

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235331	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/16/2024
NAME OF PROVIDER OR SUPPLIER Medilodge of Howell		STREET ADDRESS, CITY, STATE, ZIP CODE 1333 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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32568</p> <p>This citation pertains to Intake Number(s): MI00145518</p> <p>Based on interview and record review, the facility failed to ensure administration of a scheduled long acting antipsychotic medication for one (R601) of three residents reviewed for medication administration. Findings include:</p> <p>A review of a complaint submitted to the State Agency revealed an allegation that the facility did not administer R601's injectable antipsychotic medication that she required every two weeks. It was alleged the missing injection resulted in an increase in mental health symptoms and R601 was no longer at her mental health baseline .</p> <p>A review of a Contact Notes written by R601's Community Mental Health Case Manager (CMH CSM 'D') revealed the following documentation:</p> <p>An in person contact note dated 6/13/24 at 2:35 PM documented, (CSM 'D') arrive to (facility) to deliver (R601's) Haldol (an antipsychotic medication) injection. CSM informs (R601) they are delivering injection for the purpose of this visit. CSM directly hands unit manager, (Registered Nurse - RN 'C'), R601's most recent injection dispense note, medication review note, and injection vials with the information that (R601's) injection was due yesterday. (RN 'C') states she will give this to (R601) as soon as she can.</p> <p>A telephone contact note dated 6/24/24 at 2:24 PM documented, CSM calls (facility) for the purpose of coordinating (R601's) next Haldol injection. CSM speaks with (RN 'C'). (RN 'C') states it is hard to get a hold of Haldol injections at their location but they can attempt to get it. (RN 'C') states they will call CMH if they are unable to get Haldol injection by Thursday (6/27/24 the day before R601's injection is due). CSM informs (RN 'C') they will be on vacation from tomorrow (6/25/24) to 7/2 and she (RN 'C') would need to speak to someone else if there are any issues. (RN 'C') acknowledges this.</p> <p>A telephone contact note dated 7/8/24 at 1:49 PM documented, CSM calls (facility). CSM is transferred to (the Director of Nursing - DON). (The DON) reports that (R601) got her last Haldol injection on 6/14/2024. CSM asks if (R601) got an injection since then as it is prescribed for every two weeks. (The DON) reports there is no documentation of an injection since 6/14/2024 .</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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of a Medication Review Note from the CMH agency dated 5/13/24 documented R601 had a history of hearing voices, paranoia, and multiple suicide attempts. R601's prescribed medications included Haldol Decanoate (D) 100 milligram (mg)/1 milliliter (ml) take 175 mg intramuscular (IM) once every two weeks.</p> <p>A review of R601's clinical record revealed R601 was admitted into the facility on [DATE] and discharged home on 6/29/24 with diagnoses that included: schizoaffective disorder, bipolar disorder, and schizophrenia. A review of R601's Minimum Data Set (MDS) assessment dated [DATE] revealed R601 had moderately impaired cognition.</p> <p>A review of R601's physicians orders between 6/12/24 and 6/29/24 revealed an order for Haldol D (Haldol D) 100mg/ml Inject 1 ml intramuscularly one time a day every 14 days for antipsychotic. The start date for the order was 6/14/24.</p> <p>A review of R601's Medication Administration Record (MAR) for June 2024 revealed Haldol D was administered by RN 'C' on 6/14/24 and the next dose was due on 6/28/24. An H (to indicate the medication was held) was documented on 6/28/24.</p> <p>A review of R601's progress notes revealed no documentation regarding attempts to contact or obtain R601's 6/28/24 dose of Haldol D from the CMH agency.</p> <p>A review of a Discharge Summary progress note dated 6/28/24, written by Nurse Practitioner 'E', revealed R601 was being discharged on [DATE]. There was no documentation regarding whether R601 would receive the Haldol D injection prior to being discharged .</p> <p>On 7/16/24 at 11:02 AM, an interview was conducted with RN 'C' (who was a unit manager during the time R601 was a resident). When queried about R601's Haldol D injections, RN 'C' explained on 6/13/24 the CSM 'D' brought the first dose to the facility and it was administered on 6/14/24. When queried about any discussion on that date or future dates about how to obtain the next scheduled dose, RN 'C' could not recall any further discussion and reported any communication would be documented in the clinical record. When queried about why R601's Haldol D was held on 6/28/24, RN 'C' reported she would look into it.</p> <p>On 7/16/24 at 11:02 AM, RN 'C' followed up with additional information. RN 'C' provided R601's physician's order for Haldol D which showed the DON changed the order to be held on 6/19/24 (the order was signed by Physician 'B' on 6/24/24). The reason for the medication hold was CMH to administer and bring. RN 'C' further explained she did not have any additional information on what happened after 6/19/24 when the medication was put on hold. It should be noted that CSM 'D' documented a telephone conversation with RN 'C' on 6/24/24.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 7/16/24 at 12:00 PM, an interview was conducted with the DON. When queried about why R601's Haldol D was put on hold as of 6/19/24 and what was done to coordinate with the CMH agency to ensure she received it per her regular schedule, the DON stated, It was arranged before we admitted her. The DON reported CSM 'D' brought the first dose on 6/13/24 and R601 was discharged home the day after the next dose was due The DON further explained that the social worker asked R601 to follow up with the CMH agency after discharge. The DON reported the CMH agency never brought the second dose to the facility. When queried about what was done to try to obtain the other dose of the Haldol D, the DON reported the agreement before R601 was admitted was that the CMH would bring it and there was no further communication after that and no attempt to coordinate with the pharmacy or CMH agency to obtain the medication.</p> <p>A review of the referral sent from the hospital to the facility revealed it was arranged with CSM 'D' to bring R601's schedule Haldol D injection to the facility on [DATE]. (This was done and the medication was administered on 6/14/24).</p> <p>A review of a form titled, Discharge to Home . dated 6/27/24 revealed R601 was discharged home on 6/29/24. There was no documentation that R601 did not receive the Haldol D injection that was due on 6/28/24.</p> <p>A review of the home care referral and list of medication order provided to the home health care agency did not include any documentation regarding R601's missed dose of Haldol D.</p>		