STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235370	A. Building B. Wing	10/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of St Clair	4220 S Hospital Dr East China, MI 48054

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49699 Based on observation, interview, and record review, the facility failed to meet professional standards of care for medication administration for two residents (R71, R107) of nine residents reviewed for medication administration. Findings include: On 10/2/24 at 7:40 AM, during the dining room observation, Registered Nurse (RN) J was observed administering medication from a cup which contained a yellowish fruit puree to R107. When RN J completed the medication administration with R107, the nurse subsequently administered medication from a different medication cup to R71, without first returning to the medication cart, sign off that R107 had received their medications, performed hand hygiene, and separately prepare R71's medications. The facility record revealed R71 was admitted on [DATE] with the following pertinent diagnoses: Cerebral Infarction (Stroke), Atrial Fibrillation, Dysphagia, Aphasia, and Alzheimer's Disease. The facility record revealed R107 was admitted on [DATE] with the following pertinent diagnoses: Injury of Head, Fatigue, Repeated Falls, and Major Depressive Disorder. On 10/3/2024 at 11:30 AM, the Director of Nursing (DON) was queried regarding their expectation when a nurse provides medication to two different residents without returning to the medication cart in between. The said that practice was unacceptable. On 10/3/24 at 12:00 PM, Infection Control Nurse I was asked if facility practice was to pass medications to two different residents without returning to the medication cart, their response was no.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235370	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/03/2024
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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46956 Based on observation, interview, and record review, the facility failed to apply compression stockings as physician ordered for one (R111) of four residents reviewed for care standards. Findings include: Review of the facility record for R111 revealed an admitted [DATE] with diagnoses that included Chronic Obstructive Pulmonary Disease and Localized Edema. R111's Physician Orders included an active status order which stated Compression stockings to be applied to bilateral lower extremities before getting out of bed for the day and removed at bedtime one time per day for pedal edema. On 10/01/24 at 12:23 PM, R111 was observed in the dining room waiting for lunch. The resident's feet/ankles were visible as they were wearing slippers that only covered the toes and outer edge of the feet and the feet appeared to be swollen and more red in color than their skin otherwise. Compression stockings were notobserved to be in place. On 10/01/24 at 03:25 PM, R111 was asked about compression stockings and they stated They don't put them on anymore. Additional review of R111's record revealed the current care plan dated 08/28/24 with the Focus statement Resident has an impaired metabolic status related to Hyperkalemia, pedal edema and the associated Intervention statement Administer treatments and medications as ordered. The Activities of Daily Living (ADLs) portion of the care plan indicated that R111 required one-person assistance for lower body dressing. The Dietary Progress Note dated 10/01/24 included the statement [R111] continues with compression stockings. On 10/02/24 at 04:02 PM, R111 was interviewed in their room and the compression stockings were not on. R111 reported that they were not put on and stated I haven't had them on for probably three weeks or so. On 10/03/24 at 10:18 AM, R111 was observed in the morning coffee activity. Their feet were visible as they were wearing slippers and compression stockings were not on. Further review of R111's record revealed no documentation of resident refusals of the compression stockings or any clinical justification for the stockings not being applied. It was further noted the Treatment Administration Record (TAR) reflected that the compression stockings had been applied on 10/01/24, 10/02/24, and 10/03/24. On 10/03/24 at 12:40 PM, the facility Director of Nursing (DON) was made aware of the concern regarding R111 and said they were not aware of any reason why the compression stockings were not being used. The DON verified the use of the check mark symbol in the TAR indicated the compression stockings had been put on. The DON reported the expectation is the physician order for compression stockings should be followed and if there was a reason for the stockings not to be applied it should documented as such. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A facility policy addressing physician orders was requested however the provided policy specifically addressed only initial processing of physicians orders received from consulting providers. A facility policy addressing clinical documentation was requested however the provided policy did not address accuracy of clinical documentation.

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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** 40330 Based on observation, interview, and record review, the facility failed to update the status of wound from non-pressure to pressure classification and implement interventions (adequate seating and positioning) for a Stage 4 (full thickness skin loss that extends through the skin into the muscle, bone, tendon or joint) pressure ulcer for one Resident (R64) of three residents reviewed for pressure ulcers. Findings include: On 10/01/24 at 10:17 a.m., R64 was observed in their room seated in a high back manual wheelchair, in a reclined position. Their right leg was internally rotated, with their legs positioned up on elevating footrests. R64 reported they had pain all over, reported as 5/10 with 5 being moderate pain. R64 was seated directly on their buttocks and thighs on a pressure relief cushion in their wheelchair. On 10/01/24 at 10:31 a.m., Certified Nurse Assistant (CNA) S was asked about R64's care, and reported R64 was dependent for all care including feeding. Review of R64's Minimum Data Set (MDS) assessments, dated 12/17/23, 3/17/24, 6/16/24, and 9/15/24, revealed in Section M, Skin, R64 had MASD (Moisture-Associated Skin Damage - Inflamed, swollen, wrinkled skin susceptible to damage from moisture, which is non-pressure related). Each assessment showed no pressure ulcers. Review of R64's physician orders revealed a current wound care order, started on 5/23/24, which showed R64's wound was treated daily with calcium alginate (a wound care protective treatment) with honey (an antibacterial agent) applied to the wound bed on the left thigh/buttocks crease, and Calmoseptine (moisture barrier ointment) to the peri (outer) wound. The order showed the wound was covered with a border foam (protective) dressing for a full-thickness non-pressure injury, and as needed. On 10/01/24 at 10:33 a.m., the wound care nurse, Registered Nurse (RN) F, was asked about R64's left thigh wound. RN F reported the wound started a couple years ago as Moisture Associated Skin Damage (MASD) and was a non-pressure full-thickness skin injury. Review of R64's, Skin and Wound Note, dated 10/01/24, documented the left rear thigh wound was covered by 20% slough (dead tissue) and 80% granulation (healing tissue), with moderate exudate serosanguineous (healthy drainage from wound - no infection). The document noted the wound had increased in size in the past week. The Standards of Care, wound meeting note same date, described the wound as a full-thickness, non-pressure injury, had increased in size related to area and depth. The note further revealed R64 declined to offload (pressure), as they chose to stay up in their wheelchair throughout the day. Review of R64's Wound Evaluation note, accessed 10/03/24, revealed R64 had a current wound on their left thigh classified as Other [non-pressure]- Rear Left Thigh. Status: Stable - 2 years old. Acquired: In-House [facility] Acquired. The document showed the wound was at the left ischium (a pressure point of the lower pelvic bone), with the following measurements: 10/01/24: 3.2 cm2 (Sq centimeters). 1.91 cm (Length) x 1.96 cm (Width) x 2.3 cm (Depth). (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	9/24/24: 2.8 cm2 x 1.82 cm x 2.02 cm x 2.1 cm. 9/17/24: 4.34 cm2 x 2.39 cm x 2.13 cm x 1.3 cm. 9/10/24: 2.5 cm2 x 1.77 cm x 1.6 cm x 1.2 cm. On 10/01/24 at approximately 10:40 a.m., RN F stated the previous wound care provider never restaged the R64's wound, just below the gluteal (buttocks) cheek fold, when it opened and said to document it as MASD, and the current NP (Nurse Practitioner) wound care provider said to document it as a non-pressure area. RN F stated all the wound providers (nurse practitioners) had classified the left thigh wound as a non-pressure wound over a year. RN F acknowledged this could potentially be a pressure area. RN F also explained R64 was not compliant with offloading. Review of the facility matrix revealed R64 had a Stage 4 facility-acquired pressure ulcer. On 10/01/24 at 10:35 a.m., RN C reported they may have completed the matrix incorrectly, as R64's left thigh wound was a non-pressure wound. RN C explained for the past 15 months R64 frequently chose to stay up in their wheelchair daily, from 9:30 or 9:45 a.m. until 7:00 p.m. RN C reported R64 used a positioning wedge and a heels up device in their air bed, for offloading. On 10/01/24 at approximately 10:50 a.m., the Director of Nursing (DON) stated R64's wound was slowly healing due to being a smoker (vaping) and diagnoses including quadriplegia (paralysis of the arms and legs) with spasticity (increased muscle tone), diabetes, and respiratory failure. The DON described the wound as non-pressure, stating it started as MASD, and in the last two years it opened, and the wound was not on a pressure point. The DON reported all the wound care doctors had classified it as non-pressure. The DON clarified R64 was in an offloading recline wheelchair, and the therapy department was trying to get them a power tilt in space wheelchair but there were insurance issues. On 10/01/24 at approximately 11:00 a.m., the MDS (Minimum Data Set) assessment nurse, RN T, was asked why the wound showed as a Stage 4 pressure ulcer on the matrix yet there was no pressure ulcer noted on the past three MDS assessments. RN T reported the matrix the facility provided to the survey team was incorrect. On 10/03/24 at 9:20 a.m., R64 stated they received the wound about eight months ago from their wheelchair, when the chair hit [them] there, pointing to their left buttocks. R64 reported they were sometimes uncomfortable in their wheelchair, on their bottom, and confirmed they stayed up in their wheelchair most days due to vaping. Review of R64's MDS assessment, dated 9/15/24, revealed R64 was admitted to the facility on [DATE], with diagnoses including quadriplegia, respiratory failure, anxiety, depression, and diabetes. R64 was dependent for all self-care, bed mobility, and transfers. R64 was able to be understood and made herself understood. Review of R64's wound care provider notes revealed a left ischial (pelvic) pressure ulcer (left thigh wound), Stage 4, on 3/26/24, noted as 1.64 cm2 (centimeters squared) and on 4/02/24, noted as 6.43 cm2, showing the wound worsened significantly. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of the 3/26/24 wound care provider note revealed a wound history beginning on 1/16/24 of a Stage 4 pressure ulcer on the left ischial tuberosity (pressure point on the pelvis), with subsequent notation of the Stage 4 pressure ulcer on 2/13/24, 2/20/24, 3/12/24, and 3/19/24. Review of R64's surgical report, dated 5/22/23, documented their left inferior buttocks wound debrided. Review of R64's wound care provider report, dated 6/10/20, documented a Stage 3 pressure ulcer of the left buttocks. Review of R64's wound care provider report, dated 8/01/24, with a new wound care provider, documented the wound (prior noted as a Stage 4 pressure ulcer) was classified as left ischial non-pressure ulcer and not healed, with an area of 4.2 sq cm. Subsequent notes dated 8/12/24, 9/12/24, 9/19/24, 9/26/24, and 10/01/24 revealed the wound remained classified as a non-healing, non-pressure ulcer of the left ischium. On 10/03/24 at 9:30 AM, during an interview, Registered Nurse (RN F) explained that R64's wound started as MASD (moisture associated skin damage) and was continued to be labeled as MASD but at some point, the area had opened. RN F when they started working at the facility the wound was already open and was relabeled as full thickness non pressure. On 10/03/24 at 9:36 AM, R64 was observed lying flat on their back in bed with a pillow under their left arm. R64's heels were observed to be resting directly on the bed. R64 explained that the wound started from something from my wheelchair. On 10/03/24 at 9:41 AM, RN F and RN O were observed to turn R64 onto R64's right side. An approximately 2.5-centimeter circular full thickness wound extending to muscle tissue was observed on R64's left ischium (lower pelvis bone at base of buttocks). A large amount of brown purulent drainage was noted on the wound dressing and on R64's brief. RN F explained they do dressing changes on Tuesdays and also takes pictures and wound measurements at that time then also rounds with the wound doctor on Thursdays. RN F was then observed to ask R64 if the staff used R64's positioning wedge today. R64 stated no. RN F was observed to look around R64's room and in the closet. A positioning wedge was found on the floor in the opposite corner of the room by the doorway on R64's roommate's side. On 10/03/24 at approximately 11:55 p.m., the Rehabilitation Director, Occupational Therapist U, was asked if R64 had the ability to relieve pressure (offload) in their high-back, reclining manual wheelchair. OT U reported R64 was unable to relieve any pressure themselves, and they were dependent for positioning and pressure relief. OT U stated R64 needed a power, tilt in space wheelchair for offloading and noted there had been no efforts made to obtain alternative seating in the interim for R64. On 10/03/24 at approximately 12:00 p.m., R64 was observed in the dining room with (OT) U. R64 was seated in their high back recline wheelchair with an air pressure-relieving cushion. R64 was observed to have pressure fully on their bottom and thighs. OT U confirmed R64 the pressure areas. OT U stated, All areas are pressure. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R64's Care Plan, accessed 10/03/24, revealed R64 used a manual recline wheelchair for mobility, pressure relieving boots, a positioning wedge, and heels offloaded. The Care Plan showed R64 had MASD to their left rear thigh upgraded to a full-thickness non-pressure injury on 12/26/23. On 10/03/24 at 9:30 AM, during an interview, Registered Nurse (RN F) explained that R64's wound started as MASD (moisture associated skin damage) and was continued to be labeled as MASD but at some point, the area had opened. RN F when they started working at the facility the wound was already open and was relabeled as full thickness non pressure. On 10/03/24 at 9:36 AM, R64 was observed lying flat on their back in bed with a pillow under their left arm. R64's heels were observed to be resting directly on the bed. R64 explained that the wound started from something from my wheelchair. On 10/03/24 at 9:41 AM, RN F and RN O were observed to turn R64 onto R64's right side. An approximately 2.5-centimeter circular full thickness wound extending to muscle tissue was observed on R64's left ischium (lower pelvis bone at base of buttocks). A large amount of brown purulent drainage was noted on the wound dressing and on R64's brief. RN F explained they do dressing changes on Tuesdays and also takes pictures and wound measurements at that time then also rounds with the wound doctor on Thursdays. RN F was then observed to ask R64 if the staff used R64's positioning wedge today. R64 stated no. RN F was observed to look around R64's room and in the closet. A positioning wedge was found on the floor in the opposite corner of the room by the doorway on R64's roommate's side. Review of the policy, Pressure Ulcer Prevention and Management, revised 3/20/2024, revealed, This facility is committed to the prevention of avoidable pressure injuries and the promotion of healing of existing pressure injuries. Definitions: Pressure Ulcer/Injury refers to localized damage to the skin and/or underlying soft tissue usually over a bony prominence or related to a medical or other device .c. Evidence-based interventions for prevention will be implemented for all residents who are assessed at risk or who have a pressure injury present. Basic or routine care interventions could include but are not limited to: i. Redistribute pressure (such as repositioning, protecting and/or offloading heels, etc.) .iii. Provide appropriate, pressure-redistributing, support surfaces .d. Evidence-based treatments in accordance with current standards of practice will be provided for all residents who have a pressure injury present. i. Pressure injuries will be differentiated from non-pressure injuries, such as arterial, venous, diabetic, moisture, or incontinence related skin damage. iv. Treatment decisions will be based on the characteristics of the wound, including the stage, size, amount of exudate [wound drainage], and presence of pain, infection, or non-viable tissue . Monitoring. The attending physician will be notified of: i. The presence of a new pressure injury upon identification. ii. The progression towards healing, lack of healing, or worsening of any pressure injuries weekly . .

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40330 This citation has two deficient practice statements. Deficient Practice #1. Based on interview and record review, the facility failed to provide recommended restorative therapy for one (R59) of three residents reviewed for restorative therapy services. Findings include: On 10/01/24 at 12:45 p.m., R59 was observed seated in their wheelchair in their room. On 10/01/24 at 12:48 p.m., R59 reported they were not walking with staff, or regularly receiving their restorative therapy exercises. R59 stated, .I don't even get it [restorative therapy] once a week. I ask them in the hallway what they are doing and say range of motion [with other residents]. That bothers me, I need to walk . Review of R59's Restorative Program referral, dated 7/29/24, revealed, Walking: Distance: 3' with 2 WW [two-wheeled walker]. Assistance Required: Min [minimal assistance]. Instruct to increase t [weight] on right [side] .ROM: Extremity: See exercise sheets. Frequency: 5x/ wk. [five times a week] . Review of R59 restorative therapy logs revealed during the past month (September 2024), R59 participated in walking one time out of eight opportunities. There were no refusals documented, and it was unclear why the sessions were missed or not offered, 7 of the entries showed, not scheduled this shift, and one showed response not required. Review of the range of motion logs showed R59 participated one time of ten opportunities. The other 9 of the entries documented, not scheduled this shift. There was no monthly summary provided for September 2024. Review of R59's, Restorative therapy monthly documentation, dated 9/3/24, revealed a program summary for one month, from 8/01/24 through 8/31/24. The document showed R59 participated 4 times in a walking program and 3 times in a range of motion program. There was one refusal of range of motion in August, and no refusals documented for that month with walking. Review of R59's Minimum Data Assessment (MDS) assessment, dated 9/01/24, revealed R59 was admitted to the facility on [DATE], with diagnoses including heart failure, anxiety, and depression. The assessment revealed R59 required moderate assistance with transfers, minimal assistance with walking, and maximal assistance with toileting, The Brief Interview for Mental Status (BIMS) assessment revealed a score of 13/15, which showed R59 was cognitively intact. The assessment revealed, Restorative Nursing Program, number of days each of the following restorative programs was completed (for at least 15 minutes a day in the last 7 calendar days): Technique: Range of motion, passive, 0 [minutes], Range of motion, active, 0 [minutes]. Training and skill practice in: E. Transfer, 0 [minutes]. F. Walking, 0 [minutes] . (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/01/24 at 12:48 p.m., Restorative Aide, Certified Nurse Aide (CNA) K was asked why the logs showed R59 participated only one time in the restorative program in the last month. CNA K confirmed R59 was currently on their restorative program caseload, and this was an accurate reflection of R59's being offered restorative therapy, and their participation. CNA K stated they had not consistently offered R59 restorative therapy services, as they were sometimes pulled from the floor to assist residents with [providing their] showers. CNA K reported this concerned them, and they had spoken to their supervisors and nursing management regarding residents missing restorative services. On 10/03/24 at 2:21 p.m., the DON was asked about R59's missing restorative therapy. R59 stated, I will look into this. I would expect [CNA K] to go to [the Restorative Nurse] . Review of the policy, Restorative Nursing Program revised 1/1/2022, revealed, The goal(s) of Restorative Nursing includes improving and/or maintaining independence in activities of daily living and mobility. A Restorative Nursing Program, when appropriate is based on a the [sic] comprehensive assessment and resident .Re-visit at least quarterly to determine if the resident would still benefit .Determine resident and/or family goals for restorative care .Each facility should establish a monitoring program to ensure success .Each program must occur 6 out of 7 days a week for a minimum of 15 minutes in a 24 hour period .Restorative documentation requirements include .Comments if refused, withheld, or change in status (improvement/decline) as applicable .Each facility should establish a monitoring program to ensure success . Establish a daily review of documentation to discern delivery of care . 44750 Deficient Practice #2. Based on observation, interview, and record review, the facility failed to apply an immobilization devices (arm sling and cervical collar, c-collar) for two residents (R5 and R107) out of two reviewed for mobility. Findings Include: R5 On 10/1/2024 at 9:30 AM, R5 was observed in their room and sitting in their wheelchair. R5 stated they were getting dressed for bingo. R5 was observed in the room alone and attempting to put on shoes. R5 then wheeled in the hallway and received assistance putting shoes on from staff. No arm sling was observed in use. On 10/1/2024 at 11:38 AM, R5 was seen in the hallway asking for their arm sling to be applied. R5 was then observed going into their room with their nurse to apply their arm sling. A review of the medical record revealed that R5 admitted into the facility on [DATE] with the following medical diagnoses, Recurrent Dislocation, Left Shoulder and Pain in Left Shoulder. A review of the Minimum Data Set assessment (MDS) revealed a Brief Interview for Mental Status score (BIMS) of 12/15 indicating an impaired cognition. R5 also required staff assistance with transfers and bed mobility. Further review of the physician's orders revealed the following active orders, (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Sling and Swathe to left upper extremity at all times. May remove for skin checks and showers. Status: Active. Ordered:2/9/2023. Apply arm sling to left upper extremity when out of bed, adjust snug to chest. Check for circulation after each application. Only Apply when resident is out of bed. Status: Active. Ordered: 9/17/2024. On 10/3/2024 at 9:30 AM AM, R5 was observed in bed with no arm sling in use. On 10/3/2024 at 10:57 AM, R5 was observed in activities with no arm sling in use. On 10/2/2024 at 11:14 AM, R5 was observed leaving the activities room. R5 stated they were going to tell the staff to apply their arm sling. R5 was asked if they have to tell them often to apply it. R5 stated they always forget; I just remind them, and they apply it when out of bed. On 10/3/2024 at 9:17 AM, an interview was completed with Unit Manager (UM) A. UM A stated R5 should have the arm sling on when they are out of bed and the staff should be applying it. 50223 R107 On 10/01/24 09:56 AM, R107 was observed lying in bed with the head of their bed elevated approximately 30 degrees (not upright). A cervical collar (c-collar) was observed to be on a wheelchair across the room. Certified Nurse Assistant (CNA) L was observed to be sitting in the room saying, R107 just returned from the hospital. CNA L confirmed R107 wears a c-collar when they are out of bed. 10/02/24 at 7:48 AM, R107 was observed sitting up in their wheelchair at a table in the common area eating breakfast. R107 was observed to not be wearing a c-collar. On 10/2/24 at 8:23 AM, R107 was observed to still be sitting in a wheelchair at a table and was now observed wearing their c-collar. On 10/03/24 at 9:17 AM, R107 was observed in bed with head up 45 degrees (not upright). The c-collar was observed across the room in the wheelchair. A review of R107's Electronic Medical Record (EMR) revealed that R107 was admitted to the facility on [DATE] with the following diagnosis: Unspecified injury of head; Unspecified dementia; Fall on same level A review of R107's Brief Interview for Mental status revealed a score of 4 indicating cognitive impairment. A further review of R107's record revealed a hospital History and Physical dated 9/9/24 revealed the following: CT- C-spine: Nondisplaced anterior/inferior C4 vertebral body fx (fracture). A review of R107's physician orders revealed the following: Order dated 9/19/24 C-Collar on while out of bed. May have c-collar off when lying in bed. Must have on when sitting upright in bed. Discontinued 10/2/24. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235370	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of St Clair	4220 S Hospital Dr East China, MI 48054

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Order dated 10/2/24 3:00PM C-collar on while out of bed. May have C-Collar off when eating, showering or lying in bed. Must have on while sitting upright in bed. A review of R107's care plan revealed the following: Resident is at risk for falls/injury related to dementia, recent falls from standing. Resident removes (their) C-Collar (themselves), monitor resident to ensure (they) are wearing when up out of bed. Date initiated 9/18/24. I wear a C-collar on while out of bed. I may have C-Collar off when eating, showering or lying in bed. I must have on when sitting upright in bed. Date initiated 9/11/24 revised 10/3/24. A NP/PA (Nurse Practitioner/Physician Assistant) progress note dated 10/1/24 revealed the following: Per chart review (they) have taken multiple falls. (they) were taken to the hospital sometime after the fall for another fall in the bathroom where (they) fell backwards and hit (their) head. CT scan revealed possible C4 vertebral body fracture, but MRI demonstrated a non bridging enthesophyte calcification, confirming no fracture. (They) were evaluated by neurosurgery. (They) came back with a C-Collar in place. Physical exam: . C-collar in place: adjusted to support chin . Assessment/Plan .C-collar when out of bed .9/19 .keep C-collar on when OOB (out of bed or upright in wheelchair. 9/26 Recurrent attempts to self-transfer without staff. C-Collar not in appropriate position upon arrival for visit. Education provided to staff . On 10/2/24 at 8:25 AM, during an interview, Unit Manager (UM) C explained R107 is supposed to wear the C-collar when out of bed or if head of bed is elevated. UM C also explained the resident does not like to wear the c-collar when eating or lying down. On 10/3/24 at 10:53 AM, during an interview, Registered Nurse (RN M), explained R107 is confused and they have to wear a c-collar whenever they are out of bed because they had a fall. On 10/3/24 at 11:05 AM, during an interview, Physical Therapist (PT) N explained R107 has to wear the c-collar due to a nondisplaced C4 fracture of the cervical spine. PT N said R107 is unsteady and has poor balance and every time R107 stands up they fall backward and their reactions are delayed. PT N said if R107 was not wearing the c-collar R107 would be at risk for making the fracture worse or could injure a muscle or ligament and saying, I would hate for that to happen, that would be bad. When you're dealing with something that close to the central nervous system, we definitely want to take all the safety precautions. On 10/3/24 at 11:33 AM, during an interview, the Director of Nursing (DON) explained R107 is very impulsive and has to wear a c-collar because they fell and hit their head. The DON explained initially the resident had to wear the collar around the clock but stated I just had the PA (Physician Assistant) assess (them) and now (they) can have it off when (they're) eating and when they're lying down. When (they're) awake we try to keep it on. A review of a facility policy titled; Physician/Practitioner Orders-Consulting did not address applying mobility devices.

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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** 28776 Based on observation, interview, and record review, the facility failed to safely and properly store portable oxygen for one (R27) of four residents reviewed. Findings include: Review of the facility record for R27 revealed an admitted [DATE] with diagnoses that included Chronic Obstructive Pulmonary Disease and Chronic Respiratory Failure. R27's current physician orders include O2 two liters continuous with humidification. On 10/01/24 at 10:03 AM, during initial interview R27 was using their oxygen concentrator. A portable oxygen tank was observed in a tank holder attached to the resident's four wheeled walker. A second portable tank was observed in a wheeled cart near the bathroom. R27's roommate was not using oxygen and when asked about the second tank R27 stated That's mine. They keep an extra one sometimes so they don't have to go get it but I'm not sure why its over by [R27's roommate]. On 10/02/24 at 01:09 PM, the extra oxygen tank observed on 10/01/24 remained stored in R24's room near the bathroom. On 10/03/24 at 10:30 AM, the oxygen tank previously observed remained stored in a wheeled cart near R27's bathroom. On 10/03/24 at 12:33 PM, the facility Director of Nursing (DON) reported the expectation is that an extra oxygen tank should not be stored in the resident's room and should only be in the oxygen storage room that is on that unit. Review of the facility policy Oxygen Safety dated 01/01/22 revealed the entry 4. Oxygen Storage - a. Oxygen storage locations shall be in an enclosure or within an enclosed interior space of non-combustible or limited-combustible construction, with doors or gates that can be secured against unauthorized entry.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49699 Based on observation, interview, and record review, the facility failed to provide respiratory care consistent with professional standards of practice for two (R61, R93) of two residents receiving nebulizer treatments. Findings include: R61 On 10/1/24 at 9:02 AM, R61 was observed with a nebulizer treatment in progress. R61 was adjusting the positioning of the device. A nurse was not present. On 10/1/24 at 9:30 AM, R61 was observed to have completed their nebulizer treatment. A nurse was not present. Review the facility record revealed R61 was readmitted to the facility on [DATE] after hospitalization for exacerbation of Chronic Obstructive Pulmonary Disease (COPD), Obstructive Sleep Apnea, and Dyspnea. A Brief Interview for Mental Status revealed a score of 11/15 indicating Mild Cognitive Impairment. On 10/3/2024 at 9:24 AM, a query of R61 revealed the nurse usually sets up their nebulizer treatment and starts it, then usually leaves the room. R61 revealed most nurses do that. R61 revealed when the treatment is complete, they take off the mask and put on their oxygen. Further inquiry revealed that R61 is ok with that practice. A record review of R61's comprehensive care plan does not reflect independence with nebulizer treatment after set-up, in the care plan. R93 On 10/1/24 at 9:23 AM, R93 was observed sitting in a wheelchair, completed breakfast tray on bedside table, receiving a nebulizing treatment. A few minutes after entering R93's room, Nurse H then entered the room observed resident during the nebulizer treatment. On 10/1/24 at 9:35 R93 was observed putting the nebulizer equipment in a protective bag. R93 was not observed rinsing or drying the equipment. There was not a nurse present. A review of the record revealed R93 was readmitted on [DATE] after a hospitalization for COVID-19 and acute on chronic respiratory failure. R93's relevant diagnoses are as follows: Chronic Obstructive Pulmonary Disease, Covid-19, and Dementia. R93's Brief Interview for Mental Status revealed a score of 9/15 indicating a Mild Cognitive Impairment. On 10/02/24 at 09:45 AM, R93 was interviewed and revealed they had been taking nebulizer treatment for [AGE] years. R93 further revealed the nurse typically leaves the room. R93 revealed the nurse set me up yesterday, then left the room because a kitchen person was talking to me when the nurse came in. R93 revealed the nurse then left the prepared nebulizer and R93 turned it on when the kitchen person left, completing their own treatment and putting the equipment in the bag. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A record review of R93's comprehensive care plan does not reflect independence with nebulizer treatment after set-up, in the care plan. An interview on 10/2/24 with the Unit Manager C a query regarding the practice of residents completing nebulizer treatments revealed the activity of completing a nebulizer treatment without nursing supervision should be reflected in the care plan. An interview with the Director of Nursing (DON) on 10/3/24 a query regarding the practice of residents completing nebulizer treatments revealed the activity of completing a nebulizer treatment should be reflected in the care plan.

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40330 Based on observation, interview, and record review, and facility failed to provide medically related social services for two Residents (R23 and R73) of eight residents reviewed for medically-related social services. Findings include: R23 On 10/02/24 at 3:03 p.m., R23 reported they had asked multiple staff to be discharged from hospice services, as they wanted to have therapy assess them to see if they could improve their transfers to possibly be discharged home. R23 reported they felt frustrated, as they had been on hospice a couple of years and had never been on therapy. R23 was aware they had a guardian but had been unable to reach them about their wishes and also felt frustrated with having a guardian. R23 reported they had also shared their wishes with facility staff and the hospice nurse and had not heard back. On 10/02/24 at approximately 3:30 p.m., the Director of Nursing (DON) was asked about R23's reported wishes to come off hospice care and related concerns. The DON reported they had been made aware of their concerns about a month prior, and had referred the Social Services Designee, Staff P, to follow-up. Surveyor noted there were no Social Services notes in the medical record related to R23's wishes. The DON confirmed they would expect to see documentation of follow-up. Review of R23's Minimum Data Set (MDS) assessment, dated 6/30/24, revealed R23 was admitted to the facility on [DATE] with diagnoses including stoke, heart failure, anxiety, and depression. R23 was dependent for toileting, transfers, and bed mobility. The Brief Interview for Mental Status (BIMS) assessment revealed a score of 12/15, which showed R23 had moderate cognitive impairment. The assessment revealed R23 received hospice services. On 10/02/24 at 5:20 p.m., a phone call was made to R23's hospice agency/nurse to clarify R23's request and any follow-up. No response was received by the end of the survey. Review of R23's hospice documentation revealed no mention of R23's wishes to be discharged from hospice care. On 10/03/24 at 8:40 a.m., Staff P was asked about R23's wishes to come off hospice services. Staff P confirmed they were aware of R23's wishes and had meetings with R23 and the hospice team related to R23 being an unsafe discharge, requiring 24-hour care, and being on hospice related to a chronic, non-healing wound and requesting the highest pain medications. Staff P reported they had addressed R23's guardianship concerns about a year prior. Review of the medical record with Staff P revealed no social services notes since April 2024. When asked why there was lacking documentation, Staff P reported they were not comfortable documenting nursing complexities and were struggling with documenting medical explanations in their social services notes. Staff P was asked if they had discussed this with their supervisor or the DON and reported they had not. Staff P reported last night (10/02/24) they had requested any hospice documentation of the meetings and discussions about R23's wishes, since they had no documentation. Documentation was not received by survey exit. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R73 Review of R73's MDS assessment, dated 6/30/24, revealed R73 was admitted to the facility with diagnoses including heart failure, end stage renal failure, pneumonia, and depression. The BIMS assessment revealed a score of 14/15, which showed R73 was cognitively intact. Review of the medical record revealed R73's Family Member, FM Q, had become their guardian by 7/2024, and they were a code status of DNR: Do Not Resuscitate. On 10/01/24 at 1:50 p.m., R73 stated they wanted guardianship back, as they believed their guardian, Family Member (FM) Q, was only their power of attorney if they became incapacitated, and did not know believe they had authorized guardianship, and regardless, did not want to keep it in place. R73 reported they were able to make their own decision as they had good cognition. During the interview, R73 was oriented to himself and his surroundings, situation and time (x 4). R73 reported they were choosing to stop receiving dialysis, and they understood FM Q was trying to make them receive dialysis. On 10/02/24 at 12:08 p.m., the Social Services Designee, Staff P, reported they were aware R23 had guardianship through an outside agency, until July, 2024, when R23's guardianship had been switched from the agency to FM Q. Staff P stated, They [the agency] never gave me valid reasons why they petitioned him [FM Q]. Staff P reported they would follow-up with R73, as they had a right to petition for guardianship at any time, regardless of their cognition or medical status. Staff P was aware of R23's wishes to stop dialysis, and they were working with the Director of Nursing (DON) on this during the survey. Staff P reported they understood R73's wishes, and had been meeting with them regarding their concerns. Surveyor reviewed the medical record with Staff P and showed them there was no documentation of any visits with R73 since 6/2024 to address their guardianship concerns, which were in process at that time, and a social services assessment on 7/03/24. The Staff P was asked if the facility had any competency assessment by physicians, declaring R73 incompetent. Staff P reported they had no competency document, however the guardianship papers declared R73 incompetent. SS P clarified R73 was alert and oriented x 4. On 10/02/24 at approximately 4:30 p.m. the DON was asked about R73's wishes to pursue guardianship. The DON reported they had asked Staff P to follow-up with R73 about a month prior, and they would have expected this to be in their Social Services documentation. On 10/02/24 at 4:50 p.m., R73 stated they had been asking the facility for reevaluation of their guardianship for a long time, since [FM Q] became their guardian. R73 stated, No one is helping me. When asked if they told their physician and facility staff, R73 reported, Everyone is aware here, and confirmed they had told nursing and management staff their wishes, and the facility social worker. A telephone call was made to R73's guardian, FM Q , on 10/02/24 at 5:41 p.m., with no return call received by the end of the survey on 10/03/24. Review of R73's Social Services assessment, dated 7/03/24, completed by Staff P, revealed R73 was cognitively intact, fully oriented and was independent at decision making. The depression assessment showed no signs or symptoms of depression. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/03/24 at 1:24 p.m., Staff P was asked if they had followed up with R73 about their concerns related to pursuing guardianship, since learning of the concerns on 10/02/24. Staff P reported they had not, and understood the concern and R73's right to petition for guardianship. When asked why they had not documented any reported conversations with R73 since 6/2024 related to guardianship or their wishes to stop dialysis in the last month, Staff P reported they did not know what to document medically on a resident. When asked for clarification, Staff P stated they did not know how or what to document when a resident had medical concerns. When asked if they had discussed this with their supervisor, Staff P reported they had not. Staff P affirmed they received a referral regarding R73 and their concerns, and had been addressing them but not documenting them. On 10/03/24 at 2:37 p.m., the DON was made aware of the ongoing guardianship wishes of R73, and Staff P's documentation concerns. The DON reported they understood the concerns and would follow-up. Review of the policy, Social Services, revised 10/30/23, revealed, The facility, regardless of size, will provide medically related social services to each resident to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. Definition: Medically related social services are services provided by the facility's staff to assist residents in attainment or maintenance of a resident's highest practicable well-being .4. The social worker, or social service designees, will pursue the provision of any identified need for medically related social services of the resident. Attempts to meet the needs of the resident will be handled by the appropriate discipline(s). Services to meet the resident's needs may include: 0/a. Advocating for residents and assisting them in assertion of their rights within the facility .4. h. Assisting residents with financial and legal matters 5. The facility should provide social services or obtain needed services from outside entities .

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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** 44750 Based on interview and record review, the facility failed to put a 14 day stop date on an PRN (as needed) antianxiety medication for one resident (R60) out of two reviewed for unnecessary medications. Findings Include: A review of the medical record revealed that R60 admitted into the facility on [DATE] with the following medical diagnoses, End Stage Renal Disease and Atrial Fibrillation. A review of the Minimum Data Set (MDS) revealed a Brief Interview for Mental Status (BIMS) score of 14/15 indicating an intact cognition. R60 also required staff assistance with transfers and bed mobility. A review of the physician orders revealed the following order. Ativan Oral Tablet 0.5 MG (milligrams) (Lorazepam). Directions: Give one tablet by mouth every 4 hours as needed for restlessness or anxiety. Status: Active. Start Date: 8/28/2024. No end date was noted on the order. On 10/3/2024 at 10:36 AM, an interview was conducted with Social Worker (SW) B. SW B stated R60 is on hospice, and they put PRN orders in often and don't communicate it sometimes. SW B stated they are working on it and there should be a stop date on the order. On 10/3/2024 at 12:04 PM, an interview was conducted with the Director of Nursing (DON). The DON stated there should be an end date on the Ativan order for R60. A review of a facility policy titled, Use of Psychotropic Drugs and Gradual Dose Reductions noted the following, .7. PRN orders for psychotropic drugs shall be used only when the medication is necessary to treat a diagnosed specific condition that is documented in the clinical record and for a limited duration (i.e. 14 days).

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 40330 Based on observation, interview, and record review, the facility failed to ensure one unattended medication cart (the C-wing cart) of three carts reviewed was locked during medication administration. Findings included: On 10/02/24 at 9:00 a.m., Registered Nurse (RN) R was observed preparing R49's medications to be passed from the C-wing cart. R49 agreed to Surveyor observing them take their medications. Once RN R placed R49's medications in a pill cup, they walked into R49's room, and left the medication cart unlocked, leaving the cart unsupervised and accessible to residents and staff. RN R began administering medications to R49, in the second bed in the room, and was not aware they left the medication cart unlocked, as they did not stop and lock the cart, and their back was to the cart. Surveyor was observing R49's medication administration when they saw R49's roommate wheel into the hallway and place their wheelchair on the left side of the medication cart. Surveyor next observed a maintenance staff member place their wheeled maintenance supply cart in front of the medication cart. Surveyor observed the cart until RN Q arrived back outside the room, and ensured no medications were accessed. On 10/02/24 at approximately 9:15 a.m., once outside R49's room, RN Q was asked about leaving the medication cart unlocked and unattended while they were in R49's room, administering their medications. RN R observed the unlocked drawer, and responded, Yes. I forgot. Someone could get into it and take medications . RN Q showed Surveyor the narcotic drawers were locked on the medication cart, which ensured no one had access to narcotic medications, however had access to both pharmaceutical and over the counter medications. On 10/02/24 at approximately 11:00 a.m., the Director of Nursing (DON) was asked about the medication cart being left unlocked and unattended during the morning medication pass of R49's medications. The DON acknowledged the concern, and the potential for unauthorized access to the medication cart for non-narcotic medications. Review of the policy, Medication Storage, revised 1/30/24, revealed, It is the policy of this facility to ensure all medications housed on our premises will be stored according to the manufacturer's recommendations and sufficient to ensure proper sanitation, temperature, light, ventilation, moisture control, segregation, and security. Policy Explanation and Compliance Guidelines. 1. General Guidelines. a. All drugs and biologicals will be stored in locked compartments (i.e. medication carts, cabinets, drawers, refrigerators, medication rooms) under proper temperature controls. b. Only authorized personnel will have access to the keys to locked compartments (see attached listing). c. During a medication pass, medications must be under the direct observation of the person administering medications or locked in the medication storage area/cart .

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44750 Based on observation,interview and record review, the facility failed to maintain complete and accurate medical records for two residents (R5 and R60) out of two reviewed for medical records. Findings include: R5 A review of the medical record revealed that R5 admitted into the facility on [DATE] with the following medical diagnoses, Recurrent Dislocation, Left Shoulder and Pain in Left Shoulder. A review of the Minimum Data Set assessment (MDS) revealed a Brief Interview for Mental Status score (BIMS) of 12/15 indicating an impaired cognition. R5 also required staff assistance with transfers and bed mobility. Further review of the physician's orders revealed the following active orders, Sling and Swathe to left upper extremity at all times. May remove for skin checks and showers. Status: Active. Ordered:2/9/2023. Apply arm sling to left upper extremity when out of bed, adjust snug to chest. Check for circulation after each application. Only Apply when resident is out of bed. Status: Active. Ordered: 9/17/2024. On 10/3/2024 at 9:17 AM, an interview was conducted with Unit Manager (UM) A. UM A stated the order dated 9/17/2024 was the active one because they had a follow up with orthopedics. UM A stated they would discontinue the other order. R60 A review of the medical record revealed that R60 admitted into the facility on [DATE] with the following medical diagnoses, End Stage Renal Disease and Atrial Fibrillation. A review of the MDS revealed a BIMS score of 14/15 indicating an intact cognition. R60 also required staff assistance with transfers and bed mobility. Further review of the physician orders revealed the following active orders, Resident has hemodialysis on M-W-F at DaVita; Chair time is at 10:30am. Resident to be up and ready to be there at 09:45am; Bring [NAME] for transferring into chair while at DaVita. Lidocaine 2.5% and prilocaine 2.5% cream apply to left AV fistula and wrap with saran wrap from kitchen 1 hour prior to leaving for dialysis. On 10/2/2024 at 9:32 AM, an interview was conducted with R60. R60 stated they were no longer receiving dialysis because they were on hospice and elected to stop. R60 stated they have to tell staff that may not know them that they do not have to get up because they are no longer on dialysis. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235370	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/03/2024
NAME OF PROVIDER OR SUPPLIER: Medilodge of St Clair		STREET ADDRESS, CITY, STATE, ZIP CODE: 4220 S Hospital Dr, East China, MI 48054	

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/3/2024 at 9:17 AM, an interview was conducted with Unit Manager (UM) A. UM A stated that all the orders should have been discontinued and that they will get rid of them. On 10/3/2024 at 12:04 PM, an interview was conducted with the Director of Nursing (DON). The DON stated R60 is no longer on dialysis and that they will have to discontinue those orders.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235370	A. Building B. Wing	10/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of St Clair	4220 S Hospital Dr East China, MI 48054

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 49699 Based on observation, interview, and record review the facility failed to follow infection prevention and control guidelines for glove use for one (R92) of one resident reviewed for infecton control. Findings include: On 10/2/24 at 7:40 AM, RN J was observed providing a subcutaneous injection to R92 without wearing gloves during a community breakfast. On 10/3/24 at 10:30 AM, the Infection Control and Prevention Practitioner (ICP) I was queried regarding the need for gloves during any injection. ICP I revealed gloves are required for IM injections, not necessarily for subcutaneous (insulin) injections. On 10/3/24 @ 11:30 AM, the Director of Nursing (DON) was queried regarding giving injections without gloves. The DON revealed that giving a subcutaneous injection (insulin) without gloves was OK. A review of the Infection Prevention and Control Program Policy, dated, Reviewed/Revised: 10/25/2022, under the subtitle Standard Precautions, revealed Licensed staff shall adhere to safe injection and medication administration practices, as described in relevant facility policies. The Center for Disease Control, (CDC) recommendations titled, Considerations for Blood Glucose Monitoring and Insulin Administration | Injection Safety | CDC revealed under the heading Hand Hygiene, wear gloves during blood glucose monitoring and during any other procedure that involves potential exposure to blood or body fluids.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235370	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/03/2024
NAME OF PROVIDER OR SUPPLIER Medilodge of St Clair		STREET ADDRESS, CITY, STATE, ZIP CODE 4220 S Hospital Dr East China, MI 48054	

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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 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22960 Based on observation, interview, and record review, the facility failed to maintain a pest-free environment, resulting in flies in the facility and resident complaints. This deficient practice had the potential to affect all residents in the facility. Findings include: On 10/1/24 at 2:45 PM, there were several flies observed in the 100 hallway. On 10/1/24 at 2:50 PM, the window in room [ROOM NUMBER] was observed to be open. The exterior screen frame was observed to be bent, leaving an approximately 1 inch gap. The screen was not tight-fitting, to prevent pest entry into the room. On 10/1/24 at 3:00 PM, Maintenance Supervisor V confirmed the bent screen, and stated he would take care of it right away. Maintenance Supervisor V stated that he was unaware of any current fly issue in the facility. Review of a Quality Assistance Form dated 4/4/24 noted: Details: Rm 224-2 .screen has gap and not fitting frame of window. Would like to open window when weather permits .Plan of Action: .unable to bend frame back. 40330 On 10/01/24 at 10:12 a.m., R64 was observed in their room seated in a reclining manual wheelchair. Two flies landed on Resident 64, who reported this bothered them. R64 attempted to swat them away however had trouble moving their arms due to decreased range of motion of their elbows and hands, which were flexed. On 10/01/24 at approximatley 10:15 a.m., Certified Nurse Aide (CNA) S was asked about the flies landing on R64. CNA S stated R64's room (117) and the room across the hall (118) were really bad with the flies. CNA explained, I have noticed flies in these two rooms. CNA S reported they had told maintenance over a couple weeks ago, and it bothered R64. CNA S stated, I am not sure where they are coming from.