STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235283	A. Building B. Wing	04/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of East Lansing	1843 N Hagadorn Rd East Lansing, MI 48823

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46955 This citation pertains to intake MI00143527 Based on observation, interview, and record review, the facility failed to prevent the development of a medical device related pressure ulcer for 1 (Resident #1) of 3 residents reviewed for pressure ulcers resulting in the development of a facility acquired deep tissue injury (DTI-intact or non-intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration or epidermal separation revealing a dark wound bed or blood filled blister) with the potential for delayed wound healing and/or worsening pressure ulcer. Findings include: Review of the medical record revealed that Resident #1 (R1) was readmitted to the facility 3/27/24 with diagnoses including acute respiratory failure, protein-calorie malnutrition, tracheostomy status, cognitive communication deficit, and retention of urine. Review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 4/2/24 revealed that R1 was rarely/never understood with a staff assessment of mental status indicating short- and long-term memory impairment with severely impaired cognitive skills for daily decision making. Section GG of MDS reflected that R1 was dependent for oral hygiene, toileting hygiene, showering/bathing, bed mobility, and transfers. Section H reflected that R1 had an indwelling catheter. Section M of the same MDS revealed that R1 was at risk for developing pressure injuries, had 2 unhealed stage 1 pressure injuries, and was not on a turning/repositioning program. In an observation and interview on 4/10/24 at 8:58 AM, R1 was observed lying in bed, on back, with the head of the bed positioned at an approximate 60-degree angle. R1 was observed to have eyes open and was noted to clear throat frequently with small amount of clear white mucous noted at tracheostomy. R1 stated that she was fine when questioned as to how she was doing but provided no further verbal response to follow-up questions. In an interview on 4/10/24 at 9:16 AM, Certified Nurse Aide (CNA) G confirmed familiarity with R1 and that she was her assigned CNA that date. Per CNA G, R1 was dependent on all care, was incontinent of both bowel and bladder, and required frequent repositioning as had a wound on her bottom. Review of R1's medical record completed with the following findings noted: (continued on next page)

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

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Nursing Evaluation Summary dated 3/27/24 at 5:15 PM stated, Res [resident] readmitted from [name of local hospital] .Resident has couple different wounds (see description under skin assessment and skin & wound evaluation from Wound nurses who completed initial skin assessment upon admission . Pertinent Charting Initial - Skin Note dated 3/28/24 at 4:38 AM stated, Per wound nurse report: Left Big toe (stage 1), scratch 3rd left toe, pressure to left inner thigh, stage one to left elbow, pink coccyx. Nurse Practitioner (NP) Encounter Note with an indicated Date of Service of 4/2/24 stated, .Problem: Initial wound care visit History of Present Illness: 77yr [year] old female requested by facility for evaluation of wounds and follow up related to left medial hallux stage 1 pressure wound and groin to inner thigh MASD [Moisture Associated Stasis Dermatitis] .Review of Systems .Skin: erythema to bilateral inner thighs and groin with macerated tissue .Wound #1 Wound Assessment: Wound-left medial foot hallux stage 1 pressure . No indication noted within documentation to reflect assessment of left buttock alteration. Nurses' Notes dated 4/2/24 at 6:05 PM stated, Observed residents bottom on wound assessment. Observed bruising to left buttock. Bruising aligned with catheter tubing. Area cleansed, evaluated, measured, dressing not needed. Catheter anchor adjusted .NP, DON [Director of Nursing], and RP [responsible party] updated. Bruise followed in skin and wound. Standard of Care-Wound assessment dated [DATE] at 1:47 PM reflected Stage 1 Pressure Injury at left hallux and left elbow present at admission, a Stage 2 Pressure Injury at right thigh present at admission, and a new bruise at left buttock. Pertinent Charting-Skin Note dated 4/8/24 at 12:00 PM stated, .left buttock area opened, skin prep changed to foam til wound team sees tomorrow. NP Encounter Note with an indicated Date of Service of 4/9/23 stated, .Follow up wound care visit History of Present Illness: 77yr old female requested by facility for evaluation of wounds and follow up related to left medial hallux stage 1 wound .Wound Assessment: Wound- left medial foot hallux stage 1 pressure -RESOLVED- . No indication noted within documentation to reflect assessment of left buttock alteration. Skin & Wound Evaluation dated 4/2/24 at 11:53 AM reflected a new in-house acquired bruise at left gluteus (buttock), staged by in-house nursing, measuring 5.9cm (centimeters) x (by) 4.0cm with 100% epithelial tissue in wound bed. Treatment indicated as skin prep. Skin & Wound Evaluation dated 4/9/24 at 3:13 PM, with Lock Date of assessment indicated at 4/9/24 at 5:10 PM, reflected an in-house acquired bruise at Left Gluteus present for 1 week. Wound was indicated to measure 3.7cm x 2.2cm x < (less than) 0.1cm with a pink or red wound bed and to have light serous drainage. A foam dressing treatment was indicated with wound progress noted to be stalled with a note reflecting that Tx [treatment] updated. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the same Skin & Wound Evaluation dated 4/9/24 at 3:13 PM was completed again on 4/11/23 with the Lock Date of assessment now indicated to be 4/10/24 at 6:37 PM. Upon further review, the evaluation was noted to be changed to reflect the Left Gluteus wound to be a Pressure-Medical Device Related Pressure Injury (versus prior bruise) with same evaluation now indicating the stage of the wound to be a Deep Tissue Injury (DTI): Persistent non-blanchable deep red, maroon or purple discoloration . Standard of Care-Wound assessment dated [DATE] at 6:37 PM reflected the Left Buttock wound location now to be a deep tissue pressure injury (versus prior bruise) which was indicated to be a change in the wound classification. Notes included within the Interdisciplinary Team (IDT) recommendations and comments at bottom of assessment stated, .Wound updated to DTI biased [sic] on discussion .Continued dti for deep red area to central wound . Care Plan Focus with a 4/10/24 date of revision stated, .at risk for impaired skin integrity Bruise on Left Buttock. Review of the same Care Plan Focus, with a 4/10/24 date of revision, was completed again on 4/11/24 and was noted to be clarified to state, .at risk for impaired skin integrity .DTI on Left Buttock. On 4/10/24 at 12:48 PM, Registered Nurse/Wound Nurse (RN/WN) C was observed to complete R1's left buttock wound care. R1's left buttock was noted to present with an open area measuring approximately 4cm x 2cm with area of deep reddish/purple discoloration noted toward central aspect of opening as well as small area of pale white tissue. RN/WN C stated that the alteration was similar in size to onset and that the area of deep red discoloration remained similar but that as the area was now open with newly noted pale, white tissue that she would be following up with the IDT regarding wound presentation. In an interview with RN/WN C following completion of R1's wound care, RN/WN C confirmed familiarity with R1, stated that she had been readmitted from the hospital approximately 2 weeks prior with a pressure ulcer to her right thigh from her catheter as well as pressure ulcers to her left elbow and left great toe all of which had since resolved. RN/WN C stated that she had completed R1's readmission skin assessment and had not noted discoloration or alterations to buttocks at that time but approximately 1 week after R1 had returned from the hospital, she observed what appeared to be a bruise at R1's left buttock. RN/WN C stated that, per her request, Director of Nursing (DON) B also assessed R1's left buttock discoloration and that upon further assessment and discussion, alteration was determined to be a bruise correlated to placement of R1's foley catheter tubing. RN/WN C confirmed that R1's left buttock bruise resulted from the placement of R1's foley catheter tubing (a medical device) as the tubing would have been in direct contact with the purple area of skin at the left buttock if positioned up and under R1 and therefore the alteration was documented as a bruise or suspected hematoma from catheter tubing. RN/WN C stated that DON B completed staff education regarding the placement of R1's foley catheter tubing and that R1's catheter had since been discontinued. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	RN/WN C further stated that she had updated R1's physician regarding the left buttock discoloration on 4/2/24, the day of identification, and had received a treatment order but that to her knowledge R1's physician or NP had not yet assessed the now open wound. RN/WN C stated that since initial presentation, the purple discoloration at the left buttock had opened, that on 4/8/24 R1's assigned nurse had received a treatment change order, that she herself had observed the area to be superficially open with the completed assessment on 4/9/24 and that she felt the new bordered foam treatment was appropriate. RN/WN C reiterated that due to the change in R1's left buttock wound presentation, she would be further discussing with the facility's IDT that date. In a follow-up telephone interview on 4/11/24 at 9:07 AM, RN/WN C stated that as the wound nurse she assessed and followed pressure ulcers, arterial and venous ulcers, diabetic ulcers, significant skin tears, some surgical incisions, or any other type of skin alteration that needed support to ensure that progressed in desired manner. RN/WN C stated that R1's left buttock originally presented with what appeared to be a bruise with brown and purple non-blanchable discoloration but that as looked like alteration came from R1 lying on catheter tubing that it could have been a deep tissue pressure injury and therefore wanted to follow closely just in case it wasn't an actual bruise. RN/WN C further stated that as R1's left buttock alteration now presented as a DTI, IDT had further discussed on 4/10/24 and that upon visualization of wound picture, Wound NP agreed that alteration presented as a DTI and therefore she had reopened the prior completed Skin & Wound Evaluation dated 4/9/24 and clarified the left buttock alteration to reflect a DTI from a medical device and that she had updated R1's care plan, as well. In an interview on 4/11/23 at 9:40 AM, DON B stated that the facility's wound management program included completion of a weekly assessment, including a picture, on any noted pressure, diabetic, venous, arterial ulcer or any other skin alteration that may require close monitoring. Per DON B, a bruise would be followed weekly based on location and if there was a question as to whether the identified area was a bruise, or a deep tissue injury based on the initial presentation of the alteration. DON B confirmed familiarity with R1, stated that she and RN/WN C had assessed R1's left buttock alteration together and that area had initially presented as an irregular shaped area of dark purple, light greenish/tan discoloration that was non-blanchable at inner aspect but blanchable toward the edges and that the entire alteration correlated to the shape of the catheter tubing. DON B stated that as R1 did get up into a reclining chair, was uncertain as to whether the catheter tubing somehow got underneath her bottom to cause trauma or pressure from lying or sitting on the tubing and that an order was obtained for twice daily skin prep application so that a nurse would be looking at the area twice daily as was unsure if area was a bruise or a deep tissue pressure injury from the catheter tubing. DON B further stated that upon identification of R1's left buttock alteration, on 4/2/24, she initiated CNA and Nurse education regarding the proper placement of medical devices and making sure that foley catheter tubing was properly secured and not underneath a resident when repositioning as again confirmed that R1's left buttock alteration correlated to the shape of the catheter tubing. Per DON B, as R1's left buttock alteration was observed to be open on 4/8/24, an order was obtained for a bordered foam dressing and an IDT meeting was held on 4/10/24 with R1's left buttock wound classification changed from a bruise to a DTI at that time. The National Pressure Injury Advisory Panel (2016) updated staging system provides the following definitions related to Pressure Injuries: (continued on next page)

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