

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235330	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/11/2025
NAME OF PROVIDER OR SUPPLIER Medilodge of Livingston		STREET ADDRESS, CITY, STATE, ZIP CODE 3003 W Grand River Howell, MI 48843	

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)
<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49083</p> <p>This citation pertains to intake MI00149991 and MI00150073.</p> <p>Based on interview, and record review, the facility failed to assess the integrity of a mechanical transfer sling for one resident (R901) reviewed of three for accidents resulting in an avoidable fall requiring emergent transfer to a higher level of care and surgery for fractures sustained to the left and right lower extremities and pain.</p> <p>Findings include:</p> <p>A review of complaint reported to the State Agency included an allegation R901 was dropped from a mechanical (Hoyer) lift and sustained a fracture because the sling was not safe for use.</p> <p>On 2/11/25, a clinical record reviewed revealed R901 was readmitted to the facility on [DATE] with a medical history of atrial fibrillation (abnormal heart rhythm) and required Eliquis (blood thinning medication), chronic osteomyelitis, and diabetes. R901 had an ADL (Activity of Daily Living) self-care deficit related to muscle weakness, reduced mobility, and morbid obesity. R901 required two persons assist and use of a mechanical lift for all transfers from bed to chair. Brief Interview of Mental Status (BIMS) assessed on 11/21/24 scored 15/15 indicating R901 is cognitively intact.</p> <p>On 2/11/25 at 9:42 AM, an interview with the Nursing Home Administrator (NHA) acknowledged on 1/30/25 after their shower, R901 was hanging from a bariatric sling and the strongest part of the sling ripped resulting in R901 falling from the lift and required to be transferred to the hospital. The NHA said no other areas of the sling appeared compromised and was weird because it ripped from its strongest support strap when asked if the manufacturer was contacted, the NHA replied they were not, and the sling was thrown in the garbage (and not available).</p> <p>(continued on next page)</p>

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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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 2/11/25 at 10:04 AM, a telephone interview was conducted with R901. When asked about the 1/30/25 accident, R901 commented that they knew how the fall happened, stating I was in a sling that should not have been used. When asked for further clarification, R901 said the sling had a worn-out appearance and the fabric sewn to the strap look old and worn out. R901 said the two Certified Nurse Assistants (CNA) transferring them remarked that soon as they placed them (R901) back into bed, We need to throw this one out. R901 said they were about three-four feet up from the ground, the left strap supporting their left side gave out ,was ripped, tearing the loop strap from the lift and fell injuring their left leg and right ankle. During the interview, R901 said they are still hospitalized , had required surgery for a fractured left femur and broken right ankle because of the fall and had pain as a result.</p> <p>On 2/11/25 at 10:33 AM, a telephone interview with CNA A identified as one of the two CNA's providing the transfer to R901 confirmed they were assisting the lower portion of the sling guarding R901's position as to not hit the walls and the sling just snapped and R901 fell to the ground. CNA A was unable to verify who had the last responsibility of checking the integrity of the slings and confirmed R901 had the sling under them and could not confirm the integrity.</p> <p>On 2/11/25 at 12:15 PM, a telephone interview with Licensed Practical Nurse (LPN) F who authored the Progress Note dated 1/30/25 at 6:04 PM confirmed they heard a loud sound from R901's room, observed them on the ground stating they fell from the lift and had pain in their left leg. LPN F revealed that the upper left loop had ripped from the stitching, was dangling from the hook and the rest of the sling had ripped apart. When asked who is responsible for checking the integrity of the slings, LPN F was unable to answer.</p> <p>An interview on 2/11/25 at 12:30 PM with Laundry Services C clarified when slings are brought to be laundered, they are inspected pre and post washing. If a sling is compromised in any way, the NHA and or Maintenance Manager is notified, and the sling should be disposed of. The last recall of a sling being removed was over two months ago. When asked who has the final inspection of the slings, Laundry Services C remarked they were not sure but it should be the Nurses because they are the ones who retrieve the slings and put them on the residents.</p> <p>On 2/11/25 at 1:33 PM, the Director of Nursing (DON) confirmed that it is the responsibility of the CNA's or whomever is placing a resident into a sling who had the final responsibility of verifying the integrity of the sling. The DON and NHA were informed of the remarks made during the above interviews and confirmed they will reinforce the final check of integrity of the sling is done by the staff placing residents into the sling.</p> <p>During the review of a Past Non-Compliance Binder revealed on 1/31/25 an audit of the slings was conducted and identified a green sling labeled #809A was thrown away and not placed back into circulation (an additional sling was identified as not safe and thrown away).</p> <p>On 2/11/25 at 2:17 PM, LPN G returned a phone call and acknowledged the sling R901 was in was torn from the sling and strap loop and witnessed the Resident laying on the floor complaining of pain. When asked the overall condition of the sling, LPN G stated, it was not a newer sling and it had been in rotation for a while.</p> <p>Review of the facility's policy titled; Safe Lifting and Movement of Residents, dated 1/2022 Documented:</p> <p>(continued on next page)</p>		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	.Mechanical lift equipment shall undergo routine checks and maintenance by the nursing and maintenance staff, respectively, to ensure that equipment remains in good working order . During the onsite survey, past noncompliance (PNC) was cited after the facility implemented actions to correct the noncompliance which included education, training, reviewing current slings and removing worn slings to correct the past noncompliance. The facility was able to demonstrate monitoring of the corrective action and maintained compliance.		