STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235293	A. Building B. Wing	09/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Farmington	34225 Grand River Ave Farmington, MI 48335

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 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** 34208 This citation pertains to intake #MI00146596 Based on observation, interview, and record review, the facility failed to ensure appropriate treatment and services for pressure ulcers for one resident (R504) of three residents reviewed for pressure ulcers, resulting in the potential for worsening of pressure ulcers. Findings include: On 9/17/24 at 10:05 AM, R504 was observed in their bed uncovered. R504 was positioned slightly on their right side exposing their left trochanter. An undated border foam dressing was observed to be applied and shadowing from wound drainage was present. On 9/17/24 at 12:05 PM, a review of R504's clinical record was conducted and revealed they admitted into the facility on [DATE] with diagnoses that included: stroke, respiratory failure, diabetes, presence of a tracheostomy and feeding tube. Continued review of the record further revealed R504 developed a stage III (full-thickness tissue loss that extends through the skin into deeper tissue and fat, but does not expose bone, tendon, or muscle) during their stay in the facility. On 9/17/24 at 12:15 PM, R504's physician orders and Treatment Administration Record (TAR) were reviewed and revealed treatments to the left trochanter scheduled on the night shift not documented as completed on 9/7/24, 9/10/24, 9/13/24, 9/15/24, and 9/16/24. On 9/17/24 at 12:35 PM, R504's family was visiting in the room. At that time, they were repositioning R504 and they were asked if the left trochanter could be observed. They gave permission and the border foam dressing to the left trochanter was observed undated with shadowing from wound drainage present. On 9/18/24 at 9:43 AM, an observation of R504's left trochanter was conducted with Nurse 'D'. R504's left trochanter had an undated, border foam dressing with shadowing from wound drainage present. Nurse 'A' was asked about the undated dressing and said they had not completed the treatment yet on their shift. On 9/18/24 at 10:30 AM, an interview was conducted with the facility's Director of Nursing. They reported staff should perform the treatments on their shift and document on the TAR. (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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of a facility provided policy titled, Pressure Ulcer/Skin Breakdown-Clinical Protocol revised 3/2024 was conducted and read, Policy: Based on the comprehensive assessment of a resident, a resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and a resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice to promote healing, prevent infection, and prevent new ulcers from developing .

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 34208 This citation pertains to intake #MI00146596 Based on observation, interview, and record review, the facility failed to ensure safe wheelchair transport for two residents (R#'s 505 and 506) of two residents reviewed for accidents, resulting in the potential for injury. Findings include: On 9/17/24 at 10:42 AM, Certified Nurse Aide (CNA) 'B' was observed transporting R505 back to their room from the shower room. R505 was seated in a shower chair facing backward and CNA 'B' was observed to be pulling the chair in a forward motion, as opposed to having R505 in the chair facing forward and the chair being pushed from behind. On 9/17/24 at 10:46 AM, CNA 'C' was observed transporting R506 to their room from the shower room. R506 was seated in a geri-chair facing backward and CNA 'C' was observed to be pulling the chair in a forward motion, as opposed to having R506 in the chair facing forward and the chair being pushed from behind. On 9/18/24 at 10:30 AM, an interview with the facility's Director of Nursing was conducted and they were asked if it was appropriate to have a resident in a wheelchair, shower chair, or geri-chair facing rearward being pulled down the hall and they said it was not. A review of a facility provided policy titled, Use of Assistive Devices revised 10/2023 was conducted and read, .4. Facility staff will provide appropriate assistance .6. The resident's assigned nurse will monitor for the consistent use of the device and safety in the use of the device .

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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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34208 This citation pertains to intake #MI00146596 Based on observation, interview, and record review, the facility failed to ensure indwelling urinary catheter care, proper positioning of urinary catheter drainage bags, and the use of catheter anchors for three residents, (R#'s 501, 502, and 504) of three residents reviewed for indwelling urinary catheters resulting in the the potential for the development of infection and genitourinary injury. Findings include: R502 On 9/17/24 at 9:28 AM, R502 was observed in their bed. R502 was not responsive to attempts at verbal communication. R502 was further observed to have an indwelling urinary catheter with a drainage bag to the right side of the bed. The bag was observed to be in contact with the tile floor. On 9/18/24 at 10:06 AM, R502's urinary catheter drainage bag was observed on the right side of the bed in contact with the tile floor. A review of R502's clinical record revealed they admitted to the facility on [DATE] with diagnoses that included: acute respiratory failure, anoxic brain damage, sepsis, quadriplegia, urinary retention, tracheostomy, dependence on mechanical ventilation, and presence of a feeding tube. A Minimum Data Set (MDS) assessment dated [DATE] revealed R502 had severely impaired cognition and was dependent on staff for all activities of daily living (ADL's). Continued review of R502's clinical record included a review of the Certified Nurse Aide (CNA) tasks and it was noted there was no task on the list for urinary catheter care. A review of R502's physician's orders was conducted and revealed orders to monitor R502's urine, and orders to change the drainage bag, and ensure an anchor was in place, but no orders for urinary catheter care. R502's care plan for an indwelling urinary catheter was reviewed and revealed an intervention that read, Assist resident with indwelling catheter care as needed. R504 On 9/17/24 at 12:25 PM, R504 was observed in their bed. It was observed R504 had an indwelling catheter with a drainage bag to the left side of the bed. R504's family was at the bedside and was asked if they could uncover R504's left upper leg for an observation of the presence of a urinary catheter anchor. When the upper leg was uncovered a urinary catheter anchor was not present and the catheter tubing appeared taut, leaving a deep indentation into R504's thigh. On 9/18/24 at 9:43 AM, R504 was observed with Nurse 'D'. It was observed R504 did not have a urinary catheter anchor in place and the tubing appeared taut, leaving a deep indentation into R504's thigh. Nurse 'D' acknowledged the absence of catheter anchor and concern for the potential for skin breakdown due to the catheter on R504's thigh. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of R504's clinical record revealed they admitted to the facility on [DATE] with diagnoses that included: stroke, acute respiratory failure, diabetes, neuromuscular dysfunction of the bladder, tracheostomy, and presence of a feeding tube. A review of R504's physician's orders and Medication Administration Record (MAR) and Treatment Administration Record (TAR) was conducted and it was noted the presence of a catheter anchor had been signed out as completed on both the day and night shift on 9/17/24, despite no anchor observed on 9/17/24 or in the morning of 9/18/24. R501 A review of R501's closed clinical record was conducted and revealed they admitted to the facility on [DATE], discharged to the emergency roiagnom on [DATE], readmitted on [DATE], and discharged on [DATE]. R501's diagnoses included: stroke, dysphagia, diabetes, and presence of a feeding tube. Continued review of R501's clinical record included a review of the CNA tasks and it was noted there was no task on the list for urinary catheter care after their re-admission to the facility on [DATE]. A review of R501's physician's orders was conducted and revealed orders to monitor R501's urine, and orders to change the catheter and drainage bag monthly or as needed, however; their were no orders to perform catheter care. On 9/18/24 at 10:30 AM, an interview was conducted with the facility's Director of Nursing (DON), they were asked who was responsible for performing urinary catheter care and where it was documented. They indicated the CNA's performed the care and it appeared on their task list for them to document the care was completed. They were also asked if catheter anchors should be in place and said they should be. Observations of R504's catheter and the indentations into their skin caused by the catheter tubing were shared with the DON and they said they would be looking into it. A review of a facility provided policy titled, Appropriate Use of Indwelling Catheters revised 12/2023 was conducted and read, .Policy Explanation and Compliance Guidelines: 1 It is the policy of this facility to ensure residents with urinary incontinence .c. Who is incontinent of bladder receive appropriate treatment and services to prevent urinary tract infections .8. Indwelling urinary catheters (urethral or suprapubic) will be utilized in accordance with current standards of practice, with interventions to prevent complications to the extent possible .

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. 34208 This citation pertains to intake #MI00146596. Based on observation, interview, and record review, the facility failed to address tube feeding pump errors in a timely manner for two residents (R#'s 503 and 507) of three residents reviewed for tube feeding, resulting in the delay of delivery of tube feeding nutrition and the development of a clogged feeding tube. Findings include: R503 On 9/17/24 at 9:53 AM, R503 was observed in their room. R503 was not responsive to attempts at verbal communication. It was observed R503 had a tube feeding pump and pole with a bottle of feeding formula and an empty bag that was to contain water for hydration and flush connected to the pump. The pump was audibly beeping and the digital screen on the front of the pump indicated there was a, Flush error. On 9/17/24 at 10:42 AM, R503's tube feeding pump remained audibly beeping, the water bag was empty, and the pump indicated a, Flush error. Observations from the hallway were conducted from 10:42 until 11:06 AM and the beeping pump in R503's room could be heard from the hallway. Multiple staff members were observed up and down the hallway performing their duties and at no time during the observation did anyone enter the room and address the beeping tube feeding pump. R507 On 9/17/24 at 11:08 AM, R507 was observed in their bed slightly agitated, fidgeting and had had partially removed their gown. R507 was observed to have a tube feeding pump and pole with a full bag of water for hydration and flush, and a bottle of tube feeding formula with 325 mL (milliliters) of formula remaining in the bottle. The pump was audibly beeping and the digital screen on the pump indicated there was an error that read, Clog in the line downstream of the pump. On 9/17/24 at 12:20 PM, R507 was observed in bed, no longer fidgeting or restless and a gown had been placed on them. R507's tube feeding pump was audibly beeping with an error that read, Clog in the line downstream of the pump. The tube feeding bottle revealed 325 mL of formula remained in the bottle, and the water bag was full. On 9/17/24 at 1:00 PM, 2:05 PM, 3:06 PM, and 4:09 PM, R507's tube feeding pump was audibly beeping with an error on the pump that read, Clog in the line downstream of the pump. The tube feeding bottle had 325 mL of formula remaining and the water bag was full. A review of R507's clinical record was conducted and revealed orders for tube feeding formula to be delivered at 75 mL per hour. A calculation of 75 mL per hour for five hours revealed 375 mL of formula should have been delivered between 11 AM and 4 PM, however; the feeding formula bottle observed approximately hourly between 11:08 AM and 4:09 PM revealed 325 mL remained in the bottle during each observation. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/17/24 at 4:17 PM, an interview was conducted with Nurse 'D', R507's assigned nurse. They said they were assigned to care for R507 at 3:15 PM, they checked on them around that time and noticed the tube feeding pump was off. They were asked why the pump was off and said they did not know but they turned the pump on and exited the room. They were asked if they were aware the tube feeding pump had been beeping with an error message since approximately 11:00 AM and multiple observations between 11:00 AM and 4:00 PM revealed 325 mL of feeding formula remained in the bottle. They said they were not aware, but would check on it. Nurse 'D' went to R507's room and was observed to attempt to flush the feeding tube and discovered it was clogged. Nurse 'D' was not able to unclog the tube with warm water and had to obtain a specialized tube feeding de-clogging device. On 9/18/24 at 10:30 AM, an interview was conducted with the facility's Director of Nursing (DON) They were asked if they were aware of the tube feeding concerns communicated to staff on 9/17/24. They said they were. They were asked if Certified Nurse Aides (CNA's) should turn off tube feeding pumps and said they should not. They were then asked if staff should address alarming tube feeding pumps and said staff should let the nurse know so the nurse could address it. A review of a facility provided policy titled, Feeding Tubes revised 6/2022 was conducted and read, .Feeding tubes will be maintained in accordance with current clinical standards of practice, with interventions to prevent complications to the extent possible .

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34208 This citation pertains to intake #MI00146293 Based on observation, interview, and record review, the facility failed to ensure tracheostomy and ventilator care was performed and respiratory medications were administered per physician's orders for three residents (R#'s 502, 503 and 504) of four residents reviewed for respiratory care and services, resulting in the potential for respiratory complications. Findings include: R502 On 9/17/24 at 10:40 AM, R502 was observed in their bed with a tracheostomy receiving mechanical ventilation. R502 was not responsive to attempts at verbal communication. A review of R502's clinical record revealed they admitted to the facility on [DATE] and readmitted on [DATE]. Their diagnoses included: acute respiratory failure, anoxic brain damage, sepsis, quadriplegia, tracheostomy, and dependence on mechanical ventilation. R503's Minimum Data Set assessment date 7/13/24 indicated they had severely impaired cognition and required assistance from staff for all activities of daily living. A review of R502's Physician's orders, Medication Administration Record (MAR), and Treatment Administration Record (TAR) was conducted and revealed the following: An order for an evaluation/assessment of a resident on a ventilator with a tracheostomy scheduled every shift not signed out as completed on 8/5/24, 8/13/24, 8/16/24 thru 8/18/24 on the night shift, and 8/22/24, 8/26/24, and 8/27/24 on the day shift. An order for tracheostomy care every shift and an order for visual checks on ventilator residents every shift not signed out on 8/5/24, 8/13/24, and 8/16/24 on the night shift. An order for ipratropium-albuterol medication (respiratory medication) administered via the ventilator four times a day not signed out as administered on 8/3/24 at 9 PM, 8/4/24 at 3 AM and and 9 PM, 8/6/24 at 3 AM, 8/7/24 at 9 PM, 8/13/24 and 8/14/24 at 3 AM, and 8/17/24 at 3 AM and 9 PM. R503 On 9/17/24 at 9:34 AM, R503 was observed in their bed with a tracheostomy, on mechanical ventilation, and had a feeding tube. R503 was not responsive to attempts at verbal communication. A review of R503's clinical record revealed they admitted to the facility on [DATE] and most recently readmitted to the facility on [DATE]. R503's diagnoses included: acute and chronic respiratory failure, dysphagia, sepsis, quadriplegia, presence of a tracheostomy and a feeding tube. A Minimum Data Assessment (MDS) dated [DATE] revealed R503 had severely impaired cognition and required staff assistance for all activities of daily living. A review of R503's MAR and TAR was conducted and revealed the following: (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An order to change to change the tracheostomy collar every three days not signed out as done on 8/18/24, 8/24/24, and 8/30/24. An order to assess the tracheostomy stoma site not signed out as done on 8/14/24, 8/18/24, 8/20/24, 8/24/24, 8/25/24, 8/28/24, and 8/30/24 on the night shift. An order to perform tracheostomy care every shift not signed out as done on 8/14/24, 8/18/24, 8/20/24, 8/24/24, 8/25/24, 8/28/24, 8/29,/24 and 8/30/24. R504 On 9/17/24 at 10:05 AM, R504 was observed in their bed asleep. It was observed R504 had a tracheostomy, feeding tube, and indwelling urinary catheter. A review of R504's clinical record revealed they admitted to the facility on [DATE] with diagnoses that included: stroke, acute respiratory failure, diabetes, neuromuscular dysfunction of the bladder, tracheostomy, and presence of a feeding tube. An MDS assessment dated [DATE] indicated R504 had severely impaired cognition and was dependent on staff for all activities of daily living. A review of R504's physician's orders, MAR's, and TAR's was conducted and revealed the following: Physician's orders for assessing the tracheostomy stoma site and performance of tracheostomy care not signed out as done on: 8/21/24, 8/23/24, and 8/29/24 on the day shift and 8/3/24, 8/5/24, 8/6/24, 8/13/24 thru 8/15/24, 8/17/24, 8/18/24, 8/22/24, 8/24/24, 8/25/24, 8/28/24, 8/30/24, 9/1/24 thru 9/6/24, 9/9/24, 9/13/24, and 9/16/24 on the night shift. On 9/18/24 at 10:30 AM, an interview was conducted with the facility's Director of Nursing and said respiratory therapy staff were responsible for completing and documenting the respiratory tasks on the MAR and they would be letting the Respiratory Therapy Manager know of the concern. A review of a facility provided policy titled, Tracheostomy Care revised 10/2023 was conducted and read, Policy: The facility will ensure that residents who need respiratory care, including tracheostomy care and tracheal suctioning, is provided such care consistent with professional standards of practice, the comprehensive person-centered care plan and resident goals and preferences .