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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235226	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/26/2024
NAME OF PROVIDER OR SUPPLIER Medilodge of Grand Blanc		STREET ADDRESS, CITY, STATE, ZIP CODE 11941 Belsay Rd Grand Blanc, MI 48439	

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37666 This Citation pertains to Intake Number MI00143979. Based on observation, interview and record review, the facility failed to prevent staff-to-resident abuse for one resident (Resident #604) of 3 residents reviewed for abuse, resulting in a staff member using verbally abusive language towards Resident #604. Findings Include: Resident #604: A record review of the Face sheet and Minimum Data Set/MDS assessment indicated Resident #604 was admitted to the facility on [DATE] with diagnoses: Paranoid schizophrenia, hypothyroidism, heart failure, anxiety, depression and intellectual disabilities. The MDS assessment dated [DATE] indicated the resident had moderate cognitive decline with a Brief Interview for Mental Status score of 8/15. The resident also needed assistance with all care. On 9/25/2024 at 10:00 AM, during an interview with the Administrator, she said there had been a Facility Reported Incident on 3/27/2024 for Resident #604 related to Staff Member J telling Resident #604 to Shut your mouth. The incident occurred in the main dining room after an activity and had been overheard by several staff members. The Administrator said the staff who overheard: a Unit Manager Nurse F and Staff Scheduler K approached the resident and Staff J during the incident after hearing loud words. Staff Scheduler K said she overheard Staff J tell Resident #604 to Shut your mouth. The Unit Manager and Staff Scheduler immediately reported the incident to the Administrator. On 9/25/2024 at 10:40 AM, during an interview with Unit Manager F, she said there was an incident on 3/27/2024 between Resident #604 and Staff J. She said she was in an office beside the Main dining room and an activity for the residents had been going on. She said she overheard the Staff J saying something to Resident #604 and the resident started yelling. She said he seemed very upset. Unit Manager F said the Staff Scheduler heard more of the interaction between the resident and the Staff J. (continued on next page)

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

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/25/2024 at 11:02 AM, Staff Scheduler K was interviewed about the incident on 3/27/2024 between Staff J and Resident #604. She said her office was next to the Main dining room and the door was open. She heard Staff J tell Resident #604 to Keep my name out of your mouth. She said Staff J then told Resident #604 to shut up. Staff Scheduler K stated, I came out of my office and (Resident #604) was upset. That's when (Unit Manager F) and I went to the Administrator. On 9/25/2024 at 11:12 AM, Human Resources Staff/HR L was interviewed while reviewing Staff J's personnel file. It revealed Staff J had been reprimanded 3 times at the facility for inappropriate conversations with co-workers: 11/3/2023, 1/16/2024 and 3/13/2024. HR L was asked about the repeated incidents and she said they had occurred in a short amount of time, as Staff J was hired on 10/17/2023. It was noted each incident involved inappropriate verbalizations to Staff J's co-workers. Then on 3/27/2024 Staff J was verbally abusive to Resident #604. HR L said Staff J was terminated after the investigation into the incident with Resident #604. On 9/25/2024 at 12:05 PM, Resident #604 was sitting in the Main dining room; an activity had recently finished. He was alert and attempted to answer questions, but was difficult to understand. On 9/26/2024 at 11:00 AM Resident #604 was observed in his room, sitting in his wheelchair by the window. He was watching the baseball game on TV. He said he liked baseball and used to be a catcher. When asked about the incident with Staff J, the resident did not recall it. He began talking about moving to the room he was in and said he liked it. On 9/26/2024 at 1:45 PM, during an interview with the Administrator about the incident between Staff J and Resident #604, she said she had not worked at the facility during all of Staff J's prior incidents, but terminated his employment after completing the investigation for the incident on 3/27/2024, which was his 4th incident involving inappropriate comments to others. A review of the facility policy titled, Abuse, Neglect and Exploitation, date implemented 7/28/2020 and reviewed/revised 1/10/2024 provided, It is the policy of this facility to provide protections for the health, welfare, and rights of each resident . The facility will develop and implement written policies and procedures that: a. Prohibit and prevent abuse . Identifying, correcting, and intervening in situations in which abuse, neglect, exploitation, and/or misappropriation of resident property is more likely to occur .

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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 38471

This Citation will have two Deficient Practice Statements (DPS).

DPS #1:

This Citation pertains to Intake Number MI00147169.

Based on interview and record review the facility failed to assess, monitor and implement substantial interventions to prevent Resident #608's overdose, resulting in Resident #608 admitting with a Polysubstance abuse disorder of 40 + years without further facility follow-up, assessment or increased monitoring,and a fentanyl patch being applied in a reachable area resulting in subsequent ingestion of the patch, which resulted in an overdose.

Findings Include:

Resident #608:

On 9/25/2024 at approximately 2:00 PM, a review was completed of Resident #608's medical records and it revealed he admitted to the facility on [DATE] with diagnoses that included, Femur Fracture, Major Depressive Disorder, Hypertension, Adjustment Disorder with mixed anxiety and depressed mood and diabetes. Further review of the resident's chart revealed the following:

Discharge Hospital Records:

.Pt (patient) has a history of being on Oxy & Methadone .Methadone Clinic 80mg 2 years. New dr. discontinued started Suboxone. Approx. 1 year .Consultation for Addiction/Pain Evaluation & Recommendation/Management .Polysubstance abuse, Dependency, Withdrawal .

Care Plan:

Resident has behaviors related to (dx major depressive disorder) as evidenced by: medication seeking .40+ year addiction to drugs, crushes and snorts pills (in the community) . initiated 5/15/2024.

The care plan did not list interventions to address the resident's substance abuse history or medication seeking.

On 9/25/2024 at 2:15 PM, an interview was conducted with Unit Manager F regarding Resident #608. Manager F explained Resident #608 admitted in April 2024 after hospitalization due to a fracture. Although, he was wheelchair bound he had mobility in both of his arms. His Fentanyl patch was first applied on 09/01/2024 after a specialty consult for pain in which they recommended the patch instead of the oxycodone extended release. Manager F shared that upon admission it was noted in his discharge summary regarding his long-standing substance abuse history and his care plan.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Manager F shared at approximately 1:00 PM that Resident #608's fentanyl patch was placed, and he was at baseline, he was last observed by his assigned nurse around 1:30 PM and again was at baseline and in no distress. The dietary aide found him about 2:20 PM from what initially appeared to be a fall. Upon arrival to the room, he had decreased level of consciousness, his pupils were pinpoint, he would not respond, and he had hand tremors. Resident #608 responded to a sternum run but seemed to doze back out, his oxygen levels were low and his heart rate high. They called a code. A nonrebreather was placed which stabilized his oxygen and first dose of Narcan (medication that can reverse an overdose) was administered which did not illicit a response. The second dose of Narcan was administered which was effective. Manager F was asked if prior to ordering the medication if they alerted his prescribing practitioners to his severe substance abuse history and it was asked why his patch was placed in such an accessible area on this body. On 9/25/2024 at 3:25 PM, an interview was conducted with Social Services Director H regarding Resident #608. Director H stated the resident was transferred to her caseload in June 2024 and she was not aware of his substance abuse history until after his suspected fentanyl overdose a few days prior. She continued she was under the impression he was accustomed to a certain medications regime in the community and did not take him as medication seeking. On 9/25/2024 at 3:40 PM, discussion as held with Resident #608's guardian who reported that upon his admission she sent an email to the Social Work department detailing his substance abuse history, drug of choice and medications he has been on to curtail his addiction. Resident #608 was prescribed methadone (used to reduce withdrawal symptoms and can be used for pain relief) but consistently needed an increase and was switched to suboxone (treat opioid dependency and withdrawal symptoms), which he was on for 2.5 years and was free from all narcotics in his medication regime for two years. His guardian confirmed he had a 40+ year substance abuse history with his drug of choice being oxycodone and he would consistently seek medication at the local hospitals. They further stated they never approved the administration of fentanyl. When Resident #608 was at his worst, he was taking 10 oxycodone tablets a day in the community. Further review was completed of Resident #608's record: Occupational Therapy Plan of Treatment 5/28/2024: RUE (right upper extremity) = WFL (within functional limits); LUE (lower upper extremity) = WFL . Occupational Discharge Summary 8/30/2024: Dressing: Upper body dressing=independent; Lower body dressing= independent;Putting on/taking off footwear= independent Practitioner Progress Notes: 8/28/2024 00:00: .He claims that he notices a small improvement with Mobic but not nothing profound. Patient continues to have pain located in the tailbone region radiating into the right hip . Patient continues to have issues with pain in the tailbone and right hip region however had a long discussion with him regarding his oxycodone dose being near max level . (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	8/28/2024 at 14:37: .Recent right hip fracture .Patient reports that his pain is not controlled. He is already taking multiple pain medications including narcotics. I was hesitant to increase medication dosing as he was quite somnolent when I saw him a few days ago on 8/26/2028. Today he is a lot more alert and continues to report uncontrolled pain mainly towards the right SI joint and the groin/right hip. At this point in time would recommend considering stopping oxycodone and starting a low-dose fentanyl patch at 25 mcg an hour . Previous: Patient seen and examined. He is quite pleasant and is somnolent although easily arousable. He does report chronic tailbone and pain in his right hip. He does state that his pain is not well-controlled at this time. He is currently prescribed Tylenol, lidocaine patch, oxycodone, meloxicam . Controlled Drug Record: Indicated Resident #608's fentanyl patch was placed on his right chest on 9/23/2024 at 12:33 PM. MAR (Medication Administration Record): Fentanyl Transdermal Patch 72 Hour 50 MCG/HR- apply 1 patch transdermally every 72 hours for severe pain related to chronic trauma. Ordered initiated on 09/01/2024 and updated on 9/14/2024 to cover patch with Tegaderm and on 09/11/2024 to apply transparent film over patch after placement. On 9/23/2024 the nurse removed the Fentanyl patch at 12:31 PM and reapplied a new patch at 12:33 PM. Resident #608's Fentanyl patch would be applied to an accessible area on his body (arms, shoulder, chest). The resident had decent range of motion to his upper extremities. Resident #608 received the following pain medications in addition to his fentanyl patch: Acetaminophen 500 MG (milligrams)- give 2 tablets by mouth every 6 hours for pain Meloxicam Tablet 7.5 mg- every morning and at bedtime Lidocaine External Patch 5% patch as needed Oxycodone HCI Oral 5 MG- give by mouth every 6 hours as needed for severe break through pain Prior to the initiation of the fentanyl, Resident #608 was prescribed the following: Oxycodone HCI Oral 10 MG- give by mouth every 4 hours as needed for severe break through pain Oxycodone HCI ER tablet ER 12 hour- Abuse- Deterrent 20 MG every 12 hours Acetaminophen 500 MG (milligrams)- give 2 tablets by mouth every 6 hours for pain Meloxicam Tablet 7.5 mg- every morning and at bedtime Lidocaine External Patch 5% patch as needed (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #608 was prescribed an extensive amount of pain medications but consistently maintained his pain was not being effectively managed by the facility. There was no documentation located or presented by the facility that indicated other measures which they took to assess his pain levels other than the numerical value that Resident #608 associated with pain. Progress Notes: 9/23/2024 at 15:23: Resident was observed on the floor in his room, star track was called and resident was not at baseline. Resident was put in the bed and he could not keep his eyes open. vitals were assessed, resident still had pulse, code was called. Residents eyes were pin point, Narcan was given and no one could locate fentanyl patch I placed on him at 1300. Resident received multiple narcans before EMS arrived . 9/24/2024 at 10:22: On 9/23/24 at 14:20 dietary aide heard a loud noise followed by resident calling for help. Dietary aide called for nurse help who entered room and noted resident on the floor between the bed and night stand with wc (wheelchair) on top of him. Immediately assessed. No visible injury noted. Neuro checks initiated. Resident was presenting with decreased LOC (level of consciousness) and unable to provide description of incident. VS (vital signs) taken. Carotid pulse noted. Unable to obtain BP. SPO2 at 74%. Code blue called. 911 called buy staff. Residents pupils were noted to be pinpoint, equal and non-reactive. Placed on non-rebreather at 15 liters. SPO2 increased to 93%. Resident administered narcan via nasal x 2. Immediate change in LOC noted. resident sat up in bed and was communicating with staff, answering questions. Skin assessment completed. Fentanyl patch could not be located. New patch was applied to the left chest at 1300 by nursing staff. Root cause: Suspected opioid overdose AEB resident hx of dependence, missing fentanyl patch and reaction to narcan . It can be noted there was no documentation found that indicated informed consent was obtained from Resident #608's guardian prior to application of the fentanyl patch. Furthermore, there was no documentation regarding the facility practitioner's being informed or considering his substance abuse history prior to approval of the opioid. The facility placed the fentanyl patch in an easily accessible place (right chest) without forethought, which led to the resident overdosing and the administration of Narcan. On 9/26/2024 at 10:28 AM, Restorative Aide A reported Resident #608 had good mobility in his arms and she had observed him put his shirt on and pull it down in the back. He was able to reach to his shoulders with his finger and transfer himself to/from his wheelchair. On 9/26/2024 at 10:35 AM, Occupational Therapist B stated Resident #608 was within functional limits with his arms, was using 3-4-pound weights and could touch his shoulders as well. On 9/26/24 at 11:20 AM, an interview was conducted with Social Services Director H and Social Worker N regarding Resident #608. Social Worker N was asked how she became apprised of the resident's 40+-year substance abuse history. She reported she received the information from his guardian. They were queried if their contracted psychiatric services also provided substance abuse treatment, and they stated they do not. They were further questioned if they implemented specific substance abuse interventions, knew his drug of choice, informed the interdisciplinary team of his long-standing history to discuss how to move forward with his pain management and completed a substance abuse assessment. It was reported none of the above was completed as they were not privy to his drug of choice nor were any interventions or advocacy completed on their part related to his substance abuse. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	It can be noted the facility had the information related to Resident #608's substance abuse history and failed to take the initiative to curate a plan to ensure he did not revert to prior behaviors. His progress notes were riddled with documentation of medication-seeking behavior that went unnoticed and without an analysis of how to truly monitor his pain (without being solely reliant on the resident). There were no other assessments techniques utilized for Resident #608. On 9/26/2024 at 12:23 PM, an interview was conducted with Nurse M regarding Resident #608. She reported around 1:00 PM she placed his fentanyl patch on the opposite side from where it previously was. He was pleasant and from what she observed at this baseline; as she was gathering medications for other residents, she could see Resident #608 as he was in the doorway of his room. About an hour or so later she heard the page for a fall and responded to the room, she observed Resident #608 on the floor and he had a grip on his wheelchair that they were trying to loosen. The resident was not at his baseline as he had a glazed stare, his heart rate was high and oxygen levels low. Their Unit Manager responded to the room, and they called a code, Nurse M stated it was management that asked where his fentanyl patch was and as they searched they were unable to locate it. They administered Narcan a few times before he responded but he was not able to tell the nurse what occurred. Nurse M reported looking back on the incident his symptoms were consistent with an overdose and its plausible that he chewed his fentanyl patch as it was unaccounted for. On 9/26/2024 at 2:10 PM, a discussion was held with the Administrator regarding this incident. The facility asserts they cannot confirm if it was an overdose as they never located the fentanyl patch. It was explained the resident had a long-standing history with opioid's and his patch was applied to an accessible bodily. The physicians recommending and approving were not made aware of his long-standing history as it is plausible their treatment modality may have been altered if they were. Furthermore, there was no informed consent obtained to administer the fentanyl. Active efforts were not made to assess the potential detrimental effects of administering the resident his drug of choice nor was additional monitoring put in place to reduce the chance of this occurrence. According to the CDC (Centers for Disease Control), updated April 2, 2024.Naloxone (Narcan) is a life-saving medications that can reverse an overdose from opioid's .Naloxone quickly reverses an overdose by blocking the effects of opioid's. It can restore normal breathing within 2-3 minutes in a person whose breath has slowed or even stopped, as a result of an opioid overdose . 22348 DPS #2: This Citation pertains to Intake Number: MI00141920 and MI00144207 Based on observation, interview, and record review, the facility failed to ensure a safe environment with adequate supervision and implement interventions to prevent a fall for two residents (Resident #601 and Resident #605) and failed to do a complete investigation for both residents resulting in Resident #601 sustaining minor injuries after a fall and the potential for pain and a decline in medical condition and the likelihood of a fall with serious injury to reoccur due to incomplete investigations for both Resident #601 and Resident #605. Findings include: (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #601 (R601): According to R601's clinical record reviewed on 10/25/24 at 12:16 PM, R601 was [AGE] years old and admitted to the facility on [DATE] with a diagnosis of Right femur fracture sustained as a result of post fall, chronic kidney disease (on dialysis status) and Parkinson's Disease in addition to other diagnoses. R601's Minimum Data Set (MDS) score was 13, and section GG dated 12/22/23 revealed R601 Chair-to-chair or chair-to-bed transfer status required supervision or touching assistance. Picking up objects: The ability to bend/stoop from a standing position to pick up a small object, such as a spoon from the floor, requires partial to moderate assistance. R601 was assessed as at risk for a fall with injury related to a history of falls with a right hip fracture upon admission. R601 Care Plan initiated 11/29/23 revealed, Bathing: 1 person Extensive Assist and for Fall risk interventions initiated on 11/29/23 were: 1. Educate resident on safety interventions. 2. Encourage resident to keep needed items within reach. 3. Encourage resident to use the call light. On 9/25/24 at 2:00 PM, A review of the Incident and Accident Report (I/A) dated 12/20/2023 at 20:48 (8:23 PM) revealed, Incident Description: Resident was taking a shower and bent over to wash legs and tilted over in shower chair. Resident Statement: Stated he was washing his lower body, and chair fell over. Injuries observed: Abrasion Right Shoulder (front) . The I/A was incomplete, and the nurse did not fill out the following: Level of pain, Level of consciousness, R601's Mobility, and Mental status. Predisposing Environmental Factors: Wet Floor, Predisposing Physiological Factors: None . Predisposing Situational Factors: No entry or not filled out. In the notes done by the Director of Nursing dated 12/22/24: .Resident bent over to wash his legs, shower chair tilted, and resident slid to the floor. Resident states he was washing his lower body, and the chair tilted forward . Route cause: Resident bending/leaning forward in the shower chair, causing it to tip and resident to slide to fall. The I/A report did not describe the exact location of the nursing assistant during R601 fall. An attempt to interview the nurse assigned during the fall via phone, Nurse M, but the answering machine picked: Please check the number and dial again on 9/26/24 at 1:29 PM. The surveyor was unable to leave a message to return the call. In an attempt to interview the nursing assistant (CNA L) by phone on 9/26/24 at 1:31 PM, CNA L no longer works at the facility. When dialing the CNA's phone number, the answering machine states the phone is disconnected, changed, or no longer in service. The surveyor was unable to verify where the CNA L was when R601 fell during a shower on December 20, 2023, because the I/A report was incomplete. On 9/25/24 at 12:00 PM, the Director of Nursing (DON) was asked about who the nursing assistant assigned during R601's shower and where the nursing assistant was (precisely positioned) when the resident fell . The DON could not specify the location or position of the nursing assistant at the time of the fall. The DON claimed he received a report post-fall and noted that R601 was washing his lower body when the chair lifted over and slid down. Resident #605 (R605): (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 the facility incident (I/A) report on 9/25/24 at 2:15 PM revealed that the fall happened in R605's room on 4/26/24 at approximately 22:45 (10:45 PM). Nursing Description revealed: Nurse walked into the room and observed resident on floor. The resident was lying on his abdomen on his right side on his bed nearest the door, on his fall mat .R605, unable to give a description. Fall was unwitnessed . Guardian was notified and requested R605 be sent to the hospital for evaluation. R605's Incident Report pain level was not assessed, mental status was not evaluated, and predisposed situation was not filled. The Nursing Assistant (CNA) assigned was not identified and did not provide a statement on where she was and when the last time she had cared or was in contact or repositioned R605 in bed prior to the fall. The I/A report was partially filled and did not have the whereabouts of the CNA during the fall. The I/A report notes written by the DON dated 4/29/24 indicated the root cause: Resident upon assessment was noted to require respiratory suctioning due to accumulation of secretions .Resident has been noted in the past to cough aggressively resulting in changing position. No deficient practice. R605 was [AGE] years old and admitted to the facility on [DATE] with tracheostomy status, quadriplegia, Gastrostomy, and Chronic Respiratory Failure with hypoxia in addition to other diagnoses. Although R605's Brief Interview of Mental Status BIMS was not performed, R605's Care Plan dated 8/16/2023 for at-risk for Falls/injury was reviewed. The care plan described that R605 was quadriplegia, unaware of safety needs, had no trunk control, and was at bedridden status. He has contractures to his upper and lower extremities and is unable to use the call light or ask for assistance. All needs are met by staff anticipation of resident's needs. Upon Record Review on 9/25/24 at 12:10 PM, The care plan for Falls/injury and Care Plan for Respiratory was initiated on 8/16/23, and the revision date of 8/16/23 was reviewed. It did not indicate nor address the coughing aggressively causing him to be repositioned in bed. No interventions were updated regarding the aggressive coughing or the root cause of the fall, per DON's notes. R605's care plan related to the root cause was not addressed before or after the fall incident. There was no mention of aggressive coughing resulting in changing position and interventions to avoid further or repeated fall incidents after the fall on 4/26/24. On 9/25/24 at 12:00 PM, the surveyor requested the facility's investigation file from the DON Instead, the DON brought the Emergency Department summary and underlined the results, not the fall investigation. There was no fall investigation, and according to the DON, He did not have an actual statement gathered from staff. The DON indicated that according to the I/A report dated 4/26/24 at 22:45 (10:45 PM), R605 was found on the floor by the nurse and was an unwitnessed fall. The DON admitted that R605 was quadriplegic and could not move on his own. He needed to be repositioned and relied on staff to anticipate his needs and maintain safety. On 9/25/24 at 12:15 PM, the DON further stated that it was the guardian's request to send R605 to the hospital. An MRI was requested, and it was ruled out that there was no fracture after the fall. An attempt to interview the Nurse on duty during R605's fall on 4/22/24. The surveyor called Nurse LM on 9/26/24 at 1:26 PM and left a voicemail. No reply was received. NO CNA Statement, No other investigation (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235226	A. Building B. Wing	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Grand Blanc	11941 Belsay Rd Grand Blanc, MI 48439

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Nursing Assistant CNA, LS no longer works for the facility. The call was done on 9/26/24 at 1/25/PM. A voicemail was left to return the surveyor's call. In the facility's I/A report, there was no statement made by the CNA LS assigned to R605 when he was found on the floor. A review of the facility's Policy: Falls Clinical Protocol dated 10/30/2020 Indicated, An accident/incident report will be completed and forwarded to the DON as part of the facility's internal Quality Assessment and Assurance Program .Post-fall analysis items to be considered: . Review staff and witness statements (to include last time resident seen, provided care, and what type of care) . 10. Analysis of the causative factors and rationale for interventions developed and implemented should be documented in the Standards of Care notes. 11. Update the plan of care with the new or revised interventions.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235226	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/26/2024

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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 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 22348

This Citation pertains to Intake Number MI00146559.

Based on observation, interview, and record review, the facility failed to ensure proper Personal Protection Equipment (PPE) gowning for treating one resident (Resident #605), resulting in the likelihood of contamination during Percutaneous Endoscopic Gastrostomy (PEG) tube site care and the spread of infection.

Findings include:

Resident #605 (R605):

On 9/29/24 at 1:00 PM, Nurse D was observed during a PEG tube care dressing change for R605, who was on an Enhanced Barrier Precaution (EBP) due to the resident's tracheostomy and gastrostomy status.

On 9/28/24 at 3:00 PM, a review of R605's Electronic Medical Record revealed that R605 was [AGE] years old and admitted to the facility on [DATE] with tracheostomy status, quadriplegia, Gastrostomy, and Chronic Respiratory Failure with hypoxia in addition to other diagnoses. Although R605's Brief Interview of Mental Status (BIMS) was not performed, R605's Care Plan, initiated on 8/16/2023, was reviewed. The care plan described that R605 was quadriplegia, unaware of safety needs, had no trunk control, and was at bedridden status. He has contractures to his upper and lower extremities and is unable to use the call light or ask for assistance. All needs are met by staff anticipation of resident's needs.

Nurse D was observed for Peg site care on 9/29/24 at 1:05 PM. Nurse D performed hand washing, sanitizing, and putting on the PPE (Gown and gloves). Nurse D did not tie her gown to the neck portion, and the waist belt was not securely tied. During the stoma/wound site care, the waist belt got caught in the resident's linens/bed, and when she turned, it ripped and created a hole in the waist of her gown. Meanwhile, she continued cleansing R605's peg site with normal saline with the stoma exposed before covering it with a clean dressing. While performing the cleansing and applying the clean, dry dressing, the ripped gown kept falling off her body, shoulders, and sleeves because she did not tie up the neck part of the gown. Nurse D explained that the dressing change was not sterile but using a clean technique. Nurse D used Q-tips (cotton tips) on the stoma with soap and water. Nurse D continued to adjust the shoulders and sleeves back in place during the entire dressing change.

On 9/29/24 at 1:20 PM, After the dressing was applied on R605's Peg site, the surveyor validated the observation with Nurse D especially the gowning observation: was not tied from the neck, torn, and the waist belt that was not tied and secured before starting her dressing change from dirty to clean. Nurse D acknowledged that the gown was torn and not tied during the peg cite care and stated she would ensure PPE's are appropriately worn next time.

The Facility Policy for Personal Protective Equipment PPE dated 07/28/2020, reviewed on 2/29/24 at 3:30 PM indicated the following:

(continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235226	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/26/2024
NAME OF PROVIDER OR SUPPLIER Medilodge of Grand Blanc		STREET ADDRESS, CITY, STATE, ZIP CODE 11941 Belsay Rd Grand Blanc, MI 48439	

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Policy: This facility promotes appropriate use of personal protective equipment to prevent the transmission of pathogens to residents, visitors, and other staff. Definitions: Personal protective equipment, or PPE, refers to various barriers used alone or in combination to protect mucous membranes, skin, and clothing from contact with pathogens. It includes gloves, gowns, face protection (facemasks, goggles, and face shields), and respiratory protection (respirators). Policy Explanation and Compliance Guidelines: 1. All staff who have contact with residents and/or their environments must wear personal protective equipment as appropriate during resident care activities and at other times in which exposure to blood, body fluids, or potentially infectious materials is likely. 2. PPE will be utilized as part of standard precautions regardless of a resident's suspected or confirmed infection status . The facility Policy for Infection Prevention and Control Program, dated 8/20/2020, was reviewed on 9/29/24 at 3:45 PM. The policy indicated: Policy: This facility has established and maintains an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections as per accepted national standards and guidelines .