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	07/03/2024

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

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38383 This citation pertains to intake MI00145078. Based on interview and record review, the facility failed to ensure the physician was notified of a change in treatment orders when one resident (Resident #3) did not transfer to the emergency room (ER) for bleeding, as ordered. Findings include: Review of the medical record reflected Resident #3 (R3) admitted to the facility on [DATE] and readmitted [DATE], with diagnoses that included respiratory failure, tracheostomy status and morbid (severe) obesity due to excess calories. The quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 5/8/24, reflected R3 scored 15 out of 15 (cognitively intact) on the Brief Interview Status (BIMS-a cognitive screening tool). According to the medical record, R3 was his own responsible party. R3 was transferred to the hospital on 6/9/24 and did not reside in the facility at the time of the survey. According to R3's medical record, his most recent weight was 768.4 pounds on 5/18/24. A Situation, Background, Assessment, Recommendation (SBAR) document, dated 6/8/24 at 9:20 AM reflected the nurse suspected R3 had a femoral artery bleed due to profuse bleeding, in the lower right abdomen, that worsened with movement. Additionally, the SBAR reflected a large blood clot was found on examination, and blood was shooting out of the area of concern. The document reflected Physician O ordered for R3 to be sent to the ER. According to the SBAR, dated 6/8/24, EMS arrived and was unable to transfer R3 due to his size (weight). An alternate ambulance service was called and did not have the ability to transfer R3 until later in the afternoon. The SBAR reflected, .It was determined that bleeding is uncontrolled at the moment with ice bag pressure and to not move resident unless needed, to allow a clot of [sic] form in area of concern. If profuse bleeding starts again, call 911 and they will risk transferring resident per EMT [Emergency Medical Technician] . (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235283	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/03/2024
NAME OF PROVIDER OR SUPPLIER Medilodge of East Lansing		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/3/24 at 7:57 AM, Licensed Practical Nurse (LPN) H reported when she lifted R3's abdominal fold to assess his bleeding, blood shot out at her. She reported observing a large blood clot in R3's abdominal fold. LPN H reported she notified Assistant Director of Nursing (ADON) G of R3's change in condition. During an interview on 7/3/24 at 2:45 PM, ADON G stated she was on-call at the time of R3's bleeding. ADON reported she spoke to Physician O about the situation and received the directive to send R3 to the hospital. LPN H later notified her that EMS said to call them back if R3 began bleeding again. ADON G reported she did not hear anything for the rest of the day. When asked if the doctor was made aware that EMS did not transport R3 to the hospital, ADON G denied that she had made the doctor aware. An EMS document for 6/8/24 reflected they were dispatched to the facility for a complaint of a hemorrhage from the right groin area. Staff stated they rolled R3, and blood squirted about 8 inches. Staff placed an ice pack in a towel at the site. R3's bleeding was controlled upon EMS arrival, and they were unable to transport R3 due to his weight of approximately 900 pounds to 1,000 pounds. EMS equipment was only rated for up to 700 pounds, per the document. The document reflected R3 refused further treatment and transport. R3's medical record did not reflect Physician O had been notified that R3 did not transfer to the ER, as ordered, on 6/8/24. During a phone interview on 7/3/24 at 3:14 PM, Physician O reported ADON G called her on 6/8/24 to notify her that R3 started bleeding from a wound in his abdomen, and it was significant. Physician O stated she agreed that R3 needed to be sent to the hospital. She denied that she had been notified of anything further on 6/8/24.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38383 This citation pertains to intake MI00145078. Based on interview and record review, the facility failed to routinely assess and monitor a change in condition for one (Resident #3). Findings include: Review of the medical record reflected Resident #3 (R3) admitted to the facility on [DATE] and readmitted [DATE], with diagnoses that included respiratory failure, tracheostomy status and morbid (severe) obesity due to excess calories. The quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 5/8/24, reflected R3 scored 15 out of 15 (cognitively intact) on the Brief Interview Status (BIMS-a cognitive screening tool). According to the medical record, R3 was his own responsible party. R3 was transferred to the hospital on 6/9/24 and did not reside in the facility at the time of the survey. According to R3's medical record, his most recent weight was 768.4 pounds on 5/18/24. A Situation, Background, Assessment, Recommendation (SBAR) document, dated 6/8/24 at 9:20 AM reflected the nurse suspected R3 had a femoral artery bleed due to profuse bleeding, in the lower right abdomen, that worsened with movement. Additionally, the SBAR reflected a large blood clot was found on examination, and blood was shooting out of the area of concern. The document reflected Physician O ordered for R3 to be sent to the emergency room (ER). According to the SBAR, dated 6/8/24, Emergency Medical Services (EMS) arrived and was unable to transfer R3 due to his size (weight). An alternate ambulance service was called and did not have the ability to transfer R3 until later in the afternoon. The SBAR reflected, .It was determined that bleeding is uncontrolled at the moment with ice bag pressure and to not move resident unless needed, to allow a clot of [sic] form in area of concern. If profuse bleeding starts again, call 911 and they will risk transferring resident per EMT [Emergency Medical Technician] . During an interview on 7/3/24 at 7:57 AM, Licensed Practical Nurse (LPN) H reported observing bright red blood on R3's bed after being notified that the Certified Nurse Aide (CNA) observed blood during care. LPN H' reported when she lifted R3's abdominal fold to assess his bleeding, blood shot out at her. She also observed a large blood clot in R3's abdominal fold. LPN H reported she immediately held pressure and sent another staff member to get ice and a towel. LPN H reported she notified Assistant Director of Nursing (ADON) G of R3's change in condition. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During the same interview, LPN H stated that whenever the facility had to send R3 out, they had to make special arrangements due to obesity. LPN H reported 911 was called (on 6/8/24), and they did not have the means to safely transport R3 to the hospital. She described that R3's weight exceeded the weight of EMS gurney's. When EMS arrived on 6/8/24, they said the bleeding was controlled, and they did not want to move R3. According to LPN H, EMS would only return for transport if R3 was bleeding, and it was life-threatening. An EMS document for 6/8/24 reflected they were dispatched to the facility for a complaint of a hemorrhage from the right groin area. Staff stated they rolled R3, and blood squirted about 8 inches. Staff placed an ice pack in a towel at the site. R3's bleeding was controlled upon EMS arrival, and they were unable to transport R3 due to his weight of approximately 900 pounds to 1,000 pounds. EMS equipment was only rated for up to 700 pounds, per the document. The document reflected R3 refused further treatment and transport. R3's medical record did not reflect Physician O had been notified that EMS did not transfer R3 to theER on [DATE], as ordered. There were no further orders for treatment, assessment or monitoring of R3's condition. During a phone interview on 7/3/24 at 9:17 AM, Registered Nurse (RN) P reported receiving report that R3 started hemorrhaging during the day shift on 6/8/24, and EMS could not transport him to the hospital due to obesity. Around 4:00 AM to 4:30 AM (on 6/9/24), R3 began hemorrhaging again. When queried about assessments being done during his shift, RN P reported staff were frequently checking for any bleeding and putting fresh towels on him. An SBAR document for 6/9/24 at 6:00 AM reflected that at 5:00 AM, R3 was placed on the bed pan and began bleeding from the right groin region. A large amount of blood and blood clots were observed on R3's bed. EMS was called, intravenous (IV) fluids were administered, but his blood pressure was slowly dropping. At 6:46 AM, R3's blood pressure was 70/42 millimeters of mercury (mmHg). A Progress Note for 6/9/24 at 5:00 AM reflected the CNA requested the nurse in R3's room. The nurse observed blood loss from R3's wound, on his right side. Approximately 250 milliliters (mL) to 300 mL of blood was pooled on the bed, with blood also dripping onto the floor. R3's blood pressure was documented to be 87/63 mmHg. EMS was called and made arrangements to get a flatbed truck to transport R3 to the ER. R3 left the facility at approximately 7:15 AM. An EMS document for 6/9/24 reflected they were dispatched to the facility for a complaint of a hemorrhage, which started the day prior at 9:00 AM. Upon visualization (on 6/9/24), R3 had blood profusely oozing out of the site, from the right groin area. EMS packed the area with a large adult brief and a bath towel, which slowed the bleeding but did not control it. EMS attempted two IVs without success before receiving authorization to use R3's peripherally inserted central catheter (PICC/a form of IV access) for fluids. An Intraosseous Infusion (IO/process of injecting medication, fluids or blood products directly into the bone marrow) was also started. R3 was transferred via hoyer lift to a horse sled, slid on the ground through the facility's rear exit and winched onto a flat bed truck. He was then transported to the hospital with EMS in attendance and police escort. One hour and 59 minutes were spent loading R3 for transport to the hospital. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a phone interview on 7/3/24 at 3:33 PM, Physician O reported if she had been notified (that R3 was staying in the facility rather than transferring to the hospital on 6/8/24), her expectation would have been that blood pressures would have been monitored more frequently, and vital signs obtained every four to six hours, depending on how R3 was doing. R3's medical record reflected the following blood pressures for 6/8/24 and 6/9/24: 6/8/24 at 7:01 AM: 117/70 mmHg 6/8/24 at 7:26 AM: 117/70 mmHg 6/8/24 at 8:59 AM: 107/66 mmHg 6/8/24 at 6:48 PM: 102/66 mmHg 6/9/24 at 6:46 AM: 70/42 mmHg R3's medical record reflected the following pulses for 6/8/24 and 6/9/24: 6/8/24 at 12:13 AM: 81 beats per minutes (bpm) 6/8/24 at 7:01 AM: 111 bpm 6/8/24 at 7:26 AM: 111 bpm 6/8/24 at 8:59 AM: 83 bpm 6/8/24 at 1:41 PM: 87 bpm 6/8/24 at 6:48 PM: 101 bpm

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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** 38383 This citation pertains to intakes MI00144740 and MI00145260. Based on interview and record review, the facility failed to ensure appropriate orders to treat pressure ulcers for one (Resident #2) of four reviewed. Findings include: Review of the medical record reflected Resident #2 (R2) admitted to the facility on [DATE] and readmitted [DATE], with diagnoses that included cardiac arrest, respiratory arrest and anoxic brain damage. R2 did not reside in the facility at the time of the survey. R2's medical record reflected a facility-acquired pressure ulcer to the sacrum that was unstageable (full-thickness skin and tissue loss where the extent of tissue damage in the ulcer cannot be confirmed due to the wound bed being obscured by slough (non-viable tissue that can present as yellow, tan, gray, green or brown) or eschar (dead or devitalized tissue that can present as black, brown, tan or scab-like)). On 6/4/24, R2's sacral pressure ulcer measured 0.47 centimeters (cm) in length by 0.8 cm in width, with a wound bed that was 100 percent (%) slough. On 6/11/24, R2's sacral pressure ulcer measured 1.42 cm in length by 1.3 cm in width. The wound bed was 20% granulation tissue (pink/red, moist tissue that fills open wounds when they begin to heal) and 80% slough. On 6/18/24, R2's sacral pressure ulcer measured 2.12 cm in length by 1.65 cm in width. The wound bed was 20% granulation tissue and 80% slough. On 6/25/24, R2's sacral pressure ulcer measured 2.31 cm in length by 1.83 cm in width. The wound bed was 40% granulation and 60% slough. A wound clinic consultation for 6/3/24 reflected a recommended sacral treatment of collagen, hydrofera blue, bordered foam and to remain clean and dry. The recommendation was to change the dressing for damage, soiling or excessive drainage. R2's June 2024 Treatment Administration Record (TAR) reflected an order with a start date of 6/3/24 and a discontinue date of 6/26/24 to cleanse the sacral wound with wound cleanser, pat dry, pack with collagen, apply skin prep around the wound, cover with hydrofoam blue and cover with border foam. The treatment was to be changed every other night. R2's June 2024 TAR reflected an order with a start date of 6/12/24 and a discontinue date of 6/18/24 to cleanse the sacral wound with wound cleanser, apply Dermasyn AG to gauze, place in the wound bed and cover with bordered foam. The treatment was ordered to be changed daily, at bedtime, and ran concurrently with the sacral treatment order that included the use of collagen, dated 6/3/24 through 6/26/24. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R2's June 2024 TAR reflected an order with a start date of 6/19/24 and a discontinue date of 6/26/24 to cleanse the sacral wound with wound cleanser, apply Medihoney gauze to the wound base and cover with bordered foam. The treatment was ordered to be changed daily, at bedtime, and ran concurrently with the sacral treatment order that included the use of collagen, dated 6/3/24 through 6/26/24. During an interview on 7/3/24 at 3:51 PM, Director of Nursing (DON) B reported staff was applying the hydrofera treatment to one of R2's old wounds and collagen and Medihoney on the new sacral wound. Regarding the concurrent sacral wound treatment orders, DON B reported her understanding was that Medihoney should have been the treatment that was applied.