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	01/22/2025

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49944 This citation pertains to intake #MI00147776 Based on interview and record review the facility failed to provide activities of daily living (ADL) care for one dependent resident (R2) of four residents reviewed for ADL care, resulting in poor skin conditions and lack of assistance with bed mobility and peri-care. Findings include: Resident #2: R2 is [AGE] years old and admitted to the facility on [DATE] with diagnoses that include spinal stenosis, history of falling, diarrhea and chronic obstructive pulmonary disease. R2 has a brief interview for mental status (BIMS) score of 15, indicating that they are cognitively intact. On 01/21/25 at 11:53am, R2 was observed sitting in the dining room getting ready to eat lunch. R2 was approached by this surveyor and an interview was conducted. R2 was asked if they had any issues or concerns with the care they were receiving in the facility. R2 stated that when he first admitted to the facility, he had some issues with the staff providing care after he had episodes of fecal incontinence. R2 stated he had loose stools when he arrived at the facility and the staff didn't seem to think it was a big deal and that they would take a long time to clean him up. R2 was asked if the staff assisted him with getting cleaned up or getting turned and repositioned. R2 stated that the staff would clean him up, but it took a long time, and this happened a few times and that turning and repositioning took a long time too. R2 stated he was left in urine or feces quite a bit. R2 also stated that he had developed sores on the left and right side of his buttocks, but that it is improving. Record review of the 5-day minimum data set (MDS), dated [DATE], revealed that R2 did not have any skin conditions present on admission. Record review of the ADL care plan revealed that R2 is a one staff assist for bed mobility and a one staff assist for personal hygiene and toileting. Record review of the admission progress note, dated 12/13/2024, revealed that on admission R2 had a surgical dressing to the lumbar (lower back) area. Record review of the wound evaluation form, dated 12/31/2024, revealed that R2 had developed moisture-associated skin damage (MASD) on their coccyx. MASD is defined as an erosion or inflammation of the skin caused by long term exposure to moisture. (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: 235175	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/22/2025
NAME OF PROVIDER OR SUPPLIER Medilodge of Frankenmuth		STREET ADDRESS, CITY, STATE, ZIP CODE 500 W Genesee Frankenmuth, MI 48734	

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 01/22/25 at 10:57am, an interview was conducted with Wound Nurse D. Wound Nurse D was asked if R2 had any skin issues while at the facility. Wound Nurse D stated that R2 admitted to the facility following a back surgery and that R2 had a small abrasion on their left calf area. Wound Nurse D stated that R2 currently has MASD on their buttocks. Wound Nurse D was asked what they thought was the cause of the MASD. Wound Nurse D stated that R2 consistently spills his urinal and when R2 admitted they had loose watery stools that kept the skin wet. Wound Nurse D stated that the combination of these two things contributed to the breakdown of the skin. Wound Nurse D stated that R2 has grab bars on their bed and can reposition themselves. On 01/22/25 at 11:30am an interview was conducted with the Director of Nursing (DON). The DON was asked about R2 and the need for ADL care. The DON stated that when R2 admitted to the facility they had watery wet stools and we had to send a test out for clostridium difficile colitis, inflammation of the colon caused by the bacteria clostridium difficile, to see if that would explain the loose watery stools. The DON was asked what they thought caused the skin issues. The DON stated they thought it was from the Hoyer sling and shearing of the skin. The DON stated that the loose stools could have caused the MASD as well. Review of the policy titled, Activities of Daily Living (ADL's), revised 12/28/2023, revealed: Policy: The facility takes measures to minimize the loss of resident's functional abilities, including activities of daily living. Activities of Daily Living in the ability to: 1. Bathe, dress, and groom; 2. Transfer and ambulate; 3. Toilet; 4. Eat, and 5. Use speech, language, or other functional communication systems. Policy Explanation and Compliance Guidelines: 3. A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49944 This citation pertains to intakes #MI00147776 and #MI00149234. Based on interview and record review the facility failed to ensure that physician ordered medications were available for one resident (R1) and administered timely for one resident after admission (R2) of four residents reviewed for medication availability and timely medication administration, resulting in medications not being available and one resident not receiving their physician ordered medications timely. Findings include: Resident #1: R1 is [AGE] years old and admitted to the facility on [DATE] with diagnoses that include pathological fracture of the right femur, rib fracture, malignant neoplasm of the prostate and malignant neoplasm of the bones. R1 has a brief interview for mental status (BIMS) score of 15 indicating they are cognitively intact. On 01/21/25 at 9:30am, an interview was conducted with the complainant E. Complainant E stated that upon admission they were told that the pain medications were unavailable and that this went on for 24 hours or so and the nurse that was working on the day of admission told her that this happens a lot. Complainant E stated they were told by the nurse that the facility wasn't ready to take care of the pain for R1. Complainant E stated that R1 called 911 and left the facility to get pain medication and then returned to the facility later on. Record review of the discharge summary, dated 8/13/24, revealed that R1 was ordered Hydromorphone (Dilaudid) 2mg, by mouth every six hours as needed and Morphine 30mg, one tablet, every eight hours, both medications are for pain. Record review of the electronic medical record (EMR) revealed a physician's order, dated 08/15/24 for Morphine Sulfate Extended Release, 30mg, give one tablet by mouth every 12 hours for pain, this order was discontinued on 08/16/24. Another physician's order was entered for Morphine Sulfate Extended Release 30mg, one tablet by mouth three times a day. This order was entered on 08/16/24. No order was located for 08/13/24, the day of admission. Record review of the EMR revealed a physician's order for Hydromorphone, 2mg by mouth every six hours as needed. The order was dated 08/16/24. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 01/22/25 at 11:34am, an interview was conducted with the Director of Nursing (DON). The DON was asked about the reason for admission for R1. The DON stated that R1 admitted to the facility after a fall at home that resulted in a fractured right hip, R1 was on hospice at home and has cancer as well. The DON was asked what the process is for obtaining pain medication. The DON stated that until the order is entered into the EMR we cannot get the medication. The DON stated that when R1 left the building they had no intention of returning and therefore we discontinued all physician orders in the EMR. The DON was asked what their expectation was for a timeframe to received pain medications. The DON stated that they believe when the physician is reviewing medication orders, they should sign the form for controlled substances and that would allow us to get the medication quicker. Is there anything the admitting nurse could have done differently to get pain medication faster The DON stated the nurse could have called the pharmacy and requested a C2 (form for controlled substances) to send to the physician to sign and to get the pain medication out of the backup system. The facility provided a list of medications that are available onsite, it revealed that Hydromorphone 2mg and Morphine Extended Release 30mg were not available onsite. This was verified with the DON that these medications were not available in backup. Resident #2 R2 is [AGE] years old and admitted to the facility on [DATE] with diagnoses that include spinal stenosis, history of falling, atrial fibrillation and chronic obstructive pulmonary disease. R2 has a brief interview for mental status (BIMS) score of 15, indicating that they are cognitively intact. On 01/21/25 at 11:53am, an interview was conducted with R2. R2 was asked if they had any concerns with getting medication timely. R2 stated that it was over 24 hours after admission until he received his medications. R2 stated this included pain medications and general medications such as Eliquis. Record review of the EMR for R2 revealed a physician's order for Eliquis 5mg, one tablet by mouth in the morning and at bedtime, it was dated 12/13/24. Record review of the December 2024 medication administration record (MAR) for R2 revealed that the 2100 (9:00pm) dose of Eliquis was not administered on 12/13/24 and 12/14/24. These findings were verified with the DON. Review of the policy titled, Medication Administration, revised 1/17/23, revealed: 11. Compare medication source with MAR to verify resident name, medication name, form, dose, route, and time of administration. b. Administer within 60 minutes prior to or after scheduled time unless otherwise ordered by physician. The policy does not reference availability of medications in backup.