STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235336	A. Building B. Wing	10/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Traverse City	2585 S Lafranier Rd Traverse City, MI 49686

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34568 Based on interview and record review, the facility failed to report an injury of unknown origin (right hip fracture) to the State Agency (SA) for one Resident (R1) of three residents reviewed for abuse. Findings include: Review of R1's Electronic Medical Record (EMR) revealed admission to the facility on [DATE] with a discharge date of [DATE] to an acute care hospital. R1's diagnoses included Rhabdomyolysis (break down of skeletal muscles, history of falls, and muscle weakness. R1's 8/29/24 Brief Interview for Mental Status (BIMS) score was 15, indicating she was cognitively intact. Review of R1's History and Physical from [Hospital Name] dated 9/8/24 read, in part, .Assessment/Plan: Patient had CT (compute tomography) scan of lumbar spines and pelvis without contrast .there is equivocal nondisplaced fracture line through right femoral neck . An interview was conducted with the Nursing Home Administrator (NHA), Interim Director of Nursing (DON) and Unit Manager/Registered Nurse A on 10/14/24 at 1130 a.m. who stated that R1 was admitted to the facility on [DATE] from the hospital after a fall from home. The hospital had conducted an x-ray and found no fractures, so R1 was admitted to the facility. When the facility was notified of R1 having a right hip fracture on 9/8/24, the hospital notes stated that it could have been from the fall prior to admission, but the facility did not report the injury of unknown origin to the SA. Review of the facility's Abuse, Neglect and Exploitation policy dated 1/10/24 read, in part, .Identification of Abuse, Neglect and Exploitation .Possible indicators of abuse include, but are not limited to: .Physical injury of a resident, of unknown source .Reporting/Response .Reporting of alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (e.g., law enforcement when applicable) within specified timeframes as required by state and federal regulations: Immediately, but not later than 2 hours after the allegation is made, if the vents that cause the allegation involve abuse or result in serious bodily injury .

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34568 Based on interview and record review, the facility failed to conduct a thorough investigation for an injury of unknown origin (right hip fracture) for one Resident (R1) of three residents reviewed for abuse. Findings include: Review of R1's History and Physical from [Hospital Name] dated 9/8/24 read, in part, .Assessment/Plan: Patient had CT (compute tomography) scan of lumbar spines and pelvis without contrast .there is equivocal nondisplaced fracture line through right femoral neck . An interview was conducted with the Nursing Home Administrator (NHA), Interim Director of Nursing (DON) and Unit Manager/Registered Nurse A on 10/14/24 at 1130 a.m. who stated that R1 was admitted to the facility on [DATE] from the hospital after a fall from home. The hospital had conducted an x-ray and found no fractures, so R1 was admitted to the facility. When the facility was notified of R1 having a right hip fracture on 9/8/24, the hospital notes stated that it could have been from the fall prior to admission. An internal investigation folder was presented at this time to this Surveyor. The folder contained a handwritten note from the Physical Therapist (PT) G for two sessions on 9/5/24 and 9/26/24, and a Statement of Witness form for R1's roommate dated 9/11/24 with no signature. There was also a Quality Assistance Form dated 9/11/24, written by RN A over concerns the family had on 9/8/24 with R1's care and being transferred to the hospital. On 10/15/24 at 10:00 a.m., The NHA provided additional witness statements from four staff members dated 10/14/24 and 10/15/24 respectively. The NHA acknowledged this was not a complete investigation per the facility abuse policy into an injury of unknown origin. Review of the facility's Abuse, Neglect and Exploitation policy dated 1/10/24 read, in part, .Investigation of alleged abuse, neglect and exploitation: An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur. Written procedures for investigations include Identifying staff responsible for the investigation, exercising caution in handling evidence that could be used in a criminal investigation (e.g., not tampering or destroying evidence), Investigating different types of alleged violations. Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations, Focusing the investigation on determining if abuse, neglect, exploitation and/or mistreatment has occurred, the extent, and cause, and providing complete and thorough documentation of the investigation .