

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  04/24/2025
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)		
<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49944</b></p> <p>This Citation pertains to Intake Number MI00152171.</p> <p>Based on interview and record review, the facility failed to notify the resident's representative of a change in condition for one resident (Resident #2) of three residents reviewed, resulting in the family not being notified of a change in condition.</p> <p>Findings include:</p> <p>Resident #2 (R2):</p> <p>R2 is [AGE] years old and admitted to the facility on [DATE] with diagnoses that include cerebrovascular disease, hypertension, apnea and peripheral vascular disease. R2 had a brief interview for mental status (BIMS) score of 15, indicating they are cognitively intact.</p> <p>On 04/24/25 record review of a progress noted dated 12/30/24 at 11:09 revealed, Resident is extremely tired this morning. He refused breakfast and has not gotten dressed or out of bed as he usually does. Resident also will not speak to nurse he was able to mumble that he was tired. Resident tested for Covid and flu A and B, all negative. Resident is afebrile and vitals are wnl. Provider aware.</p> <p>On 04/24/25 record review of an assessment in the electronic medical record (EMR) titled, Pertinent Charting Initial-Change in Condition-V2, dated 12/30/24 at 14:30, revealed that R2 experienced a change in condition. The change identified section indicated that the resident did not want to get out of bed which is not typical. Resident stated that he was really tired. The nursing intervention portion of the assessment stated, Resident placed on O2 via non-rebreather. Provider wanted CPAP placed on resident with O2 bleed in. O2 came back up. O2 sats were at 98-100% on 2L. BS was 116. BP 114/75. Resident was given fluids by Provider. Vital were stable. STAT CBC and CMP labs were drawn and picked up by [NAME]. The section of the assessment titled responsible party notification was left blank.</p> <p>(continued on next page)</p>		

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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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 04/24/25 record review of a progress noted dated 12/30/24 at 14:57 revealed, Resident O2 decreased to 61% room air. Resident not able to answer questions appropriately and kept nodding off. Nurse placed a non-rebreather on resident with 8L of O2. O2 increased to 96%. Nurse notified [NAME] (educator) and she notified the provider [NAME]. Bp was 100/66 hr 110, afebrile. Provider had nurse place CPAP on resident with 8L O2. O2 maintained at 96%. Bs was 116. Provider placed an IV in residents R hand and administered 1L of D5. One dose of PRN Narcan given in right arm. Resident not retaining urine or stool, bladder scan confirmed. At 1440 resident O2 was 99%, bp 114/75, hr 103. O2 decreased to 4L, 98%, decreased to 2L 100%. Resident is maintaining 100% on 2L with CPAP in place. Labs drawn and waiting on [NAME] to pick up. Will continue to monitor resident O2. Resident resting in bed at this time.</p> <p>On 04/24/25 record review of an assessment titled, SBAR Communication Form and progress note- V4, dated 12/31/24 at 08:40 revealed that R2 was in respiratory distress and had a reduced level of consciousness (LOC) and it started on 12/30/24, his status has worsened. Under mental status changes' the boxes are checked for decreased consciousness and unresponsiveness.</p> <p>On 04/24/25 at 11:54 AM, an interview was conducted with Unit Manager (UM) C. The director of nursing (DON) was present as well. UM C was asked about the change in condition for R2. UM C stated, I was present that day and I had heard about the change in condition, when I got to his room the Nurse Practitioner was already in there. She was the provider that ordered the fluids to be run and the IV to be started. UM C was asked if the family was notified of the changes in the residents status. UM C stated, I would have to look back at notes, but I am certain they were notified. I was assuming that the nurse on the floor that day would have notified the family of the changes. UM C could not locate any documentation that indicated the family was notified of the change in condition. UM C was asked if the family should have been notified of the change. UM C stated, Absolutely, the family should have been notified. We (me and the nurse providing care) had a conversation about that (notifying family) and the nurse was supposed to be making a call to the family. The DON was asked if the family should have been notified of those changes on 12/30/24. The DON replied, yes, they should have been notified.</p> <p>On 04/24/25 at 12:20 PM an interview was conducted with licensed practical nurse (LPN) D. LPN D was asked about the change in condition for R2 on 12/30/24. LPN D stated, I went and got a nurse manager to notify her of the change. The nurse practitioner (NP) was present in the building, she went to assess the resident. The NP asked if R2 was on narcotics, and I stated that he was taking Tramadol for pain and the NP said to give him a dose of Narcan (reverses the effects of opioids) since R2 was in out and of consciousness. The NP wanted to administer fluids, she started an IV and we started fluids. His oxygen was stabilized, she had me draw labs and monitor until the end of my shift at 7 PM. Did you notify the family about the change in condition. LPN D stated I tried to call his daughter; it went to voicemail, and I did not document that I made the call. LPN D was asked if they left the family a message or passed it along to the oncoming nurse to follow up. LPN D stated, no.</p> <p>(continued on next page)</p>		

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 04/24/25 at 12:30 PM an interview was conducted with LPN B. LPN B provided care from 7:00 PM on 12/30/24 until 7:00 AM on 12/31/24. LPN B stated that the condition of R2 had changed throughout the day of 12/30/24, prior to my shift, R2 was started on continuous passive airway pressure (CPAP) and started on intravenous (IV) fluids. When I came in, R2 had the CPAP on and his IV running, R2 took meds for me with no issues. I was under the impression that the family had been contacted about his change. I notified the family at the end of my shift on 12/31/24 that there had been a change the previous day, the family was very upset that they were not aware that the resident had started on CPAP and had an IV started. R2 was sent out later that morning (12/31/24) while the family was present. LPN B stated they were upset that the family wasn't contacted initially, and I feel he should have been sent out sooner than that. LPN B stated R2 should have been sent out the day before when the first change was noticed.</p> <p>Review of the policy titled, Notification of Changes, reviewed/ revised on 08/29/24 revealed:</p> <p>Policy</p> <p>The purpose of this policy is to ensure the facility promptly informs the resident, consults the resident's physician, and notifies, consistent with his or her authority, resident's representatives when there is a change requiring notification.</p> <p>Definitions</p> <p>Need to alter treatment significantly means a need to stop a form of treatment because of adverse consequences (such as adverse drug reaction) or commence a new form of treatment to deal with a problem.</p> <p>Compliance Guidelines</p> <p>The facility must inform the resident, consult with the resident's physician and/or notify the resident's family member or legal representative where there is a change requiring such notification.</p> <p>Circumstances requiring notification include:</p> <p>2. Significant change in the resident's physical, mental or psychosocial condition such as deterioration in health, mental or psychosocial status.</p> <p>This may include:</p> <p>a. Life-threatening conditions, or</p> <p>b. Clinical complications.</p> <p>Additional considerations:</p> <p>1. Competent individuals:</p> <p>a. The facility must still contact the resident's physician and notify resident's representative, if known.</p> <p>(continued on next page)</p>		

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>b. A family that wishes to be informed would designate a member to receive calls.</p> <p>c. When a resident is mentally competent, such a designated family member should be notified of significant changes in the resident's health status because the resident may not be able to notify them personally, especially in the case of sudden illness or accident.</p> <p>2. Residents incapable of making decisions:</p> <p>a. The representative would make any decisions that have to be made.</p> <p>b. The resident should still be told what is happening</p>		