be found in 21 CFR 182 -Substances Generally Recognized as Safe, 21 CFR 184 -Direct FOOD Substances Affirmed as Generally Recognized as Safe, or 21 CFR 186 - Indirect FOOD Substances Affirmed as Generally Recognized as Safe for use in contact with FOOD, and in FDA's Inventory of GRAS Notices, or (d) A prior sanction listed under 21 CFR 181 - Prior Sanctioned FOOD Ingredients, or (e) a FOOD Contact Notification that is effective, and (3) Be applied only to hands that are cleaned as specified under 2-301.12. C. On 9/16/20 beginning at 7:25 AM and ending at 8:37 AM observations of the morning meal preparation and service were made. At 7:29 AM Cook C was observed entering the kitchen from the service corridor, dispensing a small amount of alcohol hand sanitizer on his hands, from a dispenser

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	235292	A. BUILDING _____ B. WING _____	09/23/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MEDILODGE OF SAULT STE MARIE	1011 MERIDIAN RD SAULT SAINTE MARIE, MI 49783

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 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 6) located near the entry door from the corridor, and returning to food preparation activities. Through the following 20 minutes, Staff C was observed performing various activities in the kitchen, including the handling of soiled and clean equipment as well as placing food in the steam table. Staff C was observed using the alcohol hand sanitizer many times but never washing his hands at the hand sink. From 11:10 AM to 11:27 AM observations of the food preparation activities in the kitchen were observed for the noon meal. Staff C was again observed entering the kitchen from the service corridor, dispensing a small amount of alcohol sanitizer on his hands, and returning the food preparation table to continue to handle clean utensils and food. At no time was Staff C observed going to the hand sink and washing his hands. At 11:27 AM, while standing in the kitchen, near the sanitizer dispenser with Dietary Manager (DM) A, the bag of sanitizer was removed from the dispenser. (See above details of removal) Staff C was observed entering the kitchen from the service corridor, going to the sanitizer dispenser, pumping it once and walking away rubbing his hands together. When it was brought to his attention, by this surveyor, that the sanitizing product bag had been removed and there was in fact no sanitizer being dispensed from the dispenser, Staff C responded Oh, I got a little out of it. The 2013 FDA Food Code states: 2-301.14 When to Wash. FOOD EMPLOYEES shall clean their hands and exposed portions of their arms as specified under 2-301.12 immediately before engaging in FOOD preparation including working with exposed FOOD, clean EQUIPMENT and UTENSILS, and unwrapped SINGLESERVICE and SINGLE-USE ARTICLES (H) Before donning gloves to initiate a task that involves working with FOOD; and (I) After engaging in other activities that contaminate the hands. D. On 9/15/20 at 11:45 AM, observations of kitchen were made. The overhead sprayer located over the garbage disposal to the right of the three compartment sink was observed to have a spring which failed to keep the sprayer head above the overflow rim of the garbage disposal and flanking drain boards and sink enclosure, thereby creating an unapproved cross connection between the potable water supply and waste water. An interview with DM A was conducted at this time with the cross connection condition demonstrated to her. DM A stated, We keep it hung on the hook all the time. At 12:15 PM, and 1:16 PM on 9/15/20 the sprayer head was observed unattended and hanging into the bowl of the garbage disposal with the garbage disposal running. This same observation was made the following morning on 9/16/20 at 8:37 AM. During this last observation, an interview with DM A was made again related to the unapproved cross connection. DM A stated Oh, they put the spring on backwards. When asked who they were, she replied The maintenance department. When asked how long this installation had been in place as it was currently observed, DM A stated it had been a long time, The 2013 FDA Food Code states: 5-202.13 Backflow Prevention, Air Gap. An air gap between the water supply inlet and the flood level rim of the PLUMBING FIXTURE, EQUIPMENT, or non FOOD EQUIPMENT shall be at least twice the diameter of the water supply inlet and may not be less than 25 mm (1 inch). E. On 9/16/20 at 7:47 AM while conducting observations of the kitchen, a gallon Lexan container of canned mushrooms was observed in the three door Hoshizaki refrigerator. The label on the top was reviewed and found to indicate the product had been opened on 9/13/20. The same label stated the use by date was 10/13/20. An interview with the corporate dietitian B was conducted at 8:54 AM on 9/16/20 and asked about the length of time canned mushrooms could be held and safely served. The container was observed with staff B who stated, I'll have to look that up, I have an app that I can find that information. At 9:20 AM an interview with Staff B was conducted, who stated : I looked that up for the mushrooms, and it is only 4-7 days that it is supposed to be held. We'll change the label. The 2013 FDA Food Code states: 3-501.17 Ready-to-Eat, Time/Temperature Control for Safety Food, Date Marking. (A) Except when PACKAGING FOOD using a REDUCED OXYGEN PACKAGING method as specified under 3-502.12, and except as specified in (E) and (F) of this section, refrigerated, READY-TO -EAT, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD prepared and held in a FOOD ESTABLISHMENT for more than 24 hours shall be clearly marked to indicate the date or day by which the FOOD shall be consumed on the PREMISES, sold, or discarded when held at a temperature of 5C (41F) or less for a maximum of 7 days. The day of preparation shall be counted as Day 1. F. On 9/16/20 at 8:05 AM the three door Hoshizaki refrigerator was observed to have no functioning interior lights. The three door Victory refrigerator, located to the extreme left of the Hoshizaki refrigerator was observed to have a small night light size yellow lighted LED bulb, located in the middle unit, which produced no light to either adjacent compartment. The 2013 FDA Food Code states: 6-303.11 Intensity. The light intensity shall be: (A) At least 108 lux (10 foot candles) at a distance of 75 cm (30 inches) above the floor, in walk-in refrigeration units and dry FOOD storage areas and in other areas and rooms during periods of cleaning; (B) At least 215 lux (20 foot candles): (1) At a surface where FOOD is provided for CONSUMER self-service such as buffets and salad bars or where fresh produce or PACKAGED FOODS are sold or offered for consumption, (2) Inside EQUIPMENT such as reach-in and under-counter refrigerators;
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain proper infection control measures pertaining to 1) hand washing during wound care for one (Resident #30) and 2) maintenance of an indwelling urinary catheter (a tube that is inserted into the bladder to facilitate the drainage of urine) for two (Residents #30 and Resident #47) of four residents reviewed for indwelling urinary catheters. Findings include: 1) A review of Resident #30 Electronic Medical Record (EMR) revealed an admission date of [DATE]. Resident #30 had medical [DIAGNOSES REDACTED]. On 09/15/20 at 4:58 p.m.,an observation of Resident #30's wound care performed by Licensed Practical Nurse (LPN) F with Physician D present was made. During the wound care, LPN F removed their soiled gloves and donned clean gloves. Hand washing was not observed after LPN F removed their soiled gloves and before donning clean gloves. In a follow up interview with LPN F on 09/15/20 at 5:10 p.m., LPN F reported hand washing should be performed at the beginning and completion of wound care. LPN F was not aware hand washing should be performed when removing soiled gloves prior to putting clean gloves on. In an interview with Physician D on 09/15/20 at 5:28 p.m., Physician D reported Resident #30's wound was a stage four (the depth of the wound was to the bone) and was most likely infected. On 09/16/20 at 11:35 a.m., the Director of Nursing (DON) reported hand washing should be performed when soiled gloves were removed and clean gloves were put on. A copy of the facility's Hand Hygiene policy with the most recent revision date of 5/11/20 contained the following information, All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors .a. The use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves, and immediately after removing gloves . 2) On 09/15/20 at 2:14 p.m. - 4:48 p.m., Resident #30's indwelling catheter urinary collection bag was observed laying on the floor. The collection bag was not placed on Resident #30's bed frame and was placed on the floor. On 09/15/20 at 4:48 p.m., Resident #30's urine collection bag was emptied by Non Certified Nurse Aide (Staff)H. Staff H reported the collection bag was on the floor due to Resident #30's bed having to be in the lowest position which would make the collection bag be placed on the floor. Staff H was aware the collection bag should not be on the floor. On 09/16/20 at 7:37 a.m., Resident #30's urine collection bag was observed inside a privacy bag on the floor. On 09/16/20 at 11:35 a.m., the DON reported urine collection bag should not be placed on the floor. The DON reported the Certified Nurse Aides (CNA)s had recently been educated on indwelling catheter care. On 09/16/20 at 2:58 p.m., an additional observation was made of Resident #30's urine collection bag on the floor. The facility's Urinary & Bowel Incontinence Care-Clinical Protocol with most recent revision date of 3/23/11 did not include information pertaining to indwelling catheter maintenance. Resident #47 A review of Resident #47's record revealed admission to the facility on [DATE] with [DIAGNOSES REDACTED]. A review of the 8/20/20 Minimum Data Set (MDS) assessment revealed the score 1/15 on the Brief Interview for Mental Status (BIMS) assessment, indicating severely impaired cognition. On 9/15/20 at 12:05 p.m., Resident #47 was observed lying on their left side. A catheter bag in a privacy bag was observed hanging off the bed and making contact with the floormat beside the bed. A review of the physicians orders revealed, Insert Indwelling Catheter .One time only for to promote wound healing until 09/14/20 dated 8/14/20. On 9/16/20 at 7:50 a.m., Resident #47 was observed lying in bed, with the catheter bag resting on the floormat. On 9/16/20 at 8:47 a.m., Resident #47's catheter bag was still observed resting on the floor mat. On 9/16/20 at 4:50 p.m., an interview was conducted with Registered Nurse (RN) X. When asked about the catheter bag resting on the floor, RN X reported that she was already aware of the concern and would be educating staff. On 9/16/20 at 5:23 p.m., Resident #47's catheter bag was observed off the floor, but the catheter tubing was resting on the floor.
F 0883 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Develop and implement policies and procedures for flu and pneumonia vaccinations.** Based on interview and record review, the facility failed to ensure all eligible facility residents were offered and provided pneumococcal vaccines, per current Centers for Disease Control and Prevention (CDC) recommendations, beginning January, 2019, through September 16, 2020 (start date of this recertification survey), including for 18 of 22 sampled

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F 0883 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	(continued... from page 7) residents, with the potential to affect all 58 facility residents. This deficient practice resulted in the lack of protection from pneumonia infection for those eligible residents. Findings include: During an interview on 9/16/20 at 12:50 p.m. the DON was asked to provide evidence during the survey of flu and pneumococcal vaccines being offered/ provided to five sampled residents. The DON reported, With the pneumococcal vaccines, we have identified that as an area we are not fully compliant. We have started working with our physicians and our pharmacists who consult with us regarding our vaccination plan . Documentation of all vaccine offering and provision for five residents, #6, #25, #34, #35, and #210 was requested on 9/16/20, at 2:17 p.m., along with any consents and/or vaccination records, and the facility policy/process pertaining to pneumococcal vaccinations. During an interview on 9/16/20 at 4:23 p.m. the DON confirmed for the five residents the pneumococcal vaccinations were requested, none had been offered this vaccine. The DON reported she did not find evidence of the facility offering pneumococcal vaccines since 1/2019, the time just after the prior recertification survey (which was completed 12/14/2018). The DON confirmed, There are no notes .it hasn't been addressed. The DON acknowledged there was now a facility plan to offer the pneumococcal vaccinations beginning 9/16/20, the date discovered deficient during this annual survey. During an interview on 9/16/20 at approximately 5:30 p.m., with the NHA, the DON, and RN X, VP of Clinical Services, the facility NHA and nursing managers were asked about the reported lack of offering of pneumococcal vaccines since January, 2019. The NHA reported initially she was not aware of this deficiency. The DON confirmed they had not yet found evidence of pneumococcal vaccines being offered, and requested additional time to search records for any evidence of the facility offering these vaccines to residents. A list of 22 sampled residents (including the five aforementioned residents) was given to search for any evidence of the pneumonia vaccines were offered or provided. RN X soon after confirmed she had not found evidence of pneumococcal vaccines being offered to the five residents originally requested, Residents #6, #25, #34, #35, and #210. During a telephone interview on 9/17/20 at 10:16 a.m., the DON was asked what the facility timing/process was regarding when pneumococcal vaccinations should be offered. The DON responded, Our policy is within five days (from time of a resident's admission to the facility) . We've identified this as an area which needs improvement and we could improve to offer pneumococcal vaccines per policy. We have just started getting scripts (prescriptions) for the pneumococcal vaccines .It's an area we knew we were out of compliance, and we are working diligently to fix that. We did get the vaccines in, and will be starting today to administer the vaccines . Review of facility pneumococcal vaccination records including consents, state vaccination records, and physician requests for vaccination approval, showed 18 of 22 sampled residents were eligible for the pneumococcal vaccination. None of the 18 residents were offered the pneumococcal vaccination prior to 9/15/20, the entry date for this recertification survey. The facility provided additional documentation on 14 other facility residents not in the sample, who were eligible for the vaccination, and also not offered the pneumococcal vaccine prior to 9/15/20. Review of the facility policy, Pneumococcal Vaccine, revised 1/2020, revealed, All residents will be offered the Pneumococcal Vaccination(s) to aid in preventing pneumococcal infections (i.e. pneumonia) unless contraindicated .1. Prior to or upon admission, residents will be assessed for eligibility to receive the pneumococcal vaccines, and when indicated, will be offered the vaccination within thirty (30) days of admission to the facility unless medically contraindicated or the resident has already been immunized. 2. Assessments of pneumococcal vaccinations status will be conducted within five (5) working days of the resident's admission, if not conducted prior to admission. Before receiving Pneumococcal Vaccinations, the resident or representative shall receive information and education regarding the benefits and potential side effects of pneumococcal vaccinations. Provision of such education shall be documented in the resident's medical record .