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	09/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Grand Blanc	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)
F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. (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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to Intake Number 2607274.Based on observation, interview, and record review, the facility failed to obtain an appropriate resident assessment, physician's order, develop a care plan, and provide entrapment measurements to ensure that a resident is free from physical restraint for one resident (Resident #107) (R107) of 3 residents reviewed for use of side rails. Findings include:Resident #107 (R107):R 107 was observed in his room on September 10, 1925, at 2:00 PM. R107 was awake, lying in bed with an ongoing continuous tube feeding via pump being delivered, while R107 was restless in bed. The bed was observed in the lowest position; however, R107 appeared to be attempting to get out of bed, but the side rail was preventing him from falling out of the bed. It was noted that the floormat was placed on the floor on his right side. R107 had a padded full rail attached to the bed.During observation, Nurse K on 9/10/25 at 2:05 PM, was asked why R107 had a bedrail. Nurse K revealed he is a fall risk and may often get confused at times. Nurse K explained she was not the nurse assigned to R107 today.A review of R107's Electronic Medical Record (EMR) was conducted on September 10, 2025, at 12:00 PM. R107 was [AGE] years old and was admitted to the facility on [DATE], with the diagnosis of End Stage Renal Disease with dependence on Renal Dialysis, Gastrostomy feeding, difficulty walking, and muscle weakness in addition to other diagnoses. R107's Brief Interview of Mental Status (BIMS) Score assessed on 6/24/25 was 04/15. A BIMS score of 4 /15 indicates severe cognitive impairment. R107's Care Plan for Activities of Daily Living (ADL) required two-person assistance for Bathing, Bed Mobility, Dressing, Personal Hygiene, and Transferring.Further review of R107 Clinical Record revealed:No care plan for the use of bed rails was found in the R107 Plan of Care. There was no mention of side rails in the fall prevention care plan.No Informed Consent was found for the Use of Side rails, and no side rails assessment for R107 was found.No Initial entrapment measurements/grid of R107's bed/side rails were found.No physician orders for the use of siderails/bedrails were obtained.On 9/11/25 at 11:35 AM. The Director of Nursing (DON) and the Unit Manager were both interviewed.The DON and Unit Manager both confirmed that they did not find a consent for R107's side rails, no assessment was done for the appropriateness of side rails, no entrapment grid/measurements were taken, no physician orders were given for side rails, and no care plan was created for R107 regarding the use of side rails. The DON stated, R107 was admitted sometime in May of 2025, and he had a fall in June 2025. We missed following the protocol for R107 siderails. The Social Services Director (SSD) was interviewed on September 11, 2025, at 11:30 AM. The SSD revealed that she only does consent for the residents' Advanced Directives and Antipsychotic Meds. The consents for side rails are nursing responsibilities. R107 was deemed incapacitated, but the wife may also have dementia issues and can not be reliable with obtaining consents. SSD revealed that they have started a court-appointed guardian process for R107. Policy Review revealed:I. Restraints Policy (Date Reviewed/Revised: 10/26/2023)Policy: Restraints shall only be used for the safety and well-being of the resident(s) and only after other alternatives have been tried unsuccessfully. Policy Explanation and Compliance Guidelines: Restraints shall only be used upon the written order of a physician and after obtaining consent from the resident and/or representative (sponsor). An evaluation will be completed to determine the medical symptom requiring the device and to determine the least restrictive device to treat the symptom.II. Side Rails Policy date reviewed/revised 10/26/23Policy: It is the policy of this facility to utilize a person-centered approach when determining the use of side rails. Alternative approaches are attempted prior to installing a side or bed rail. If used, the facility ensures correct installation, use, and maintenance of the rails.The facility's definition of:Physical restraint is defined as any manual method, physical or mechanical device, equipment, or material that meets all of the following criteria:a. Is attached or adjacent to the resident's body;b. Cannot be removed easily by the resident; andc. Restricts the resident's freedom of movement or normal access to his/her bodyThe Policy Explanation and Compliance Guidelines:.c. Obtain informed consent from the resident or the resident's representative for the use of bed rails before installation/use.d. Determine whether or not the side/bed rail is a restraint. Side/bed rails will be considered a physical restraint when they limit the resident's freedom of movement and cannot be removed easily by the resident. In such cases, the facility shall follow procedures related to physical restraints.e. Document the medical diagnosis, condition, symptom, or functional reason for the use of the side/bed rail.f. Obtain physician orders for the use of side/bed rails . 4. The facility will assure the correct installation and maintenance of bed rails, prior to use. This includes:a. Checking with the manufacturer(s) to

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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** This citation pertains to intake Number 2607274.Based on observation, interview, and record review, the facility failed to ensure that Enhanced Barrier Precautions (EBP) were implemented according to the plans of care for two residents (Resident #107 and Resident #104) of the three residents reviewed for Infection Prevention and Control. Findings include: Resident #107 (R107): A review of the Electronic Medical Record (EMR) was conducted on 9/10/25 at 12:00 PM. R107 was [AGE] years old and was admitted to the facility on [DATE], with the diagnosis of End Stage Renal Disease with dependence on Renal Dialysis. R107 had a gastrostomy, a hemodialysis port, difficulty walking, and muscle weakness in addition to other diagnoses. R107's Brief Interview of Mental Status (BIMS) Score assessed on 6/24/25 was 04/15. A BIMS score of 4 /15 indicates severe cognitive impairment. R107's Care Plan was noted: Activities of Daily Living (ADLs) required two-person assistance for Bathing, Bed Mobility, Dressing, Personal Hygiene, and Transferring. Enhanced Barrier Precaution (EBP) Care Plan specified: Resident requires enhanced barrier precautions related to central line, dialysis, and feeding tube (initiated on 57/25 revision on 6/17/25) Use a gown and gloves when providing direct care. `Face protection may be needed if performing an activity with a risk of splash or spray. Utilize EBP when providing high-contact resident care activities (dressing, bathing, transferring, personal hygiene, changing linens, changing briefs/assisting with toileting, device care, central lines, urinary catheters, feeding tubes, tracheostomy/ventilators, wound care, dialysis). Review with visitors and family member show to follow the recommended precautions when visiting if prolonged physical contact is anticipated. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During observation, R107 was in his room on September 10, 2025, at 2:00 PM. R107 was observed awake, lying in bed with an ongoing continuous tube feeding being delivered. During observation, Nurse “K” on 9/10/25 at 2:05 PM, went into R107 and noticed that there was no signage of EBP outside or anywhere by the door of R107's room. Nurse “K” revealed that the roommate of R07 also goes to hemodialysis. Nurse “K” was asked how a visitor, family member, or guest would know if a resident requires special precautions to prevent the spread of infection. Nurse “K” stated, “There should have been a sign right by the door to alert everyone.” Nurse “K and the surveyor searched inside R107 room and did not find the laminated EBP sign. Nurse “K” was asked where she would find Personal Protective equipment if she were to unhook the Gastrostomy Tube feeding from the feeding tube. Nurse “K” looked everywhere in the room and did not find PPE in R107's room. There was no Personal Protective Equipment (PPE) Cart outside the hallway and inside the R107 room. There were no carts found anywhere in the 500 hallway. Nurse “K” was asked where she would go to get PPE. Nurse “K” stated that she would go inside other residents' rooms that have PPE carts inside their rooms. The surveyor asked Nurse “K”. Is that what you're supposed to do each time you need PPE? Get the PPEs in other residents' rooms. Nurse “K” hesitated and said, “I guess not.” On September 11, 2025, at 11:00 AM, an interview with the Infection Control Nurse (ICP Nurse) was conducted. She admitted that there should have been a sign and a cart nearby for PPE. R107 is vulnerable because he has a feeding tube and a port used for hemodialysis. The Care Plan was not followed. We conducted a sweep to ensure that carts were available for staff, signs were posted, and PPEs were readily accessible. On 9/11/25 at 11:25 PM. The surveyor discussed the EBP findings of R107 to both the Director of Nursing and the Unit Manager. The Facility Policy for Enhanced Barrier Precaution and Infection Control Protocol was reviewed on 9/11/25 at 2:30 PM. Resident #104 (R104): Record review of Resident 104's (R104) Medical records revealed medical diagnosis of: Traumatic Brain Injury (TBI) with major neurocognitive disorder (non-verbal), seizures, chronic sacral stage IV (full thickness) pressure ulcer and thoracic spine wound with infection (Pseudomonas Aeruginosa and Methicillin Susceptible Staphylococcus Aureus (MSSA) infection), muscle wasting, and needed assistance with personal care. On 09/10/2025 at 1:48 pm, an observation of R104 was made of resident resting in bed with eyes closed, R104's call light was on the floor and in the corner of the room and not in reach of resident. On 09/10/2025 at 2:02PM, During an interview with Nurse “F” about R104, she reported that R104 was recently at the hospital for a declining wound on sacrum/back. She stated, “she (R104) used to be on intravenous (IV) antibiotics (ABX) but is not on IV ABX anymore, she was recently put on oral ABXs for diagnosis of cellulitis (infection), I think it is for Pseudomonas and MRSA (methicillin resistant staphylococcus aureus)”. She said R 104 was no longer on tube feed and currently had a urinary catheter in place. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	It was confirmed by a record review of R104's medical chart progress notes dated 08/14/2025 that the resident was sent to hospital on [DATE] and returned to facility 08/20/2025. According to record review of hospital discharge notes from 08/18/2025 R104's diagnosis included: “T-Spine significant cellulitis of upper back concern for necrotizing fasciitis…”. Review of labs from hospitalization revealed, “MSSA and Pseudomonas infection” and that R104 received IV Vancomycin (antibiotic) while hospitalized . On 09/11/2025 at 12 Noon, An observation of R104 room with no enhanced barrier precautions posted neither inside nor outside. On 09/11/2025 at 12:02 PM, During an interview with nurse “F” she was asked how she would identify a resident in enhanced barrier precautions (EBP) and she stated, there would be a sign outside residents' door. Nurse “F” was asked if she could show where the signage was located that identified the precautions for R104. Nurse F walked over to the R 104 room door and verified that there was no sign present inside nor outside of R104's room. Nurse F stated, “I am not sure where it is”, and “one should be there for her”. Nurse “F” agreed that R104 had both a PICC and a tube feeding recently discontinued, and that R104 currently had an indwelling urinary catheter and infected wounds. Nurse “F” further agreed R104 was highly susceptible to transmission of pathogens. Nurse “F” points out an EBP personal protection equipment (PPE) drawer unit that is inside R104's room. The PPE drawer unit she pointed out was in front of R104's roommates' bed and the observation of contents revealed it had scant PPE in it, consisting of only a couple of gowns. On 09/11/2025 ~2 PM, During interview with DON she confirmed that residents in precautions will have sign indicating the type of precautions (enhanced, contact etc.…) needed outside the residents' room doors to alert staff, family and visitors. A record review of facility progress notes dated 08/22/2025 stated, “Resident recently hospitalized for declining wound. Patient presented to the hospital with worsening wounds of the sacrum and lower back. Patient has a history of chronic sacral ulcer which has been treated at our facility stage IV. Patient was also having cellulitis of the thoracic spine there was a concern for necrotizing fasciitis. Patient had a debridement done on August 15, 2025 by surgery. Patient was seen by infectious disease placed on IV antibiotics. Patient was subsequently stabilized and transferred back to our facility. Patient continues to be on IV antibiotics…”. A record review of R104's medical chart there was an order dated 08/21/2025 that read: “Use enhanced barriers while performing high-contact activity with the resident. PEG – Wound”. A record review of R104's physician and pharmacy section there was an order dated 09/04/2025 that read, “Cipro Oral Tablet 500 MG Give 1 tablet by mouth every 12 hours for Wound infection for 14 Days give with meals. Amoxicillin-Pot Clavulanate 875-125 MG Tablet Give 1 tablet by mouth every 12 hours for Wound infection for 14 Days give with meals”. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A record review of R104's care plan revealed, Interventions: Use gown and gloves when providing direct care. Face protection may be needed if performing activity with risk of splash or spray. Date Initiated: 03/14/2025; Utilize Enhanced Barrier Precautions when providing high contact resident care activities (dressing, bathing, transferring, personal hygiene, changing linens, changing briefs/assisting with toileting, device care: central lines, urinary catheters, feeding tubes, tracheostomy/ventilators, wound care, dialysis) Date Initiated: 03/14/2025; Review with visitors and family members how to follow the recommended precautions when visiting if prolonged physical contact is anticipated Date Initiated: 03/14/2025”. According to a record review of the facility's Policy & Procedure labeled infection control plan revealed, Isolation signs are used to alert staff, family members and visitors of transmission-based precautions”. According to the facility's policy on Enhanced Barrier Precautions: “Enhanced barrier precautions refer to an infection control intervention designed to reduce the transmission of Multidrug-resistant organisms that employs targeted gown, and gloves use during high-contact resident care activities” and “Initiation of enhanced barrier precautions… iii. Infection colonized with a CDC-targeted MDRO when contact precautions do not apply”.