STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235330	A. Building B. Wing	10/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Livingston	3003 W Grand River Howell, MI 48843

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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 - Few	Ensure services provided by the nursing facility meet professional standards of quality. 49083 Based on observation, interview, and record review the facility failed to ensure nursing staff maintained professional standards, and practices for one (R239) resident of four reviewed for medication administration. Findings include: On 10/15/24 at 7:43 AM, LPN H was observed preparing ordered Oxycodone (narcotic given for pain) 10 milligram (mg) for R239. When the narcotic log was reviewed, 17 tablets of Oxycodone 10 mg were documented, and the blister pack revealed 16 tablets. LPN H commented the medication was given to R239 at 4:30 AM, and acknowledged the medication was not documented in the narcotic log. Review of the facilities policy title; Medication Administration dated 1/2023 documented: .If medication is a controlled substance sign the narcotic book .

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38271 Based on observation, interview and record review, the facility failed to revise/implement effective interventions to prevent reoccurring falls for one resident (R22) of one residents reviewed for accidents/hazards/supervision. Findings include: On 10/13/24 at approximately 9:05 a.m., R22 was observed in the day room, wheeling around in their wheelchair. R22 was observed to have anti-tippers installed on their wheelchair indicating R22 was a high risk for falling. At that time, Nurse J was queried regarding the staffing levels on the unit and if they had enough staff to properly supervise R22 and they reported that having two CNA Certified Nursing Assistants) on the unit made it difficult to watch all the residents who were a fall risk and stated they reported that they liked to have three CNA's to ensure everyone was watched. On 10/13/24 the medical record for R22 was reviewed and revealed the following: R22 was initially admitted to the facility on [DATE] and had diagnoses including History (hx) of Falling, Traumatic brain injury (TBI) and Dementia. A review of R22's MDS (minimum data set) with an ARD (assessment reference date) of 9/21/24 revealed R22 needed assistance from facility staff with most of their activities of daily living. R22's cognition was documented as having memory impairments. A review of R22's plan of care was conducted and revealed the following: Resident is at risk for falls/injury related to TBI, dementia, prostate cancer, hx of falling Date Initiated: 09/19/2024 . A review of R22's falls since their admission on 9/19/24 revealed the following: 9/20/2024 at 22:30-Nurses' Notes-Resident found on the floor by CNA (Certified Nursing Assistant). CNA notified this RN (Registered Nurse).RN assessed resident for injury. Vitals taken. Risk management assessment completed. On call notified. No new orders. Fall mats placed on both sides of bed. Call light education provided. Bed lowered to the floor . 9/25/2024 at 13:15-Nurses' Notes-'I was going to get my car.' was informed by nursing staff that resident fell in hallway. resident assisted back into w/c (wheelchair) with multiple staff members, resident does not recall fall, neuro assessments initiated, VSS (vital sign stable), ROM (range of motion) and cognition at baseline, denied pain, no new skin abnormalities noted upon skin assessment. resident to be toileted after meals 9/26/2024 at 18:22-Nurses' Notes-Resident was observed on his knees on the floor pushing a chair in the activities room. Stated 'Im trying to get out of here'.States no pain. Skin assessment completed with nothing new noted. Vitals completed WNL (within normal limits). Neuros started. On-call, Administrator, DON (Director of Nursing) and guardian notified with no new orders . Fall Initial V.2 Form-12. What was resident doing prior to the fall? Sitting at the table eating dinner. Physical Evaluation- Describe other interventions:-Visual checks every 15 minutes. 2. Date care plan reviewed and/or updated, as indicated: 9/26/24 . (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	9/29/24-[Via Incident and Accident Report]-Resident was eating dinner in the TV room and writer was also in this room feeding another resident cause writer to turn and see resident on the floor on his knees and hands on the broken tray .of food was on the floor and the tray of the table was broke off the stand .Injuries at Time of incident-Bruise .Mental Status-Notes Left cheek Other info-Resident has poor self awareness and poor safety awareness . Fall Initial V.2 Form-Physical Evaluation-1a-Describe injury/suspected injury: Bruise and swelling on left cheek Describe other interventions:-Supervision while eating .G: Resident is non compliant, has poor self awareness. Does not understand his limitations and has an unreliable memory. He was incontinent at the time but the resident had been toileted an hour before and had been changed an hour before that . 10/1/2024 at 19:28-Nurses' Notes-Resident observed on the floor next to his bed. Head to toe assessment completed with nothing new noted. Vitals completed. Resident denies pain. Neuros (neurology checks) started. [Nurse Practitioner] assessed resident with no new orders . 10/8/2024 at 19:04-Nurses' Notes-Writer called by CNA to residents room at 1740. Observed resident laying on the floor next to his bed on the fall mat. Resident wearing his clothes with skid socks. Resident denied hitting his head and denies any pain. Administrator, DON, On call provider, Unit manager and guardian notified with no new orders . Fall Initial V.2 Form-12. What as resident doing prior to fall? Eating his dinner in his room on his bed. Describe other interventions:-Medication Review . On 10/15/24 at approximately 10:10 a.m., during a discussion with the Director of Nursing (DON) pertaining to R22's falls and the interventions that the facility had implemented, the DON was queried for the documentation of the 15 minute visual checks that were implemented via the Fall form for the fall on 9/26/24 and they indicated they did not have them but the visual checks intervention was not continued later on when the interdisciplinary team reviewed the fall on 9/27. The DON was queried regarding the medication review intervention that was noted on the 10/8/24 fall form and they indicated that no changes to medications were made. The DON was queired if they had implemented any other interventions after no medication changes were made and they indicated they had not. Further review of the falls for R22 indicated that a few of R22's falls were occurring during meals and that the intervention of supervision while eating was added after their fall on 9/29. The DON was informed that R22 had fallen in their room while eating on 10/8 without supervision and the DON indicated that they understood and they would have to try something else to try to prevent R22 from have reoccurring falls. On 10/15/24 a facility document pertaining to falls was reviewed and revealed the following: Policy: Each resident will be assessed for the risks of falling and will receive care and services in accordance with the level of risk to minimize the likelihood of falls .

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38271 Based on observation, interview and record review, the facility failed to follow the Physician's order for enteral nutrition for one resident (R78) of one residents reviewed for tube feeding. Findings include: On 10/13/24 at approximately 8:54 a.m., R78 was observed in their room, laying in their bed. R78 was observed to have enteral formula infusing with Jevity 1.5 at 60ml (milliliters) per hour with 55 ml an hour on autoflush. On 10/13/24 at approximately 10:29 a.m., R78 was observed in their room, laying in their bed. R78 was still observed to have enteral formula infusing with Jevity 1.5 at 60ml per hour with 55ml an hour autoflush. The rate was not written on the bottle that was hung on the feeding pole. On 10/13/24 at approximately 10:41 a.m., R78's enteral feeing was observed with the ADON (Assistant Director of Nursing) and the enteral order was confirmed in the EMR (electronic medical record) as Osmolite 1.5 @ 70ml/hour X18 hours/day. The ADON indicated they would get the correct formula and change the rate to match the Physician's order. On 10/13/24 the medical record for R78 was reviewed and revealed the following: R78 was initially admitted to the facility on [DATE] and had diagnoses including Anoxic brain damage and Chronic respiratory failure. A review of R78's MDS (minimum data set) with an ARD (assessment reference date) of 10/2/24 revealed R78 had an enteral nutrition tube (PEG) and needed assistance from facility staff with their activities of daily living. R78 was documented as having severely impaired cognition. A Physician order with a start date of 10/11/24 revealed the following: every day and night shift Osmolite 1.5 @70ml/hour X18 hours/day to provide: 1890kcal, 1260ml, 79 gram pro/day A review of R78's comprehensive plan of care revealed the following: Focus-Resident is at risk for altered nutritional status related to diuretic use, feeding tube, risk of aspiration, swallowing problems, takes psychotropic medication. Weight loss following readmission. Date Initiated: 08/30/2024 . Interventions-Administer enteral nutrition per orders. Date Initiated: 08/30/2024 . On 10/15/24 a facility document titled Feeding Tubes was reviewed and revealed the following: Policy: Feeding tubes will be used only as necessary to address malnutrition and dehydration, or when the resident ' s clinical condition deems this intervention medically necessary to maintain acceptable parameters of nutrition and hydration. Feeding tubes will be maintained in accordance with current clinical standards of practice, with interventions to prevent complications to the extent possible .7. Feeding tubes will be utilized according to physician orders .

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38271 Based on observation, interview and record review the facility failed to ensure sufficient staffing was provided for two residents (R10) was well as two anonymous residents who participated in the group meeting, out of a total census of 90 resulting in the potential for unmet care needs. Findings include: On 10/13/24 the payroll based journal report (a report generated from the facility reported staffing hours) was reviewed and documented that during the fiscal quarter three (April 1, 2024-June 30th, 2024) the facility had excessively low weekend staffing numbers and had a one star staffing rating (the lowest score). On 10/14/24 at approximately 2:06 p.m., during the anonymous group meeting, the residents were queried if the facility had enough Nursing staff to meeting their needs. Two residents (who wished to remain anonymous) reported the facility had recently improved but that the staffing during the night over the summer months was bad. They indicated that Nurse aides would come in and tell them they were short staffed and that was why they were late answering the call for assistance. One resident reported they had to wait a long time for call lights to be answered and when they were answered the staff would turn them off and leave the room and not come back. Another resident indicated that staff were not picking up the meals trays because they did not have enough help so the meal trays would just sit for hours in their rooms. On 10/14/24 the resident council minutes were reviewed for 2024 and revealed the following complaints: June-Nursing:beds not being made timely .May-Nursing: Not picking up trays .April-Aides grumpy when answering lights on the weekends On 10/15/24 at approximately 12:02 p.m., during a conversation with Certified Nursing Assistants E and F (CNA E and F), CNA E was queried regarding the staffing levels in the facility and they indicated that in the previous months during the summer they had been only two aides assigned to the unit on many shifts in which residents could not be supervised like they should. CNA F indicated that many residents on the unit are fall risks and they needed three Nurse Aides to appropriately be able to supervise while providing care. CNA E indicated that the staffing had been better in the more recent months. On 10/15/24 at approximately 12:30 p.m., during a conversation with the staffing coordinator A (SC A), SC A was queried regarding the PBJ report and the excessively low weekend staffing and one star staffing rating for quarter 3. SC A Indicated they had a few full time CNA's quit at the same time and that was why they were running short staffed during that period of time as they were unable to immediately fill the vacancies. SC A indicated that the Administrator and herself met and put a staffing plan into place called the Weekend CNA Premium Weekend Program or Weekend [NAME] Program which they started to implement in the middle of September to cover the low weekend staffing levels. SC A was queried regarding the staffing levels on the 200 unit and they indicated they try to staff it with three Nurse aides but sometimes cannot do due to their allotted amount of PPD hours (per patient day). (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/15/24 a facility document pertaining to staffing was reviewed and revealed the following: Policy: It is the policy of this facility to provide sufficient staff with appropriate competencies and skill sets to assure resident safety and attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. The facility's census, acuity and diagnoses of the resident population will be considered based on the facility assessment . 49083 Resident 10 A clinical record review revealed R10 was admitted to the facility on [DATE] with medical diagnoses that included: heart disease, renal disease, diabetes, seizure disorder, and pulmonary disease. A Brief Interview of Mental Status (BIMS) assessed on 7/13/24 revealed a score of 15/15 indicting R10 was cognitively intact. On 10/13/24, at 11:35 AM, during initial interview and introduction, R10 was observed in there room. They commented that today was different and normally there is only one Certified Nursing Assistant (CNA) for 31 patients and today there is all this extra staff. R10 stated one of the staff members commented, Why would they (State) come in on a Sunday? R10 stated they were thankful we (State) were there and mentioned the staffing is terrible and it is not fair that there are so few CNA's to help. R10 also commented it is an insult to us (residents). R10 said they were taken extra special care of today because we (SA) are here.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49272 Based on interview and record review, the facility failed to consistently ensure physician approved recommendations from the pharmacist were implemented for three (R4, R10, R19, R77) of four residents reviewed for medication regimen reviews. Findings include: R4 Review of R4's monthly medication regimen review (MRR) revealed on 8/1/24 pharmacist documented Resident is on digoxin. Please consider daily apical pulse readings prior to digoxin along with 'hold' parameters if pulse less than 60, to monitor rhythm and rate. A review of the facility's MRR binder revealed that the facility physician indicated that they agreed with the pharmacist recommendation however a review of R4's digoxin order and medication administration record revealed the recommendations were not carried out. R10 Review of R10's MRR revealed on 4/1/24 pharmacist documented 1 rec (recommendation) to physician. No physician response was found in the facility's MRR binder. On 10/14/24 at approximately 2:44 PM, the DON was notified of the missing physician response to the pharmacist's recommendation for April. The DON reported they would attempt to locate the document. No response was received prior to survey exit. R77 Review of R77's MRR revealed on 9/19/24 pharmacist documented Please monitor and document placement of fentanyl patch every shift. Review of the facility's MRR binder revealed the physician agreed however a review of R77's fentanyl patch order and medication administration record revealed the recommendations were not carried out. On 10/14/24 at approximately 2:44 PM, the DON was queried on the facility's procedure for monthly medication regimen reviews. The DON reported that they receive the recommendations from the pharmacist via email each month. The email goes to the facility physicians and to the DON directly. She further reported that she will follow up with the appropriate physician if a response (to agree/disagree with the pharmacists recommendation) is not received in a timely manner and the expectation is that the physicians are making the changes/entering any new orders at the same time as they acknowledge that they agree with the recommendations. The DON reported that her double check stops at following up for recommendations that aren't received back and that she trusts when the order is signed and that the physician is entering the order at the same time. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility policy titled, Addressing Medication Regimen Review Irregularities updated 12/28/23, documented in part The pharmacist must report any irregularities to the attending physician, the facility's medical director and director of nursing, and the reports must be acted upon .The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it .If documentation of the findings is not in the active record, it will be maintained within the facility and available for review. 49083 Resident 19 A clinical record reviewed revealed R19 was admitted to the facility on [DATE] with End Stage Renal Disease (ESRD) and requires hemodialysis. R19 had diabetes, atrial fibrillation (abnormal heartbeat) schizophrenia, and major depressive order. A Brief Interview of Mental Status (BIMS) score assessed on 8/20/24 revealed a score of 15/15 indicating R19 was cognitively intact. On 10/14/24 at 1:12 PM, a record review revealed the Medication Regimen Review (MMR) from Pharmacy dated 9/3/24, Recommendation to Nursing to update Abilify (antipsychotic medication) diagnosis listed as Antianxiety and change to Major Depressive Disorder. The Medical Administration Record (MAR) was reviewed and revealed the Abilify order remained with the diagnosis of antianxiety and was not changed to Major Depressive Order. A review of the recommendation from Pharmacy to the facility documented multiple requests for blood work to include a Lipid Profile (blood test that measures cholesterol and help assess risk of heart disease) and Glycated Hemoglobin (HgA1C) (blood test to obtain the average blood sugar levels over three months) on the following dates: 2/5/24, 5/2/24, 6/21/24, 8/23/24, 10/2/24. On 10/15/24, A record review revealed no lab values for Lipid Profile or HgA1C were documented. The MMR dated 10/2/24 was provided by the Director of Nursing (DON) and Pharmacy documented .Labs recommended: fasting lipid profile and HgA1C (no results from 6-23-24 order). The DON provided documentation of laboratory results and revealed a blood draw for Lipid Profile and HgA1C were collected and reported on 8/27/24. The DON acknowledged the results were not drawn from the first recommendation dated 2/5/24, acknowledged multiple requests were missed, and results from the 8/27/24 collection were not uploaded for the Pharmacist to review.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38271 Based on observation, interview and record review, the facility failed to ensure non-pharmacological interventions were attempted prior to PRN (as needed) psychotropic mediation administration for one resident (R22) of six residents reviewed for unnecessary psychotropic medications. Findings include: On 10/13/24 the medical record for R22 was reviewed and revealed the following: R22 was initially admitted to the facility on [DATE] and had diagnoses including History (hx) of Falling, Traumatic brain injury (TBI) and Dementia. A review of R22's MDS (minimum data set) with an ARD (assessment reference date) of 9/21/24 revealed R22 needed assistance from facility staff with most of their activities of daily living. R22's cognition was documented as having memory impairments. A Physician's order dated 10/7/24 revealed the following: Ativan Oral Tablet 1 MG (Lorazepam) Give 1 tablet by mouth every 8 hours as needed (PRN) for Anxiety for 14 Days. A review of R22's comprehensive careplan revealed the following: Focus- Resident has behavior(s) such as agitation at times such as biting, hitting, kicking. Date Initiated: 10/02/2024 A review of R22's October 2024 MAR (medication administration record) revealed R22 was administered their PRN Ativan on 10/1, 10/2, 10/3, 10/4, 10/5, 10/6, 10/7, 10/8, 10/11 and 10/12. A review of R22's progress note documentation of the non-pharmacological interventions being attempted prior to PRN administration revealed no documented non-pharmacological interventions were attempted prior to PRN administration of the Ativan for any of the dates in which it was administered from 10/1 through 10/12. On 10/15/24 at approximately 10:10 a.m., during a conversation with the Director of Nursing (DON), the DON was queried regarding the implementation of non-pharmacological interventions prior to the administration of R22's PRN Ativan. The DON reported that the Nurses should be attempting and documenting non-pharmacological interventions before administering the PRN Ativan. The DON was informed of the lack of documentation of any non-pharmacological interventions in the progress notes and they reported that it was expected that the interventions should be in the notes. On 10/15/24 a facility document titled Medication-Psychotropic was reviewed and revealed the following: Policy: Residents are not given psychotropic drugs unless the medication is necessary to treat a specific condition, as diagnosed and documented in the clinical record, and the medication is beneficial to the resident, as demonstrated by monitoring and documentation of the resident ' s response to the medication(s) .2. The indications for initiating, withdrawing, or withholding medications(s), as well as the use of non pharmacological approaches, will be determined by: a. Assessing the resident ' s underlying condition, current signs, symptoms, expressions, and (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	preferences and goals for treatment. b. Identification of underlying causes (when possible) .4. The indications for use of any psychotropic drug will be documented in the medical record. a. Pre-admission screening and other pre-admission data shall be utilized for determining indications for use of medications ordered upon admission to the facility. b. For psychotropic drugs that are initiated after admission to the facility, documentation shall include the specific condition as diagnosed by the physician. i. Psychotropic medications shall be initiated only after medical, physical, functional, psychosocial, and environmental causes have been identified and addressed. ii. Non-pharmacological interventions that have been attempted, and the target symptoms for monitoring shall be included in the documentation .7. Residents who use psychotropic drugs shall also receive non-pharmacological interventions to facilitate reduction or discontinuation of the psychotropic drugs .

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 49083 Based on observation and interview, the facility failed to ensure appropriate medication storage and labeling in two of three carts reviewed for medication storage and labeling. Findings include: On 10/15/24 at 8:10 AM, an observation of Medication Cart C Hall #2 was conducted with Licensed Practical Nurse (LPN) H and revealed on the bottom of the second drawer, loose medications were not contained in bottles, or blister packs. Observation included: 1 white round pill, 1 orange oval pill, 1 tan oval pill, and 1/2 tablet of a purple pill and LPN H commented it was midodrine (a medication to raise blood pressure). An open albuterol inhaler (medication to relax the airways and ease breathing) was identified as not dated. LPN H acknowledged the box was opened and not dated per protocol by dating the box. On 10/15/24 at 8:40 AM, an observation of Medication Cart E 500 Hall was conducted LPN I and revealed the first drawer had a bottle of opened nitroglycerin (medication to relieve chest pain) with no resident identifiers. LPN I commented that it was for a resident who experienced chest pain the day before. When questioned how we would know which resident it belonged to, LPN I responded we don't. Drawer two revealed medications were not contained in bottles or blister packs. Observation included: 1 round white pill, 1/4 white pill, 1/2 tan pill. The narcotic box was accessed and revealed 1/2 tab of a peach colored pill on the bottom of the box and LPN I remarked looks like a Xanax (a controlled medication to treat anxiety). Three open boxes of albuterol inhalers were not dated and when questioned if they should have an open date marked on the box, LPN I commented that they believed the policy changed and no longer had to date the inhalers. On 10/15/24 at 1:27 PM, the Director of Nursing (DON) and Assistant Director of Nursing (ADON) were questioned what was the facility's procedure for dating inhalers and the DON acknowledged nursing should be marking the date the medication was opened on the box. The DON and ADON were made aware nursing staff had not dated inhaler boxes and staff were unclear what the procedure was. The DON and ADON were also informed of numerous loose medications lying within the medication carts and acknowledged that their staff has made them aware of the observations and this was not appropriate medication storage or labeling.