STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235175	A. Building B. Wing	10/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Frankenmuth	500 W Genesee Frankenmuth, MI 48734

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37771 This Citation pertains to Intake Number MI00146717. Based on observation, interview and record review, the facility failed to ensure that residents' rights/dignity were maintained when concerns/grievances were not addressed and call lights were not answered timely for four residents (Resident #2, Resident #3, Resident #6 and Resident #9), of five residents reviewed for call light response and grievances, resulting in incontinence, feelings of frustration and anger, and needs not met timely. Findings include: Resident #2: A review of Resident #2's medical record revealed an admission into the facility on [DATE] with diagnoses that included sprain of ligament of left ankle, obesity, diabetes, lymphedema, muscle weakness, difficulty in walking and shortness of breath. A review of the Minimum Data Set (MDS) assessment revealed the Resident had a Brief Interview of Mental Status (BIMS) score of 15/15 that indicated intact cognition, and the Resident needed partial/moderate assistance with oral hygiene, and substantial/maximal assistance with toileting hygiene, bathing, dressing, and most types of mobility. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/19/24 at 10:45 AM, an interview was conducted with Resident #2 who answered questions and engaged in conversation. The Resident was asked about any concerns he had with his care at the facility. The Resident reported an issue with a Nurse that did not change his dressing on a wound correctly, indicated that the other nurses wash it with a wound cleanser that this nurse does not do, and the nurse did not change the whole dressing, just the top portion. The Resident indicated that he had told the nurse that she needed to clean it with the wound cleanser, but she continued to not follow the treatment order. The Resident when queried indicated he had spoken to Nurse B about the issue, but the nurse had not changed her ways. The Resident was asked if he had filled out a concern form or had staff filled one out for him. The Resident reported he was not given one to fill out and did not know if Nurse B had filled one out. The Resident then said to ask about the concern of the same nurse putting her finger inside the cup that his medication is brought in for him and touches the pill with her finger. The Resident demonstrated how the nurse holds the cup and expressed concern that of proper hand hygiene and contamination of the medication he had to swallow. When asked if a grievance or complaint form was filled out for this concern, the Resident reported he did not know and stated, She is still doing it. The Resident indicated it has been an issue for the last couple months but did not have a specific date. When asked about call light response times, the Resident reported that it depended on how busy staff were. When asked if had to wait a half an hour, the Resident indicated yes. On 9/19/24 at 11:05 AM, an interview was conducted the Nurse B regarding Resident #2's concerns of his wound dressing not cleansed and changed properly. The Nurse reported she was made aware of the concerns from the Resident and reported the Resident had reported it to her about one month ago, complained the nurse had not been doing the dressing correctly, and indicated it had been an ongoing issue. The Nurse reported that the Nurse in question only worked the weekends on the night shift. When asked about concerns of administration of medication with fingers touching the Resident's medication, Nurse B stated, Yes, he complained about that, and reported she could not tell if it was a legitimate complaint or not due to them joking about it. The Nurse was asked about facility policy on reporting resident concerns, the Nurse reported that there was a concern form that can be written up. When asked if a concern form was completed for Resident #2's concerns, the Nurse indicated there could have been one filled out for him but reported she did so many, she was not sure if that was done or not for Resident #2. The complaint/grievance forms were requested for July and August. The forms received from the Administrator did not reveal any filled out concern form for Resident #2. On 9/19/24 at 3:46 PM, an interview was conducted with the Administrator, NHA regarding resident or resident representative concerns. The NHA reported that the facility had a grievance form that the Resident can fill out and stated, If they can then we have them do it, if a Resident needs help, then we can do it for them, and listed places throughout the facility where concern forms could be obtained. The NHA indicated that if issues were identified, a form should be started. When asked if the Resident had concerns that were voiced to staff, the NHA stated, If the Resident has a complaint or has concerns then they should be filling out a grievance (form). The NHA indicated they did not receive a grievance form from Resident #2. The NHA revealed that they had a program called Caring Partners and staff went and asked a different group of questions every week and if concerns were raised, a grievance form would be filled out, it would be investigated, and corrected action taken if needed. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/23/24 at 11:55 AM, an observation was made of Resident #2 lying in bed. An interview was conducted with the Resident who answered questions and engaged in conversation. The Resident was asked regarding any concerns he had. The Resident reported that he had an issue on Saturday night, that he had put on the call light to use the bed pan for a bowel movement and it took staff 20 to 30 minutes to come in and stated, They left me for 45 minutes on the bed pan. They knew I was on it, they put me on it, and reported having to call back and stated, took them 45 minutes, to answer the call light and stated, it hurt, I was sore, reported being on the bedpan that long was uncomfortable and painful. The Resident reported he had been put on a bedpan another time and saw staff leaving, indicated the cars parked in the parking lot out his window and stated, They just left, and reported he had to wait until they came back. The Resident reported that the third shift had the most issue with not answering call lights timely and indicated call lights on for 30 minutes or more, at times. The Resident was queried regarding concerns with the nurse administering his medications and replied, She is still putting her finger on my pills, holds the cup by the rim, I can see the finger touching the pill, it's just one pill but I don't want that, and expressed frustration. Regarding the wound dressing the Resident reported the Nurse did not clean the dressing and stated, She just removes the top part and replaces it, never cleans it out, that's not right. A review of Resident #2's wound care order revealed the following: -Start date on 9/4/24, Cleanse pubic/lower shaft, pat dry. Apply collagen wound filler (powder) activate with normal saline apply to wound bed and cover with silicone dressing. Change BID (twice a day) and PRN (as needed). Every morning and at bedtime for pubic/lower shaft. Order dated 8/7/24, Cleanse pubic/lower shaft, pat dry. Apply collagen with silver and cover with dry dressing, Change BID and PRN, every morning and at bedtime for pubic/lower shaft. -Start date 8/28/24, Cleanse scrotum, pat dry apply collagen with silver to wound bed cover with ABD and secure with brief BID and PRN, every morning and at bedtime for MASD (Moisture-Associated Skin damage). Order dated 7/11/24, Cleanse scrotum pat dry appl xeroform to wound bed cover with ABD and secure with brief BID and PRN every morning and at bedtime for MASD. Resident #3: A review of Resident #3's medical record revealed an admission into the facility on [DATE] and re-admission on 9/18/24 with diagnoses that included urinary tract infection, chronic respiratory failure, diabetes, obesity, anxiety disorder and history of falling. A review of the MDS revealed the Resident was had a BIMS score of 10/15 that indicated moderately impaired cognition, and the Resident needed substantial/maximal assistance with most activities of daily living and mobility. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/19/24 at 10:02 AM, Resident #3 was observed in the dining room in their wheelchair. The Resident was slumped back with her head back over the back of the wheelchair and legs outwards and looked like she was going to slide out of her wheelchair. The Resident looked like she was sleeping but aroused when approached and stated, I had a fall big time. The Resident had on a hospital type gown that was hanging off her shoulder. The gown had a large area under her right hand that looked like old, dried blood. There was dried blood on the resident's hand and wrist. Two CNA's approached and indicated they were taking the Resident back to her room to lay down. When asked about the stain on the Resident's gown, CNA A stated, Thought it might be pudding. Staff started pushing the Resident's wheelchair, but it would not go forward, the CNA adjusted the wheel, and the Resident was pushed out of the dining/common area with her feet sliding on the floor. The Resident did not have foot pedals on the wheelchair and were unable to hold her feet up. On 9/19/24 at 11:01 AM, an observation was made of Resident #3 lying in bed with the head of the bed elevated. The Resident was seen earlier in the dining/common area. A new gown was on the resident. When asked about the spot on her gown, the Resident reported they draw blood gases every day. The Resident was asked questions and engaged in limited conversation. An observation was made of the Resident's bed against the wall and the cord for the call light was in the wall outlet but not in reach of the resident. The push mechanism was on the floor and not in reach for the Resident. When asked if she used the call light, the Resident reported she does use the call light but can't reach it right now. The Resident was asked about call light response times and reported sometimes it was more than a half an hour for staff to respond and sometimes longer than that. Resident #6: A review of Resident #6's medical record revealed an admission into the facility on [DATE] with diagnoses that included stroke affecting right dominant side, obesity, lupus, anxiety disorder and muscle weakness. A review of the MDS revealed a BIMS score of 15/15 that indicated the Resident had intact cognition and dependent on staff for most activities of daily living and mobility. On 9/23/24 at 2:34 PM, an observation was made of Resident #51 in their room. The Resident answered questions and engaged in conversation. The Resident was asked if she used the call light. The Resident indicated she did use the call and stated, For the bathroom mostly. When asked about staff response to call light use, the Resident indicated that at times it could take a while. When asked if they had to wait 30 minutes, the Resident stated, Yes, sometimes longer, sometimes up to an hour. When asked if she had accidents or incontinence, the Resident stated, Yes I have while waiting for them to answer. Resident #9: A review of Resident #9's medical record revealed an admission into the facility on [DATE] and re-admission on 9/20/24 with diagnoses that included cancer of laryngeal cartilage, respiratory failure, tracheostomy status, and anxiety. A review of the MDS revealed the Resident was independent for cognitive skills for daily decision making and the Resident needed partial/moderate assistance with oral hygiene, toileting hygiene, dressing, personal hygiene and most types of mobility. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/23/24 at 12:58 PM, an observation was made of Resident #9 dressed and in bed. The Resident had a tracheostomy and was able to answer questions. The Resident was asked if his call light was answered timely and indicated not always. When asked if he has had to wait up to 30 minutes for staff to answer, the Resident shook his head yes; up to an hour? The Resident mouths sometimes. When asked which shift he had the most problem with adequate call light response, the Resident shook head yes to the night shift and then mouths words that were not comprehended. On 9/25/24 at 2:28 PM, an interview was conducted with CNA U regarding facility policy for call lights in reach. The CNA reported call lights need to be in reach. Clip as needed to the gown. When asked about facility policy for call light response times, the CNA stated, as soon as possible, five minutes if not busy with another resident. A review of facility policy titled, Call Lights: Accessibility and Timely Response, reviewed/revised 12/28/23 revealed, Policy: The purpose of this policy is to assure the facility is adequately equipped with a call light at each residents' bedside, toilet, and bathing facility to allow residents to call for assistance. Call lights will directly relay to a staff member or centralized location to ensure appropriate response . 1. Staff are educated in the proper use of the resident call system, including how the system works and ensuring resident access to the call light . A review of facility policy titled, Quality Assistance Procedure, reviewed/revised 10/30/23, revealed, Policy: Residents .may file a Quality Assistance Form . 1. Any resident . may file a Quality Assistance Form concerning treatment, medical care, behavior of other residents, staff members . without fear of threat or reprisal in any form . 4. Quality Assistance request may be submitted orally or in writing . 5. Upon receipt of a written Quality Assistance Form/request, the department manager will investigate the allegations and submit a written report of such findings to the administrator .

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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** 37771 This Citation pertains to Intake Numbers MI00146717, MI00147164, MI00147177 and MI00147178. Past Non-Compliance (PNC) was presented by the facility during investigation of the allegations and was accepted by the survey team upon exit from the facility for this citation. Following discussion with the State Manager, Past Non-Compliance was accepted. The Compliance Date was 09/26/2024. Based on observation, interview and record review, the facility 1) Failed to ensure that one resident (Resident #11) was assessed and monitored after a fall with a head injury and who was returned back to the facility after hospital evaluation, 2) Failed to ensure that an incident report was completed for one resident (Resident #12), who sustained an injury of unknown origin and failed to treat the occurrence as a fall, and 3) Failed to report an injury of unknown origin for two residents (Residents #11 and Resident #12) of 6 residents reviewed for falls and injuries of unknown origin, resulting in the potential for signs and symptoms of a head injury to go undetected and left untreated for Resident #12, and injuries of unknown origin not investigated with a delay in evaluation, assessment and monitoring and the potential for abuse to not be detected for Resident #12. Findings include: Resident #11: A review of Resident #11's medical record revealed an admission into the facility on [DATE] with diagnoses that included dementia with behavioral disturbance, and seizures. A review of the Minimum Data Set assessment revealed the Resident had a Brief Interview for Mental Status (BIMS) score of 00/15 that indicated severely impaired cognition. A review of Resident #11's incident report, dated 9/14/24 at 10:15 AM, revealed, Incident Description, Resident had been resting in bed, upon rising she got up and had picked up a roll of trash bags and as she walked out of the room staff reported that it appeared that she was reaching for another resident and he pushed her away from him and she fell to her butt and hit her head on the floor/wall. Nurses note dated 9/14/24 at 10:52 AM, .Nurse assessed resident, and she was sent out to the hospital to be checked out. Nurses note dated 9/14/24 at 12:07 PM, At approximately 10:15 am this nurse responded to CNA (certified nursing assistant) yelling for help and observed resident laying on the hallway floor in a supine position. Upon nursing assessment, resident appeared to have a small hematoma on her left side of head and verbally expressing pain when area touched. Skin appeared dry/intact. Resident is not on any blood thinners. CNA witnessed resident being pushed by another resident. Administrator notified by this nurse of accident. Physician notified and resident transferred to (name of hospital) for further evaluation and treatment. Residents niece arrived to visit resident and made aware of situation. Residents POA (power of attorney) nephew made aware. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Nurses note dated 9/14/24 at 6:01 PM, Resident arrived to facility via (ambulance service) from (Hospital name) x-ray and head CT were performed and negative for any abnormalities. Resident appeared restless and anxious, biting her blanket this nurse not able to re-direct . Further review of the medical record revealed a lack of monitoring of the fall and head injury after returning to the facility from the emergency department. On 10/7/24 at 11:00 AM, an interview was conducted with the Director of Nursing (DON) regarding Resident #11's fall on 9/14/24 with injury to the head. The DON reported that the Resident had hit her head, and she came back from the hospital and stated, We were concerned with behaviors and not with the fall. CT was negative but we missed the follow up assessment for the fall. The DON indicated that neuro checks were not completed as per facility policy that should be completed every 12 hours by the nurse and stated, With (Resident #12's name) coming back, neuro's should have been completed and they were not. When we reviewed it, we realized they were not completed. The DON reported that they educated the staff, and a past non-compliance was completed. Past Non-Compliance (PNC) was presented by the facility during investigation of the allegation and was accepted by the survey team upon exit from the facility for this citation. Following discussion with the State Manager, Past Non-Compliance was accepted. The Compliance Date was 9/26/24. The corrective action plan to attain and maintain compliance with F-689 included the following: -Residents with falls occurring in the last 14 days were audited by DON or Designee to ensure neurochecks were completed for residents who are not interviewable and had an unwitnessed fall as well as residents that hit head upon fall. Of these residents, those who did not have neurochecks completed were assessed by a licensed nurse by 9/26/24. -Licensed nurses were re-educated by the Staff Development coordinator or designee regarding the Falls Clinical Protocol policy to include assessments post fall and neurochecks per Provider order. -The DON or designee will complete and audit of falls weekly to ensure appropriate follow up assessments are completed. -Audit findings will be reviewed by QAPI committee and will only be discontinued with compliance and approval of the facility QAPI Committee. -Date of completion of plan of correction: 9/26/24 The State Surveyor verified the facility's corrective action plan by interviews with facility staff to confirm education was completed and reviewed and AD HOC Meeting Committee agenda and sign-in was completed on 9/26/24. Resident #12: (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident #12's medical record revealed an admission into the facility on [DATE] with diagnoses that included dementia with behavioral disturbance, cancer of large intestine, and anxiety. The MDS revealed the Resident had a BIMS score of 4/15 that indicated severely impaired cognition, and the Resident needed supervision/touching assistance for oral hygiene, toileting hygiene, upper body dressing and personal hygiene. A review of Resident #12's facility reported incident, the documentation included the following: Date/Time Incident Discovered: 9/24/24 at 1:45 PM. Date/Time Incident Occurred: 9/20/24 at 12:30 AM. Incident Summary: Resident was reported to have a skin tear on his left elbow on Friday, 9/24/24, it was discovered that resident had a large bruise on his left rib cage. The center is investigating and this we feel like he sustained a fall and got himself up off the floor. Due to the residents cognition he most likely did not notify anyone and no one saw the incident. The center is scheduling X-rays of the rib area as the resident now indicated by his actions that it hurts . A review of the document for Resident #12's investigation on the facility reported incident included the following: Date of 2 hour investigation: 9/24/24. Date of 5 day investigation: 9/30/24. . admitted to our dementia unit on 8/21/24. He has been doing well with no issues until a skin tear was discovered to his left elbow on 9/20/24 . The Director of Nursing became aware of the skin tear and went to assess resident, noting a bruise like area to left flank also. Investigation initiated. Staff that cared for (Resident #12's name) were interviewed and noted he had been less active related to UTI (urinary tract infection) . An additional interview with nurse (initials of Nurse V) was obtained and it was noted that this nurse on night shift saw him sitting on the floor in his room just before she left work on 9/20/24 at approximately 0600. She thought he was care planned to sit on the floor and did not complete an incident report at that time. When this was discovered an incident report was updated and Nurse Practitioner as well as responsible party was notified. Staff education was immediately initiated. Skin and pain assessments were on all like residents. Nurse Practitioner saw resident on 9/24/24 and she ordered x-rays to rule out any injuries. No injuries were identified from x-rays . Conclusion: The center did not substantiate an injury of unknown source as reported to the state of Michigan. It was determined that (Resident's name) sustained a fall but the nurse failed to complete an incident report because she thought (Resident's name) was care planned to sit on the floor where she found him. A past non-compliance was completed. On 9/23/24 at 9:00 AM, an observation was made of Resident #12 sitting up in bed and being assisted by staff with the breakfast meal. The Resident answered some questions but was unreliable with answers. The Resident was observed to have a healing skin tear to his elbow. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/25/24 at 12:10 PM, an interview was conducted with the Director of Nursing (DON) regarding Resident #12's fall on 9/20/24. The DON indicated that Nurse V had seen the Resident sitting on the end of his bed and then saw the Resident on the floor on the next round of checking on Resident's in the dementia unit. The Nurse seen the Resident sitting on the floor in his room before leaving her shift in the morning. The oncoming Nurse J had indicated that they thought the Resident was care planned to be sitting on the floor. The DON stated, Even if care planned to be sitting on the floor, if he was not seen putting himself on the floor, then you can't assume that he didn't have a fall. When asked about the skin tear on the elbow, the DON reported that it was found by the CNA who had gotten Nurse J right away. When asked when it was found, the DON stated, Friday about 11 am (9/20/24). The DON reported that the Nurse did not report the skin tear and stated, It should have been reported due to it being an injury of unknown origin. The DON was asked if the Resident was care planned for putting himself/sitting on the floor. The DON reported the Resident was not care planned for that intervention. The DON reported the Nurse should have done an incident report and we would have followed up on it and stated, don't know if it was a fall or not, if it is not witnessed then we can't assume it was or was not a fall whether care planned or not. The DON reported doing a past non-compliance for both deficient practices of not completing and incident report for the Resident found sitting on the floor and the reporting of the skin tear that was considered an injury of unknown origin. The deficient practices delayed the investigation, assessment, monitoring and evaluation for Resident #12. Past Non-Compliance (PNC) was presented by the facility during investigation of the allegation and was accepted by the survey team upon exit from the facility for this citation. Following discussion with the State Manager, Past Non-Compliance was accepted. The Compliance Date was 9/25/24. The corrective action plan to attain and maintain compliance with F-689 of completing facility risk management reports included the following: -Description of deficient practice: Resident sustained an unknown injury to his left elbow. After completing the investigation it was found that the resident was seen sitting on the floor at shift change on 9/20/24. The nurse did not complete and incident report as she believed that the resident had placed themselves on the ground. -Plan of Correction: Resident was assessed by NP (nurse practitioner) who ordered multiple x-rays to r/o (rule out) any unseen injuries. Nurse has been educated on the importance of completing all risk management reports as indicated per policy. Reviewed policy with both nurses who were aware a resident was on the floor without witnessing it occur. Incident report and care plan updated after becoming aware of incident. -Residents on the memory care unit were assessed by a licensed nurse on 9/24/24 via a skin assessment and a pain assessment. Remaining Residents not assessed on 9/24/24 were completed on 9/25/24. -The DON completed an audit of residents who are care planned to have a behavior of placing self on ground, care plan updated to reflect that this must be observed and documented. -Nursing staff were re-educated on importance of notifying the nurse immediately if ay resident is observed on the floor and the importance of completing a risk management per policy. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-DON or designee will compete audits weekly x 4 then monthly until substantial compliance is achieved and maintained. -Audit findings will be reviewed by QAPI committee and will only be discontinued with compliance and approval of the facility QAPI Committee. -Date of completion of plan of correction 9/25/24. The corrective action plan to attain and maintain compliance with F-689 of reporting an injury of unknown origin included the following: -Description of deficient practice: Resident sustained an unknown injury to his left elbow. After completing the investigation, it was found that the resident was seen sitting on the floor at shift change. The nurse did not complete an incident report. The nurse discovering the injury of unknown origin (left elbow laceration) should have notified the abuse coordinator to begin investigation and rule out abuse. -Plan of Correction: Resident was assessed by NP who ordered multiple x-rays to r/o any unseen injuries. Nurse educated on the importance of completing all risk management reports as indicated per policy. Nurse re-educated on the importance of notifying the abuse coordinator to rule out abuse. -All residents on the memory care unit were assessed, completed on 9/24/24. -Corrective action taken: Nursing staff re-educated on the importance of notifying the abuse coordinator for any injury of unknown cause. -Audits will be completed by the Unit Managers who will audit 5 resident skin assessments or shower sheets for any new skin issues that may have potential to be injury of unknown origin. Completed weekly x 4 then monthly until substantial compliance is achieved and maintained. -Audit findings will be reviewed by QAPI committee and will only be discontinued with compliance and approval of the facility QAPI Committee. -Date of completion of plan of correction 9/25/24. The State Surveyor verified the facility's corrective action plan by interviews with facility staff to confirm education was completed and reviewed and AD HOC Meeting Committee agenda and sign-in was completed and reviewed. The overall Compliance Date is 09/26/2024.

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Medilodge of Frankenmuth	500 W Genesee Frankenmuth, MI 48734

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37771 Based on observation, interview and record review, the facility 1) Failed to ensure that Resident #5 had an adequate supply of oxygen while up and using the portable oxygen, 2) Failed to ensure the proper storage of nebulizer treatment equipment, and 3) Failed to replace oxygen tubing, nasal cannula, nebulizer apparatus for three residents, (Resident #2, Resident #5 and Resident #8), of 3 residents reviewed for respiratory care, resulting in potential for exacerbation of respiratory conditions, lack of oxygen, respiratory infections and diminished health and well-being. Findings include: Resident #2: A review of Resident #2's medical record revealed an admission into the facility on [DATE] with diagnoses that included sprain of ligament of left ankle, obesity, diabetes, lymphedema, muscle weakness, difficulty in walking and shortness of breath. A review of the Minimum Data Set (MDS) assessment revealed the Resident had a Brief Interview of Mental Status (BIMS) score of 15/15 that indicated intact cognition, and the Resident needed partial/moderate assistance with oral hygiene, and substantial/maximal assistance with toileting hygiene, bathing, dressing, and most types of mobility. On 9/19/24 at 10:45 AM, an interview was conducted with Resident #2 who answered questions and engaged in conversation. An observation was conducted of Resident #2's nebulizer apparatus on the bedside table. The nebulizer was put together, and moisture was observed in the medication chamber. The Resident was asked when his last breathing treatment was administered. The Resident reported he gets it as needed, had some wheezing and he got the breathing treatment then and stated, It was about three days ago. The tubing and the nebulizer equipment did not have a date on them of when it was replaced. On 9/19/24 at 11:36 AM, Nurse B was made aware of Resident #2, nebulizer treatment equipment not left to air dry. The Nurse indicated she would have it replaced. On 9/23/24 at 11:55 AM, Resident #2 was observed in bed, awake. The Resident was interviewed, answered questions and engaged in conversation. An observation was made of Resident #2's nebulizer equipment stored inside a clear bag. There was no date on the tubing or nebulizer and the medication chamber of the nebulizer was wet inside. The Resident was asked if he had received new nebulizer and tubing, the Resident reported that he did not see anyone bring in new equipment. The Resident reported he did not need a breathing treatment over the weekend. On 9/23/24 at 12:24 PM, an interview was conducted with Nurse B regarding Resident #2's nebulizer equipment. The Nurse was unaware the Resident did not get another nebulizer and stated, They were supposed to put a new one in there. An observation was made with Nurse B of the nebulizer stored with the medication chamber wet inside and in the bag. The Nurse removed the nebulizer and informed the Resident he will get a new one. Resident #5: (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident #5's medical record revealed an admission into the facility on [DATE] with diagnoses that included atrial fibrillation, chronic obstructive pulmonary disease, anemia, and dementia. On 9/19/24 at 10:05 AM, an observation was made of Resident #5 sitting in his wheelchair in a common area of the facility that had dining tables. There were multiple residents in the common area. An observation was made of Resident #5 having oxygen nasal cannula in his nose. The tank on the back of the wheelchair had the arrow on the dial in the red zone which indicated the Resident was out or close to being out of oxygen in the tank. The Resident was asked questions, but answers were unreliable. The Resident did not appear to be in respiratory distress. On 9/19/24 at 11:39 AM, Resident #5 was observed to be with staff and getting ready to go back to bed per the CNA. At 11:40 AM, the Resident was now in bed. The oxygen tank was observed, and the dial remained in the red zone. CNA E was asked about the oxygen tank being on red and reported she had checked it when she had gotten him up earlier and reported the tank had oxygen in it then. The CNA indicated that she likes to make sure there was at least two hours in the tank before putting a Resident on a portable oxygen. The CNA reported getting the Resident up at 9:00 AM. The Resident had oxygen on while in bed. A review of Resident #5's order for oxygen revealed, Oxygen: run @ (at)2 L/min (liters per minute) via N/C (nasal cannula) continuous, start date 4/19/24. Resident #8: A review of Resident #8's medical record revealed an admission into the facility on [DATE] and readmission on 9/10/24 with diagnoses that included heart disease, chronic obstructive pulmonary disease, asthma, shortness of breath, obstructive sleep apnea, need for assistance with personal care, schizophrenia, anxiety and repeated falls. On 9/19/24 at 10:17 AM, an observation was made of Resident #8's room. The Resident was not in the room at this time. An observation was made of the Resident's nebulizer mask positioned over the bedside table. The medication chamber of the nebulizer equipment was wet inside with residual liquid. The nebulizer had not been set out to air dry. Debris was observed to be in the inside of the mask that is placed on the Resident's face during the administration of aerosol medication. The oxygen concentrator was left on and connected to a Bipap machine. Oxygen tubing and nasal cannula was observed inside a bag and hanging on the concentrator. The nasal cannula prongs that go into the nose when wearing the nasal cannula was visible soiled. A sticker for a date was not observed on the tubing and the clear plastic bag had a date of 4/29/24. The oxygen tubing of the nebulizer mask did not have a date on the tubing or the mask. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/19/24 at 10:25 AM, an observation was made with Nurse B regarding Resident #8's storage of the nebulizer storage. The Nurse indicated that the Resident was in therapy at this time. An observation was conducted of the nebulizer and mask hanging over the bedside table that was wet inside the medication chamber. An observation was made of the nasal cannula with the date on the bag of 4/29/24. The Nurse stated, It should be changed weekly. When asked about the Bipap machine connected to the running oxygen concentrator, the Nurse stated, It should be turned off. When asked about the facility policy on nebulizer storage, the Nurse reported it should have been rinsed out and set out to dry. The Nurse was unsure when the Resident had his last breathing treatment. Nurse D who was passing medications to Residents on the unit was asked to look up the last time the Resident had a breathing treatment. The Nurse reviewed the medical record and reported the last breathing treatment was given at 11:22 PM last night. On 9/19/24 at 11:42 AM, an interview was conducted with Infection Control Nurse F regarding the storage of nebulizer equipment. When asked about facility policy on the storage of nebulizer equipment, the Nurse reported the nebulizers needed to be cleaned, aired out, and dried before putting them into a bag and that moisture could cause mold or mildew. When asked about changing out oxygen tubing, the Nurse reported that they were to be dated and changed weekly. A review of facility policy titled, Nebulizer Therapy, reviewed/revised 5/15/24 revealed, .Care of the Equipment. a. Clean after each use . c. Disassemble parts after every treatment. D. Rinse the nebulizer cup and mouthpiece wit water. E. Shake off excess water. F. Air dry on an absorbent towel. G. Once completely dry, store the nebulizer cup and the mouthpiece in a zip lock bag. H. Change nebulizer tubing weekly . A review of facility policy titled, Oxygen Administration, reviewed/revised 10/26/23, revealed, .b. Change oxygen tubing and mask/cannula weekly and as needed if it becomes soiled or contaminated . d. If applicable, change nebulizer tubing and delivery devices every 72 hours or per manufacturer recommendation, and as needed if they become soiled or contaminated .

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 37771 This Citation pertains to Intake Number MI00146646. Based on observation, interview and record review, the facility failed to properly store medication and needles/sharps on the East Wing Unit, of three units reviewed for safe environment, resulting in the potential for medication ingestion, diversion of medication and needles, and injury. Findings Include: On 9/19/24 at 10:06 AM, an observation was made of the nurses' station. There were no staff in the area. Residents were in the vicinity and nearby in the common area. The Nurses' Station had a counter that was accessible from the hall and wheelchair accessible in height. An observation was made of a bag of multiple antibiotic IV (intravenous) medication on the counter of the Nurses' Station. There was a tube of Derma fungal cream (an antifungal cream for skin treatment of a fungal infection), Assure glucometer control solution used to calibrate glucose monitor, vial of Ertapenem 1 gram vial (antibiotic medication) and Assure ID Pen needles. The needles were in an open box on the counter. While waiting for staff to return to the area, the Administrator (NHA) came by the Nurses' Station and asked if she could help this surveyor. The NHA was made aware of medication left unattended at the Nurses' Station. The NHA indicated she would get the Nurse and left the area to retrieve the Nurse working that area. Nurse B arrived at the Nurses' Station and was made aware of the medications and the needles on the counter of the Nurses' Station. When queried about facility policy, the Nurse indicated that, no, the medication should not be left behind the desk. The Nurse removed the medications and the needles. On 9/19/24 at 10:30 AM, an observation was made of Nurse D's medication cart. The Nurse had the medication cart in the East Wing hallway and was passing medication to the Residents that resided in that hallway. An observation was made of an open box of needles positioned on top of the cart. The Nurse indicated that the needles should not be left on top of the cart and removed them. A review of the facility policy titled, Medication Storage, reviewed/revised 1/30/24, revealed, Policy: It is the policy of this facility to ensure all medications housed on our premises will be stored according to the manufacturer's recommendations and sufficient to ensure proper sanitation, temperature, light, ventilation, moisture control, segregation, and security . 1. General Guidelines: a. All drugs and biologicals will be stored in locked compartments (i.e., medication carts, cabinets, drawers, refrigerators, medication rooms) .

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37771 This Citation pertains to Intake Numbers MI00146717 and MI00147164. Based on observation, interview and record review, the facility failed to maintain a clean, safe and homelike environment on the Central Unit with an exit door latched shut, foul odors, windows not secure, disrepair of furniture, and on the East Wing Unit call lights were not in reach, for two of three Units/Wings reviewed for environmental concerns, resulting in a marked exit door not functional in case of an emergency, lack of resident, staff, and visitor safety and the potential for embarrassment, dissatisfaction with living conditions, frustration, and needs not being met. Findings include: On 9/19/24 at 10:19 AM, an observation was made in room [ROOM NUMBER]. The Resident in bed A was lying in bed, awake. The Resident indicated he wanted to get out of bed. When asked if he had a call light, the Resident reported he did not know where it was. An observation was made of the call light around the bed rail positioned at the junction of the bed rail and bed frame with the push button apparatus hanging down almost to the floor. The Resident reported he didn't know where the light was at. When asked if he could reach it where it was positioned, the Resident said he could not. On 9/19/24 at 10:21 AM, an observation was made in room [ROOM NUMBER]-B of the Resident sleeping in bed with the head of the bed elevated. The Resident's call light was positioned on the wall adjacent to the Resident, clipped on the cord and hanging on the wall, not in reach for the Resident. CNA C was asked about the Resident in room [ROOM NUMBER]-B if this Resident used the call light. The CNA reported the Resident does use her call light and stated, It should be in reach, and placed the call light with the Resident. On 9/19/24 at 10:25 AM, Nurse B was informed of Resident in room [ROOM NUMBER] not having his call light in reach and an observation was made with Nurse B of the Resident's call light not in reach for the Resident. The Nurse placed the call light with the Resident and reported the call light should be in reach. On 9/19/24 at 10:50 AM, an observation was made of room [ROOM NUMBER]. The Resident in bed A was in bed sleeping. The call light was observed to be on the floor. On 9/19/24 at 10:52 AM, an observation was made of room [ROOM NUMBER]. The Resident of 44-B was in their chair. The call light was not in reach. On 9/19/24 at 11:01 AM, an observation was made of Resident #3 lying in bed with the head of the bed elevated. The Resident was seen earlier in the dining/common area. The Resident was asked questions and engaged in limited conversation. An observation was made of the Resident's bed against the wall and the cord for the call light was in the wall outlet but not in reach of the resident. The push mechanism was on the floor and not in reach for the Resident. When asked if she used the call light, the Resident reported she does use the call light but can't reach it right now. The Resident was asked about call light response times and reported sometimes it was more than a half an hour. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/19/24 at 2:23 PM, an interview was conducted with the Administrator (NHA) about rooms on the dementia unit. An observation was made with the NHA of the room [ROOM NUMBER] that Resident #1 resided in for part of his stay at the facility. The room had an adjoining bathroom. An observation was made of a smell of urine. The NHA indicated that they were looking into having to have the flooring removed. On 9/23/24 at 12:18 PM, an observation was made of Resident #3 lying in bed awake, shaking, and answering simple questions but not engaging in conversation. The Resident's head of bed was elevated, the bed was not up against the wall. An observation was made of the call light push mechanism laying on the floor and the call light cord nor the call light mechanism was in reach of the Resident. An observation was made of a puddle of water on the floor. On 9/23/24 at 12:21, CNA A was informed of the call light on the floor and the puddle of water on the floor. The CNA stated, We just came out of there. I had spilt the water on the floor. We were coming back in there with her tray. On 9/25/24 at 9:45 AM, a tour of the locked Central Unit was conducted of rooms where the Residents were not sleeping or in the room The following were some of the observations made: -room [ROOM NUMBER]: Residents were not in the room; Dried medication in yellow substance, pudding or applesauce, splattered across the wall, dried and hard, bits of medication can be seen in the splatters; electric outlet with a bar holding the cord was partially off the wall; pillows on bed with no pillow case; room smelled of urine; head board hanging off the frame of the bed on one side; 3 of 4 plug covers off of electrical outlet with the bed by the wall that has the outlet that would be in reach for the Resident while in bed; the other outlet by the bed did not have plug covers; the dresser for bed A was missing a drawer; drawer from bed B's bedside table on top of bed A's bedside table and broken; no drawer on bed B's closet; a half used bottle of Listerine mouthwash in the closet with no door on the closet; dentures on the top shelf and not in a container; closet of bed B smelled of urine; dirty soiled briefs in a covered garbage with odor. -Bathroom of 34: smell of urine in the bathroom; liquid on the floor near and around the toilet; hole in wall around the plumbing cap; cold water does not turn on; toilet does not flush well; urinal on top of towel dispenser with brown dried substance on the bottom and in the handle of the urinal that looked like old, dried urine. -room [ROOM NUMBER]: smells of urine in the room. -Bathroom of room [ROOM NUMBER]: smelled of urine; incontinence wipes on the back of the toilet had a dried brown substance smeared on the packaging. -Bathroom between rooms [ROOM NUMBERS]: odor in bathroom; dried brown substance (bowel movement), on the floor, wall and toilet; hole in the wall around bathroom piping. -Common area: tape along the windows (staff indicate they had an issue with bees coming into the room); window slide stoppers on some of the windows were missing; door marked as an exit door had a metal slide bar up at the top of the door to prevent it from opening. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Staff G was asked to have Maintenance come up to the Central Unit. Staff G was asked about the bathroom in room [ROOM NUMBER] that did not have any cold water, the Staff was unsure why there was no cold water. When asked about the urine smell in the bathroom in room [ROOM NUMBER], the Staff reported they had a Resident who was incontinent on the floor and stated, We are trying to get rid of it (the odor), need to pull up the floor. The Maintenance Director H with the Administrator (NHA) came up to the Central Unit. The door marked as an EXIT door with the bar at the top to prevent the door from opening was observed with the Maintenance Director and the NHA. The Maintenance Director indicated that they were not using the door for an exit door and that the emergency exit door was around the corner through the opening that once had a door, but it had been removed. The Maintenance Director indicated the locked exit door was going to be taken out. A door marked as an exit door that was not functioning as an exit door was a concern that was reviewed with the NHA and Maintenance director. The windows were observed in the common area and three of the windows did not have locks on them. The Director reported that there was a resident that would break them off and that they should be on the windows. room [ROOM NUMBER] was reviewed with the Maintenance Director and the NHA. An observation was made of the bathroom door not being able to be opened due to the bed in the way of the door opening completely to enter the bathroom. The NHA indicated the Resident in bed A should not have the Listerine in their closet and indicated she would inform the family. When asked about the outlet plugs not covered, the Maintenance Director indicated those where on there due to the Resident shoving stuff into the outlet and reported staff should let him know when they were missing so they could be replaced. The urine odor in the bathroom was discussed and the Maintenance director indicated it smells like pee and they have tried to clean the floors. The concern of the holes in bathroom walls around plumbing in the bathrooms was observed with the Maintenance Director. When queried about how staff inform him of environmental concerns, the Maintenance Director indicated they can tell him directly, call and leave a message or use the computer and he would get an alert about concerns. When asked if there had been any concerns sent to him, the Maintenance Director reported he had not received any alerts. On 9/25/24 at 10:19 AM, an interview was conducted with a Confidential Person T who visited Resident #11 in the locked Central Wing Unit of the facility. The Confidential Person expressed concern of the smell of urine on Resident #11's clothes that the Resident was wearing and the Resident's clothes in the closet, the bathroom smelling of urine and was a mess, the bed was broken, no pillow on the bed, and the Resident's diaper was full. The Confidential Person expressed that clothes that smelled like urine were thrown in the closet and dirty gloves were in there also. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/25/24 at 12:43 PM, an observation was made of Resident #8 eating lunch in his room. The Resident was positioned sitting in his wheelchair with the overbed table in front of him with his food partially eaten. An observation was made of the call light on the floor and not in reach for the Resident. When asked about the call light not in reach, the Resident explained that it had fallen down there, denied that it was clipped to him. When asked if they made sure it was in reach when he got his food tray, the Resident stated, no, and that it fell before he got his food and stated, it's been down there a while, when asked again before your tray was brought in, the Resident said yup. At 12:53 PM, the CNA went in to get the Resident's food tray from his room. An observation was made of the call light that remained on the floor. CNA E who had picked up Resident #8's food tray was queried about his call light not in reach. The CNA reported the Resident had his call light when she brought his tray to him but that it was draped over the table and stated, It might have fallen if he moved his table. The CNA went into the Resident's room to place the call light in reach. On 9/25/24 at 2:28 PM, an interview was conducted with CNA U regarding facility policy for call lights in reach. The CNA reported call lights need to be in reach. Clip as needed to the gown. When asked about facility policy for call light response times, the CNA stated, as soon as possible, five minutes if not busy with another resident. A review of facility policy titled, Call Lights: Accessibility and Timely Response, reviewed/revised 12/28/23 revealed, Policy: The purpose of this policy is to assure the facility is adequately equipped with a call light at each residents' bedside, toilet, and bathing facility to allow residents to call for assistance. Call lights will directly relay to a staff member or centralized location to ensure appropriate response . 1. Staff are educated in the proper use of the resident call system, including how the system works and ensuring resident access to the call light . A review of the facility policy titled Safe and homelike Environment, reviewed/revised 1/1/2022, revealed, Policy: In accordance with residents' rights, the facility will provide a safe, clean, comfortable and homelike environment . This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk . 3. Housekeeping and maintenance services will be provided as necessary to maintain a sanitary, orderly and comfortable environment . 9. General considerations: a. Minimize odors by disposing of soiled linens promptly and reporting lingering odors and bathrooms needing cleaning to Housekeeping Department . e. Report any furniture in disrepair to Maintenance promptly .