

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  07/08/2025
NAME OF PROVIDER OR SUPPLIER  Medilodge of Grand Blanc		STREET ADDRESS, CITY, STATE, ZIP CODE  11941 Belsay Road 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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> This Citation Pertains to Intake Number MI00153753.</p> <p>Based on observation, interview and record review, the facility failed to ensure measures were in place to prevent constipation for two Residents (#1 and #3) of 3 reviewed for constipation, resulting in the potential for discomfort, restlessness and adverse reactions.</p> <p>Findings Include:</p> <p>Resident #1:</p> <p>A record review of the Face sheet and Minimum Data Set/MDS assessment indicated Resident #1 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses: Diabetes, End stage renal disease, renal dialysis, Cardiac arrest, seizures, Hepatitis B, anemia, acute and chronic respiratory failure, dysphagia, feeding tube, hypertension and pneumonia. The MDS assessment dated [DATE] revealed the resident had cognitive loss and needed assistance with all care.</p> <p>On 7/3/2025 at 11:25 AM, Resident #1 was observed lying in bed in his room, sleeping. Nurse Aides A and B assisted the resident to reposition in bed. They said he would wiggle lower in the bed. The Resident continued to sleep.</p> <p>A record review of the progress notes indicated Resident #1 had fallen on 6/3/2025. A progress note dated 6/3/2025 revealed the resident's roommates family saw the resident slide out of bed onto the floor.</p> <p>A record review of the Incident and Accident reports for Resident #1 identified the following: 6/3/2025- Resident roommates wife came and alerted floor staff that resident had slid himself out of bed .</p> <p>A review of the Tasks documentation for Bowel Elimination for 6/9/2025-7/8/2025 revealed Resident #1 did not have a bowel movement on the following dates: 6/11/2025, 6/12/2025, 6/13/2025, 6/14/2025, 6/15/2025, 6/16/2025, 6/16/2025, 6/17/2025, 6/18/2025, 6/19/2025, (10 days) then 6/26/2025, 6/27/2025, 6/28/2025, 6/29/2025/, 6/30/2025, 7/1/2025 and on 7/2/2025 he had a small bowel movement. 7/6/2025, 7/7/2025 and had not yet had one on 7/8/2025.</p> <p>A review of the June 2025 and July 2025 Medication Administration Record/Treatment Administration Records (MAR/TAR) for Resident #1 identified the following:</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:  235226	Facility ID:  235226  If continuation sheet Page 1 of 4

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 6/18/2025 and 6/30/2025 Resident #1 received Polyethylene glycol via peg tube and there was no documentation on the MAR/TAR for June 2025 that he received a suppository or enema for constipation. A nurses note on 6/17/2025 indicated he had an emesis (vomiting) and a nurses note dated 6/19/2025 said he received a Bisacodyl suppository. There was also a nurses note identifying he had emesis and a loose stool on 6/20/2025; the day after receiving the suppository; this was during the 10-day timeframe with no bowel movement.</p> <p>A review of a provider note dated 6/21/2025 identified, Situation: ABD (abdominal) x-ray results are ready for your review. Treatment: Finding suggestive of constipation, as compared with prior examination dated 6/2/2025.</p> <p>6/26/2025, an Encounter note, C/o (complaints of) nausea, emesis episodes .</p> <p>6/26/2025 at 6:33 PM, a Pertinent Charting-Change in Condition note, . Emesis: Patient had emesis twice on my shift .</p> <p>6/28/2025 at 3:14 PM, a Behavior note, . Refusing care, resisting care and combativeness .</p> <p>6/29/2025: a Behavior note, Resident continues kicking legs and swinging arms .</p> <p>6/30/2025 at 2:12 AM, a Behavior note, Resistant to care.</p> <p>7/2/2025: an Encounter note, Notified by nursing staff that Resident unable to attend dialysis due to being combative with dialysis staff .</p> <p>On 7/2/2025 Resident #1 received Polyethylene glycol via peg tube.</p> <p>7/3/2025 at 6:50 AM, a progress note Patient had another episode of emesis this morning .</p> <p>7/3/2025 at 7:05 PM, a Behavior note, When giving patient his suppository he was kicking and swinging legs.</p> <p>7/7/2025 at 4:39 AM, Resident had emesis episode this shift .</p> <p>There were additional progress notes related to behaviors during the episodes of constipation.</p> <p>On 7/8/2025 at 10:45 AM, during an interview with Nurse G she said resident #1 became very restless at times and would wiggle around, she said he had constipation at times and this was flagged in the electronic medical record after the resident had no bowel movements for 3 days. Reviewed there were instances of no bowel movement for longer than 3 days without being addressed.</p> <p>A review of the Care Plans for Resident #1 identified the following:</p> <p>Resident is incontinent of bowel and bladder, dated initiated and revised 5/15/2025 with Interventions including: Observe for no BM in 3 days, date 5/15/2025; Administer medications as ordered, date initiated 5/15/2025.</p> <p>Resident #3:</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A record review of the Face sheet and MDS assessment indicated Resident #3 was admitted to the facility on [DATE] with diagnoses: Diabetes, chronic kidney disease, end stage renal disease, renal dialysis, respiratory failure, Myocardial infarction, heart disease, hypertension, anemia, weakness, dysphagia, feeding tube, arthritis. The MDS assessment dated [DATE] revealed the resident had moderate cognitive loss and needed assistance with all care.</p> <p>On 7/3/2025 at 11: 27 AM, Resident #3 was observed lying in bed awake and answered questions.</p> <p>A record review of the progress notes for Resident #3 revealed he fell on 6/12/2025 and 6/29/2025. Each fall occurred in his room from bed to floor. Further review of the progress notes identified the following:</p> <p>6/12/2025, an Encounter note, Nurse reports pt (patient) had unwitnessed falls. He has some abrasions on both knees but he denies pain .</p> <p>6/29/2025 at 6:17 PM, a Nurse's Note, Observed resident sitting on floor at bedside .</p> <p>A record review of the Incident and Accident reports for Resident #3 identified the following:</p> <p>6/12/2025: Pt observed on the floor next to his bed in a sitting position with his bac leaning up against the bed . Injuries observed at time of Incident: Abrasion left elbow; Abrasion right knee front; Abrasion left knee front . Injuries Report Post Incident: Bruise right thigh rear; Swelling right knee front .</p> <p>6/29/2025: Observed resident sitting on floor next to bed with back leaning against the bed, facing the doorway .</p> <p>A review of the Tasks documentation for Bowel Elimination from 6/9/2025 to 7/8/2025 revealed Resident #3 had multiple instances of constipation.</p> <p>The resident did not have a bowel movement on 6/9/2025, 6/10/2025, 6/11/2025, 6/12/2025 and 6/13/2025.</p> <p>The resident did not have a bowel movement on 6/16/2025, 6/17/2025, 6/18/2025, and 6/19/2025.</p> <p>The resident did not have a bowel movement on 6/21/2025, 6/22/2025, 6/23/2025, 6/24/2025 and 6/25/2025.</p> <p>On 6/27/2025 the resident had a small bowel movement and the resident did not have bowel movements on 6/28/2025, 6/29/2025, 6/30/2025, 7/1/2025 and 7/2/2025. On 7/3/2025 and 7/4/2025 the resident had a small bowel movement and no bowel movement on 7/5/2025.</p> <p>A review of the June and July 2025 Medication Administration Record and Treatment Administration Record (MAR/TAR) for Resident #3 indicated he had received Polyethylene glycol for constipation via the feeding tube on 6/13/2025, 6/18/2025, 7/2/2025 and 7/7/2025. The resident also received a Bisacodyl rectal suppository on 6/14/2025, 6/19/2025 and 6/28/2025.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Resident #3 fell on 6/12/2025 and 6/28/2025. Both falls occurred during the time the resident had not had a bowel movement for an extended period of time. During the review of bowel elimination from 6/9/2025 to 7/8/2025, there was no period of time that the resident had a routine bowel movement.</p> <p>On 7/8/2025 at 1:10 PM, interviewed Confidential Person I, she said the resident had fallen several times trying to get out of bed. She was assisting the resident with eating and said he had recently started a food diet to attempt to wean him off the tube feedings.</p> <p>A review of the Care Plans for Resident #1 identified the following:</p> <p>Resident is incontinent of bowel and bladder, dated initiated 5/9/2025 and revised 5/16/2025 with Interventions including: Observe for no BM in 3 days, date 5/9/2025; Administer medications as ordered, date initiated 5/9/2025.</p> <p>On 7/8/2025 at 1:25 PM, Nurse H was interviewed and said she frequently was assigned to care for Resident's #1 and #3. She was asked about the residents falling and she they had both fallen from bed. She said Resident #1 was often fidgety and would move around a lot in bed. She said after he was repositioned he would continue to move in bed. Nurse H said Resident #3 would become restless and place his legs out of bed. She said they usually transferred him to a Geri-Chair and brought him out of his room, and he would be more content.</p> <p>During the interview on 7/8/2025 at 1:25 PM with Nurse H, she was asked about the facilities bowel protocol. She said if a resident had not had a Bowel Movement/BM in 3 days then on the next day (day 4) they would receive (Miralax/Polyethylene glycol) and then if the resident didn't have a BM by the next shift they would receive a suppository (sometimes this would be day 5 with no BM). She said both residents had recently received the Miralax and a suppository.</p> <p>7/8/2025 at 1:45 PM, the Director of Nursing/DON was interviewed related to Residents #1 and #3 each experiencing multiple episodes of constipation, each receiving Polyethylene glycol and a rectal suppository to aid in bowel elimination. Reviewed that each resident also experienced falls during the time they were constipated and had received the medication to encourage elimination. The DON provided a copy of document titled, Standing Bowel Protocol and said if the resident did not have a bowel movement in 3 days, it would flag in the electronic medical record and when the alert was identified, the bowel protocol would be initiated. The DON said Polyethylene glycol was given first, if no BM on that shift (12 hour shift), the next shift would administer a Bisacodyl rectal suppository, if no results on that shift, the next shift would administer an enema (This could be day 5). Reviewed with the DON that Residents #1 and #3 had a pattern of repeated constipation and often wouldn't go for 4, 5 or more days at a time. She said they would look at their process.</p>		