STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235284	A. Building B. Wing	06/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Midland	4900 Hedgewood Dr Midland, MI 48640

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39056 This Citation pertains to Intake Number MI00140074 Based on interview and record review, the facility failed to follow professional standards of nursing practice for medication administration for 4 of 8 residents (Resident #10, Resident #8, Resident #15, and Resident #17), reviewed for the provision of nursing services, resulting in medication errors and medications being administered outside of the physician-ordered parameters. Findings include: Resident #10 (R10): Review of an Admission Record revealed R10 was an [AGE] year-old male, admitted to the facility on [DATE], with pertinent diagnoses which included: Diabetes type II. Review of R10's Order Details dated 4/2/24 revealed, Insulin Glargine Solution 100 UNIT/ML Inject 12 unit subcutaneously two times a day for diabetes Hold if bs (blood sugar) less than 110. Review of R10's Medication Administration Record and Blood Sugar Summary revealed: * On 5/1/24 at 8:16 AM R10 had a blood sugar of 89 and the insulin was administered. * On 5/3/24 at 7:47 AM R10 had a blood sugar of 68 and the insulin was administered. * On 5/7/24 at 8:14 AM R10 had a blood sugar of 93 and the insulin was administered. * On 5/14/24 at 7:47 AM R10 had a blood sugar of 96 and the insulin was administered. * On 5/18/24 at 6:47 AM R10 had a blood sugar of 92 and the insulin was administered. * On 5/22/24 at 7:50 AM R10 had a blood sugar of 62 and the insulin was administered. * On 5/31/24 at 8:10 AM R10 had a blood sugar of 90 and the insulin was administered. * On 6/2/24 at 7:24 AM R10 had a blood sugar of 78 and the insulin was administered. (continued on next page)

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

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	* On 6/6/24 at 7:16 AM R10 had a blood sugar of 76 and the insulin was administered. Resident #8 (R8): Review of an Admission Record revealed R8 was an [AGE] year-old female, admitted to the facility on [DATE], with pertinent diagnoses which included: hypertension (high blood pressure). Review of R8's Order Details dated 4/4/24 revealed, Metoprolol Succinate ER Oral Tablet Extended Release 24 Hour 25 MG (Metoprolol Succinate) Give 0.5 tablet by mouth one time a day for hold if sbp (systolic blood pressure) less than 100 or pulse less than 60. Review if R8's Medication Administration Record, Blood Pressure Summary, and Pulse Summary revealed: *On 6/3/24 at 7:44 AM R8 had a heart rate of 50 and the Metoprolol was administered. *On 6/10/24 at 8:06 AM R8 had a blood pressure of 80/48 and the Metoprolol was administered. Resident #15 (R15): Review of an Admission Record revealed R15 was an [AGE] year-old female, admitted to the facility on [DATE], with pertinent diagnoses which included: neuropathy (nerve pain). Review of R15's Order Details dated 3/25/24 revealed, Gabapentin Capsule 300 MG (Gabapentin) *Controlled Drug* Give 1 capsule by mouth three times a day for Neuropathy. (Note that Gabapentin is no longer classified as a controlled substance in the state of Michigan. However, the facility licensed nurses were continuing to sign out the Gabapentin following the previous guidelines). Review of R15's Control Substance Record revealed on 6/9/24 at 1:55 PM a dose of Gabapentin was documented as removed/administered and at 8:30 PM a dose of Gabapentin was documented as removed/administered. This was confirmed due to the correct amount remaining of Gabapentin reflected on the Control Substance Record. (Nurses are required to account for each capsule removed from the residents dispensed medication by counting the remaining number of capsules at shift change.) Review of R15's June Medication Administration Record revealed all 3 doses of Gabapentin were documented as administered on 6/9/24. Review of R15's Electronic Health Record revealed no documentation that a dose of Gabapentin was held and/or a provider order to hold Gabapentin on 6/9/24. Resident #17 (R17): Review of an Admission Record revealed R17 was a [AGE] year-old female, admitted to the facility on [DATE], with pertinent diagnoses which included: chronic pain syndrome. Review of R17's Order Details dated 2/29/24 revealed, Neurontin Capsule 300 MG (Gabapentin) *Controlled Drug* Give 300 mg by mouth three times a day. (continued on next page)

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R17's Control Substance Record revealed: *On 6/2/24 at 8:00 AM a dose of Gabapentin was documented as removed/administered and at 8:40 PM a dose of Gabapentin was documented as removed/administered. *On 6/7/24 at 8:00 AM a dose of Gabapentin was documented as removed/administered and at 9:19 PM a dose of Gabapentin was documented as removed/administered. *On 6/8/24 at 8:00 AM a dose of Gabapentin was documented as removed/administered and at 8:37 PM a dose of Gabapentin was documented as removed/administered. Confirmed due to the correct amount remaining of Gabapentin reflected on the Control Substance Record. Review of R17's June Medication Administration Record revealed all 3 doses of Gabapentin were documented as administered on 6/2/24, 6/7/24, and 6/8/24. Review of R17's Electronic Health Record revealed no documentation that Gabapentin was held and/or a provider order to hold Gabapentin on 6/2/24, 6/7/24, and 6/8/24. During an interview on 06/10/2024 at 10:53 AM, Registered Nurse (RN) E reported that controlled medications were signed out of the Control Substance Record at the time they were removed from the residents medication and signed out of the Electronic Health Record after they were administered. During an interview on 6/11/24 at 5:00 PM, Director of Nursing (DON) confirmed the medication errors for R15 and R17 Gabapentin. DON confirmed that R10 and R8 received medications outside of the physician ordered parameters and reported the expectation for the licensed nurses was to ensure medications were administered and/or held following the provider orders. Review of the facility policy Medication Administration last reviewed/revised 1/17/23 revealed, .8. Obtain and record vital signs, when applicable or per physician orders. When applicable, hold medications for those vital signs outside the physician's prescribed parameters .17. Sign MAR after administered. For those medications requiring vital signs, record the vital signs onto the MAR. 18. IF medication is a controlled substance, sign narcotic book . Review of Fundamentals of Nursing ([NAME] and [NAME]) 10th edition revealed, (Nurses) are responsible for documenting any preassessment data required of certain medications such as a blood pressure measurement for antihypertensive medications or laboratory values, as in the case of Warfarin, before giving the medication. [NAME], [NAME] A.; [NAME], [NAME] Griffin; Stockert, [NAME] A.; Hall, [NAME]. Fundamentals of Nursing - E-Book (p. 609). Elsevier Health Sciences. Kindle Edition. Review of Fundamentals of Nursing ([NAME] and [NAME]) 10th edition revealed, Legal Guidelines for Documentation . Errors in recording can lead to errors in treatment or may imply an attempt to mislead or hide evidence . Record must be accurate, factual, and objective. Be certain that each entry is thorough. A person reading your documentation needs to be able to determine that a patient received adequate care. [NAME], [NAME] A.; [NAME], [NAME] Griffin; Stockert, [NAME] A.; Hall, [NAME]. Fundamentals of Nursing - E-Book (p. 366). Elsevier Health Sciences. Kindle Edition.

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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 - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39056 This Citation pertains to Intake Number MI00140074. Based on interview and record review, the facility failed to 1.) Ensure that pressure injury/wound assessments were complete and accurate, 2.) Ensure that wound treatments were ordered and completed, and 3.) Ensure that wound treatments and care planned interventions were reviewed/revised following the worsening of a wound for 6 of 8 residents (Resident #5, Resident #12, Resident #13, Resident #14, Resident #19, and Resident #20) reviewed for alterations in skin integrity/pressure ulcers, resulting in incomplete and inaccurate wound assessment and a delay in wound treatment. Findings include: Resident #5 (R5): Review of an Admission Record revealed R5 was an [AGE] year-old male, admitted to the facility on [DATE]. Review of R5's preadmission Wound, Ostomy, & Continence Nurse note dated 10/3/24 revealed, Right Ischium (buttock), stage II pressure injury, which was a blister, area measures 2.2 x 2.4 x 0.1 cm, without tunneling or undermining. Wound bed with pink base .Left Ischium (Buttock), stage II pressure injury, which appears to have a shear component given the irregular margins and peeling skin, area measures 1.2 x 1.1 x 0.1 cm, without tunneling or undermining. Wound bed with pink base .Sacrococcygeal with deep tissue injury present. Area is a deep purple/maroon, intact and without exudate. Measures 0.8 x 0.8 cm. Peri area is red and blanchable with notable superficial shearing distally . Treatment: Bilateral Ischium's & Sacrococcygeal: Cleanse with saline; apply silicone bordered foam dressing (Mepilex Foam sacrum) over wound 2 fingerbreadths above anus. Change dressing every 3 days and prn (as needed) . Indicating R5 had 3 pressure injuries prior to his admission to the facility. Review of R5's Order Summary dated 10/6/23 revealed, Cleanse buttocks with NS, par dry. Apply Mepilex to open area Q 3 days and prn for wound care one time a day every 3 day(s) for wound care for 3 Days -Start Date-10/07/2023. Review of R5's Treatment Administration Record revealed the wound treatment was not completed on 10/10/23 (was documented as completed on 10/7/23). Review of R5's Nursing Admission Evaluation-Part 1 (Section V-Skin) dated 10/6/23 revealed Moisture Associated Skin Damage (MASD) to R5's sacrum, right buttock, and left buttock. Review of the section C. Skin Related Care Plans revealed care planned interventions related to Risk of Skin Impairment were initiated but interventions for Impaired Skin were left blank. Review of the section D. Skin Related Tasks revealed the tasks floating heels, heels up cushion, pressure redistribution device to chair, pressure redistribution foot device, pressure redistribution mattress to bed, and turn and reposition per care plan and as needed were left blank. (MASD is irregular in shape and affects moist, friction-prone areas. Pressure injuries will have defined edges and will be over a bony prominence.) (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R5's Skin & Wound Evaluations (x 3) dated 10/6/23 revealed MASD to coccyx, MASD to left gluteus, and MASD to sacrum. The Nursing Admission Evaluation-Part 1 and Skin & Wound Evaluations reflected the licensed nurse inaccurately identified/staged R5's skin injuries and/or did not complete a thorough admission assessment utilizing the Wound, Ostomy, & Continence Nurse consultative assessment and recommendations. Review of R5's Skin assessment dated [DATE] revealed, Coccyx-quarter size pressure wound of superficial skin. Redness noted. No Drainage. There were no wound measurements included in the assessment. Review of R5's Nurses' Note dated 10/7/23 revealed, .Coccyx has quarter size pressure wound with redness surrounding area . Review of R5's Electronic Health Record revealed no documentation that R5's emergency contact/wife was notified of the worsening/deterioration of the skin injury. There was no treatment change made. R5's initial assessment of the breakdown was documented as MASD. This assessment indicated there was a deterioration of R5's skin injury from MASD to a stage II pressure injury. (Stage II pressure injury is a partial thickness loss of dermis (skin) presenting as a shallow open ulcer with red and/or pink wound bed.) Review of R5's Hospital Records dated 10/11/23 revealed, .Coccyx , unstageable, pressure injury, measuring 0.6 x 1.2 x 0.1 cm, without tunneling or undermining. Wound bed is obscured of yellow slough tissue. Left Ischium stage III pressure injury, area measures 1.2 x 1.1 x 0.1 cm, without tunneling or undermining. Wound bed with a mix of yellow and pink tissue . Confirming the presence stageable pressure injuries at the time of R5's hospital transfer. Resident #12 (R12): Review of an Admission Record revealed R12 was an [AGE] year-old female, admitted to the facility on [DATE]. Review of R12's Wound Evaluations from 5/1/24-6/1/24 revealed: *5/1/24 no measurements were documented *5/8/24 no depth was documented *5/13/24 no depth was documented *5/15/24 no depth was documented R12's wound assessments on 5/22/24 and 5/29/24 included a depth measurement confirming the wound had a measurable depth. Review of R12's Order Details revealed, Wash sacrum with wound wash and pat dry. Sprinkle collagen particles into wound bed, Apply skin prep to surrounding tissue and cover with silicone pad dressing daily and prn until healed. everyday shift for wound -Start Date- 4/11/2024. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R12's June Treatment Administration Record revealed R12's wound treatment was not completed on 6/6/24. Review of R12's Electronic Health Record revealed no documentation regarding a rationale for the incomplete wound assessment and/or wound treatments. Resident #13 (R13): Review of an Admission Record revealed R13 was a [AGE] year-old male, admitted to the facility on [DATE]. Review of R13's Order Details dated 6/6/24 revealed, Cleanse Stage II to coccyx with NS (normal saline), pat dry. Apply hydrogel and cover with island drsg (dressing) daily and prn (as needed) one time a day for Stage II present on admit with a start date of 6/7/24 and end date 6/10/24. Indicating the wound treatment was not ordered on the date of his admission (6/5/24). Review of R13's June Treatment Administration Record revealed R13's did not have a dressing change on 6/6/24. Review of R13's Order Details dated 6/10/24 revealed, Cleanse Stage II to coccyx with NS, pat dry. Apply xeroform. one time a day for Stage II present on admit with a start date of 6/11/24. Review of R13's June Treatment Administration Record revealed R13's did not have a dressing change on 6/9/24. Resident #14 (R14): Review of an Admission Record revealed R14 was a [AGE] year-old male, admitted to the facility on [DATE]. Review of R14's Order Details dated 3/27/24 revealed, Cleanse sacrum with wound wash and pat dry. Apply collagen, cover with telfa and secure with small amount of tape. every day shift for wounds AND as needed for wound with a start date of 3/28/24 and end date of 5/9/24. Review of R14's May Treatment Administration Record revealed the ordered treatment was not completed on 5/4/24. Review of R14's Order Details dated 5/9/24 revealed, Cleanse sacrum with wound wash and pat dry. Apply xeroform to wound bed, cover with bordered foam. Change daily and as needed every day shift for wounds AND as needed for wound with a start date of 5/10/24 and end date 5/30/24. Review of R14's May Treatment Administration Record revealed the ordered treatment was not completed on 5/18/24 or 5/20/24. Review of R14's Wound Evaluations from 5/1/24-6/1/24 revealed: *5/1/24 no depth measurement was documented (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*5/7/24 no length, width, or depth measurement was documented *5/21/24 no depth measurement was documented *6/4/24 no depth measurement was documented Review of R14's Electronic Health Record revealed no documentation for a rationale for the missed wound treatments and/or incomplete measurements. Resident #19 (R19): Review of an Admission Record revealed R19 was a [AGE] year-old female, admitted to the facility on [DATE], with pertinent diagnoses which included: pressure ulcer of sacral region-unstageable. Review of R19's Skin & Wound Evaluation dated 5/30/24 revealed R19 had an unstageable pressure injury on her intergluteal cleft present on admission. No wound measurements were documented (length, width, depth, or area). Review of R19's Order Details revealed, For sacrum wound, cleanse with dermal wound cleanser, apply nystatin powder to periwound skin and dab only with no sting skin prep to all periwound skin and allow to dry. DO NOT WIPE. Apply medihoney to wound base. Gently pack wound with 1/4 sheet of alginate, cover with allevyn life. NO saline moistened gauze, wound is too wet. in the afternoon for sacral wound -Start Date-05/22/2024 Review of R19's June Treatment Administration Record revealed R19's wound treatments were not completed on 6/7/24 and 6/9/24. Review of R19's Electronic Health Record revealed no documentation regarding a rationale for the incomplete wound assessment and/or wound treatments. Resident #20 (R20): Review of an Admission Record revealed R20 was a [AGE] year-old female, admitted to the facility on [DATE], with pertinent diagnoses which included: pressure ulcer of sacral region stage 4. Review of R20's Order Details revealed, Per Wound Clinic Recommendations: Coccyx Wound: cleanse with wound cleanser, apply skin prep peri wound, place prisma to wound base, then fill void with aquacell, cover with bordered foam dressing daily. one time a day Ok to use equivalent dressing treatments -Start Date-03/09/2024. Review of R20's May Treatment Administration Record revealed the wound treatment was not completed on 5/4/24, 5/19/24, or 5/26/24. Review of R20's June Treatment Administration Record revealed the wound treatment was not completed on 6/2/24 or 6/9/24. Review of R19's Electronic Health Record revealed no documentation regarding a rationale for the missed wound treatments. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/11/23 at 10:08 AM, Nursing Home Administrator (NHA) reported the facility had 3 Unit Managers that were wound certified and completed weekly wound evaluations. NHA reported the wound evaluations included a picture of the wound, description of the wound, and measurements following standards of care. During an interview on 06/11/2024 at 12:11 PM, Unit Manager (UM) F reported that she and the other Unit Managers worked together managing the wound program at the facility. UM F did not recall R5 specifically but reported the wound management program included initial wound assessments, initiation of treatments, and implementation of care planned interventions. UM F reported that when a resident is admitted to the facility the licensed floor nurses are responsible for completing the nursing assessment and transcribing the ordered medications and treatments into the electronic health record. UM F reported that the managers were responsible for ensuring all medications and treatments were ordered and/or reconciled for new admissions and readmissions. UM F reported that if a resident was admitted late on a Friday or over the weekend then the Unit Managers would ensure all medication and treatment orders were reconciled/ordered when they returned to the building on the following Monday and concluded that that was why there may have been a delay in R13's treatment order. UM F reported that the licensed floor nurses were responsible for the weekly skin assessments which would include notification to the provider, family/guardian, and management if a new skin injury was identified. UM F reported the unit managers were responsible for the weekly wound assessments, measurements, and wound pictures. UM F confirmed that the facility utilized a camera that would upload the picture the health record and would also measure the length and width of the wound. UM F reported the depth of a wound could not be captured by the camera and had to be measured by the unit managers and documented in the Skin & Wound Evaluations. UM F reported that the licensed floor nurses were responsible for completing wound treatments if they were scheduled during their shifts. UM F reported that if a treatment was not completed it should be documented in the Treatment Administration Record with a rationale. UM F reported R14 was not one to refuse treatment but did have a preference for the time of day it was completed. UM F reported that she was not aware that treatments were not being completed as ordered and reported that the unit managers were not currently completing audits on ordered treatments. During an interview on 6/11/24 at 2:55 PM, Director of Nursing (DON) confirmed R12, R13, R14's missed treatments in the Treatment Administration Records and reported she would review the resident's charts and provide a basis if able. During an interview on 6/11/24 at 5:00 PM, NHA and DON reported that the expectation for the licensed nurses was to complete all treatments as ordered and document in the electronic health record any refusals and/or missed treatments as well as ensuring complete and accurate assessments. Requested documentation/follow-up related to the incomplete wound treatments and/or wound assessments for R12, R13, and R14 via email on 6/11/24 at 1:00 PM. No additional documentation was received regarding the above listed treatments and/or wound evaluations prior to survey exit. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility policy Pressure Injury Prevention and Management last reviewed/revised 1/1/22 revealed, .2. The facility shall establish and utilize a systematic approach for pressure injury prevention and management, including prompt assessment and treatment; intervening to stabilize, reduce or remove underlying risk factors; monitoring the impact of the interventions; and modifying the interventions as appropriate. 3. Assessment of Pressure Injury Risk a. Licensed nurses will conduct a pressure injury risk assessment, using the [NAME] or Braden tool on all residents upon admission/re-admission, weekly x four weeks, then quarterly or whenever the resident's condition changes significantly. b. Licensed nurses will conduct a full body skin assessment on all residents upon admission/re-admission, weekly, and after any newly identified pressure injury. Findings will be documented in the medical record. c. Assessments of pressure injuries will be performed by a licensed nurse and documented in the medical record .4. Interventions for Prevention and to Promote Healing a. After completing a thorough assessment/evaluation, the interdisciplinary team shall develop a relevant care plan that includes measurable goals for prevention and management of pressure injuries with appropriate interventions .e. The goals and preferences of the resident and/or authorized representative will be included in the plan of care. f. Interventions will be documented in the care plan and communicated to all relevant staff. 5. Monitoring a. The attending physician will be notified of i. The presence of a new pressure injury upon identification. ii. The progression towards healing, or lack of healing, of any pressure injuries weekly. iii. Any complications (such as infection, development of a sinus tract, etc.) as needed. b. The effectiveness of current preventative and treatment modalities and processes will be discussed in accordance with the QAA Committee Schedule, and as needed when actual or potential problems are identified. 6. Modifications of Interventions .b. Interventions on a resident's plan of care will be modified as needed. Considerations for needed modifications include: i. Changes in resident's degree of risk for developing a pressure injury. ii. New onset or recurrent pressure injury development. iii. Lack of progression towards healing . Review of Fundamentals of Nursing ([NAME] and [NAME]) 10th edition revealed, The health care record is a valuable source of data for all members of the health care team. Data entered into the health care record serve many purposes, including facilitating interprofessional communication among health care providers, providing a legal record of care provided, justification for financial billing and reimbursement of care. Data are also used to audit, monitor, and evaluate care provided to support the process needed for quality and performance improvement. [NAME], [NAME] A.; [NAME], [NAME] Griffin; Stockert, [NAME] A.; Hall, [NAME]. Fundamentals of Nursing - E-Book (p. 366). Elsevier Health Sciences. Kindle Edition. Review of Fundamentals of Nursing ([NAME] and [NAME]) 10th edition revealed, Review of Fundamentals of Nursing ([NAME] and [NAME]) 10th edition revealed, Record the results of the nursing health history and physical examination in a clear, concise manner using appropriate terminology. This information becomes the baseline to identify a patient's nursing diagnoses and health problems, to plan and implement care, and to evaluate a patient's response to interventions . The Nurse Practice Acts in all states and the American Nurses Association Nursing's Social Policy Statement (ANA, 2010) require accurate data collection and recording as independent functions essential to the role of the professional nurse. [NAME], [NAME] A.; [NAME], [NAME] Griffin; Stockert, [NAME] A.; Hall, [NAME]. Fundamentals of Nursing - E-Book (p. 222). Elsevier Health Sciences. Kindle Edition.