STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235416	A. Building B. Wing	08/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Sterling	500 School Rd Sterling, MI 48659

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37668 Based on interview and record review, the facility failed to accurately record and obtain code status (level of medical interventions that an individual wishes to have enacted in a medical emergency situation) documentation for two residents (Resident #29 and Resident #35) of three residents reviewed for Advance Directives (legal documentation enabling an individual to specify end-of-life care decisions), resulting in lack of accurate assessment and documentation of code status and the potential for a Resident to receive life sustaining medical treatment against their wishes. Findings include: Resident #29: Record review revealed Resident #29 was admitted to the facility on [DATE] with diagnoses which included heart failure, anxiety, cognitive communication deficient, and dementia. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the Resident was cognitively intact and required moderate to substantial assistance with bathing and dressing. Review of Resident #29's Electronic Medical Record (EMR) revealed the Resident's code status was DNR. Resident #29 did not have a care plan in place pertaining to code status. A Do Not Resuscitate Order Declarant (Resident) Consent form was noted in Resident #29's EMR. The form was signed by Resident #29 on 4/25/23 and Physician K on 5/1/23. Further review of Resident #29's EMR revealed a Decision Making Determination Form specifying Resident #29 was Uncapable of making decisions regarding medical treatment . based upon . inability to understand the disease process and implication of procedures and treatments, or refusal of treatment . The incompetency determination was signed by Physician L on 8/17/21 and 8/24/21. Resident #35: (continued on next page)

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review revealed Resident #35 was admitted to the facility on [DATE] with diagnoses which included cerebral infarction (stroke) with left sided paralysis, epilepsy, depression, anxiety, dysphagia (difficulty swallowing). Review of the MDS assessment dated [DATE] revealed the Resident was moderately cognitively impaired and required maximum to total assistance for hygiene, toileting, and transferring. Resident #35's EMR indicated Full Resuscitate as the Resident's code status. Review of Resident #35's EMR revealed a Decision Making Determination Form specifying the Resident was not capable of making medical treatment decisions. The form was signed by one Physician on 6/1/23 and a second, supporting Physician on 10/24/23. Additional documentation detailed, Family Member N was Resident #35's Durable Power of Attorney and patient advocate. Further review of Resident #35's EMR revealed a form titled, Advance Directive/Medical Treatment Decisions. Under the Advance Directive section of the form, Do Not Resuscitate was checked and initialed with the date 2/2/24. Another box was checked specifying, I do not choose to formulate or issue any Advance Directives at this time with Full Code written above the statement. The form was signed by Family Member N and a Facility Registered Nurse RN on 2/2/24. An interview was completed with Social Services Designee RN O on 8/21/24 at 8:42 AM. Social Services Designee RN O was asked if a Resident who has been deemed incompetent to make medical decisions is able to sign Advance Directive documentation to be a DNR, Social Services Designee RN O verbalized that if a Resident is deemed incompetent, their DPOA and/or guardian should sign the document. When queried regarding Resident #29's code status, Social Services Designee RN O indicated the Resident was a DNR. Resident #29's Do Not Resuscitate Order Declarant (Resident) Consent form and Decision Making Determination Form were reviewed with Social Services Designee RN O. When why Resident #29 signed the DNR order in 2023 when they were deemed incompetent in 2021 if a Resident who is deemed incompetent is not able to make medical decisions, Social Services Designee RN O confirmed the DNR order should have been signed by the Resident's Representative. Social Services Designee RN O revealed Resident #29 come to the facility from a different facility and stated they accepted the documentation from the other facility. When asked if they checked the documentation for accuracy, Social Services Designee RN O did not provide a direct response but reiterated the documentation was completed at another facility. Resident #35's Advance Directive/Medical Treatment Decisions form was reviewed with Social Services Designee RN O at this time. When queried regarding the form indicating the Resident was both a DNR and full code, Social Services Designee RN O verbalized they could not be. Social Services Designee RN O stated, Think an error on the form. When queried regarding the concern pertaining to the conflicting documentation of the Resident's code status on the form, RN O verbalized understanding. On 8/21/24 at 9:36 AM, an interview was completed with the Director of Nursing (DON). When queried regarding Resident #29 and 35's Advance Directive documentation and Code Status, the DON verified concern and verbalized understanding.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 37668 Based on interview and record review, the facility failed to implement and operationalize policies and procedures to ensure prompt attending physician's review of pharmacy recommendations and documentation of rationale for lack of action related to pharmacy medication irregularity recommendation reports for one resident (Resident #11) of five residents reviewed for unnecessary medications, resulting in Resident #11 receiving double the recommended medication dosage, the potential for Adverse Drug Reactions (ADR), and additional medication errors despite pharmacy oversight. Findings include: Resident #11: Record review revealed Resident #11 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included Congestive Heart Failure (CHF), heart attack, anxiety, and weakness. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the Resident was moderately cognitively impaired, always continent of bowel and bladder, and was independent with Activities of Daily Living (ADL) with the exception of set-up to supervision for bathing and ambulation. Review of Resident #11's Electronic Medical Record (EMR) revealed Monthly Medication Reviews (MMR) were completed by pharmacy staff in a progress note. Any pharmacy recommendations related to medication regimen abnormalities were documented on a Note to Attending Physician/Provider and scanned into the EMR. Review of Note to Attending Physician/Provider from the pharmacy, dated 7/4/24 revealed Resident #11 was receiving Detrol LA (prescription medication used to treat overactive bladder) Oral Capsule Extended Release (ER) 24-hour 4 mg (milligram) . Give 1 capsule by mouth every day and evening shirt for bladder spasm. The pharmacy recommendation detailed, The maximum for ER caps is 4 mg QD (every day). The maximum for IR (Immediate Release) tablets is 2 mg BID (twice a day). Please review for reduction to Detrol LA (ER 24 hr) 4 mg once daily. The Physician/Prescriber Response on the form detailed, Continue same as ordered with no rationale and was signed by the provider on 8/6/24. On 8/8/24, the pharmacy sent another Note to Attending Physician/Provider pertaining to Resident #11's Detrol LA ER dosage of 4mg BID. The pharmacist added, The current regimen increases anticholinergic burden (associated with poor health outcomes, especially in the elderly, including increased risk of falls, dementia, and death) due to being double the FDA-approved maximum (dose). Please review for reduction to Detrol LA (ER 24 hr) 4 mg once daily. The Physician/Prescriber Response on the form was dated 8/13/24 and detailed, Change to 2 mg BID - IR tablets. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was completed with the Director of Nursing (DON) on 8/21/24 at 12:00 PM. When queried regarding Resident #11's Detrol LA order being double the recommended dosage and the Health Care Provider not providing a rationale for not following the pharmacy recommendation to reduce the ordered dosage, the DON did not provide an explanation. When queried regarding the facility policy/procedure related to the length of time providers have to review pharmacy recommendations, the DON indicated they believed they had a month. The DON was then queried regarding the pharmacy recommendation dated 8/8/24 related to the same reduction and asked why the medication was changed at that time but not previously and indicated they did not know as a rationale was not provided for continuing the medication by the provider on the July form. Review of facility policy/procedure entitled, Addressing Medication Regiment Review Irregularities (Reviewed/Revised: 12/28/23) revealed, It is the policy of this facility to provide a Medication Regiment Review (MRR) . to identify irregularities and respond in a timely manner to prevent the occurrence of an adverse drug event . 4. 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 . d. The Attending physician must document in the resident medical record that the identified irregularity has been reviewed and what, if any action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. e. The pharmacist does not need to document a continuing irregularity in the report each month if the attending physician has documented a valid clinical rationale for rejecting the pharmacist's recommendation. 5. The report should be submitted to the DON within 10 working days of the review. 6. Timeliness of the notification of irregularities depends on factors including the potential for or present of serious adverse consequences .

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 39059 Based on observation, interview and record review, the facility failed to provide appropriate medication administration and storage of insulin for one resident (Resident #139) and two inhalers for one resident (Resident #23), resulting in the likelihood of decreased medication efficacy and side effects such as mouth discomfort and/or mouth infection. Findings include: On 8/21/24, at 7:52 AM, During medication administration task, Nurse I prepared medications for Resident #23 which included Breo Ellipta and Spiriva inhalers. Nurse I entered Resident #23's room and provided one puff of Breo Ellipta inhaler and then provided two puffs of the Spiriva inhaler 15 seconds later. The required one minute during the two inhalers was not provided. Nurse I did not offer to the resident to rinse their mouth after the inhaler use. Nurse I returned to the medication cart and placed the inhalers into their corresponding boxes for storage. On 8/21/24. At 8:11 AM, Nurse H prepared morning medications for Resident #139. Nurse H gathered the Lantus insulin via insulin pen. Nurse H removed the cap, cleaned with an alcohol wipe, attached the pen needle, dialed the pen to 40 units. Nurse H did not dial the pen to 2 units which is required to prime the needle. Nurse H administered the Lantus insulin pen into the center of the deltoid at a 90-degree angle. On 8/21/24, at 2:00 PM, a record review of Resident #139's electronic medical record revealed an admission on 08/06/2024 with diagnoses that included Diabetes, Morbid Obesity and Muscle Weakness. Resident #139 had intact cognition and required assistance with Activities of Daily Living. A review of the Physician orders revealed Lantus SoloStar 100 UNIT/ML Solution pen-injector Inject 40 unit subcutaneously . A review of the Lantus pen instructions revealed DO A SAFETY TEST Always perform the safety test before every injection. This removes air bubbles and ensures the pen and needle are working properly 1. Select a dose of 2 units by turning the dosage knob . After your safety test, make sure the dose window reads 0. On 8/21/24, at 2:30 PM, a record review of Resident #23's electronic medical record revealed an admission on 03/05/2024 with diagnoses that included Chronic Respiratory Failure, Heart Failure and Chronic Obstructive Pulmonary Disease. Resident #23 had intact cognition and required assistance with Activities of Daily Living. On 8/21/24, at 3:00 PM, the Director of Nursing (DON) was asked to provide the pharmacy instructions for administration on both the Breo Ellipta and Spriva inhalers. The DON was alerted Nurse I did not provide wait time between the puff of the two different inhalers nor offer to the resident to rinse their mouth. On 8/21/24, at 3:15 PM, Resident #23 was sitting in their room and was asked if they have ever rinsed their mouth after an inhaler and Resident #23 stated, no they never have told me. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility provided Inhalers - What You Need To Know information sheet revealed . If more than (1) puff is required, (whether the same or different medication), there should be a waiting time of approximately (1) minute between puffs . for steroid inhalers, provide a cup of water for resident to rinse and spit back into the cup . clean mouth piece with water and store following manufacturer's recommendations . A review of a provide email from the pharmacy to the DON revealed . Breo Ellipta - Inhaled corticosteroid . Wait 1 minute between Spiriva Respimat and Breo Ellipta

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37668 Based on observation, interview and record review, the facility failed to provide palatable and appealing food per preference for one resident (Resident # 35) of two residents reviewed and seven of seven confidential group Residents resulting in feelings of frustration and verbalization of discontentment. Findings include: Resident #35: On 8/19/24 at 2:13 PM, an interview was completed with Resident #35 in their room. When queried regarding the food in the facility, Resident #35 stated, Food is horrible. Resident #35 was asked what is horrible about the food and replied, It's cold and doesn't taste good. Record review revealed Resident #35 was admitted to the facility on [DATE] with diagnoses which included cerebral infarction (stroke) with left sided paralysis, epilepsy, depression, anxiety, dysphagia (difficulty swallowing). Review of the MDS assessment dated [DATE] revealed the Resident was moderately cognitively impaired and required maximum to total assistance for hygiene, toileting, and transferring. 39059 Resident Council: On 8/20/24, at 3:46 PM, During resident council, the entire group complained of the following: no choice for food items the portion sizes are small the menu repeats they give you a time limit on picking an alternative the confetti eggs were awful, it was like wet custard but eggs with red and green sprinkles on top we don't get menus for our room you get what you get we don't get real butter we'd like real creamer for our coffee (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	I want a whole banana; we get banana cut up in a dish we want fresh fruit we're sick of canned fruit we get lots of macaroni unless you look at the menu on the wall, you don't know what you're getting The entire group complained of not having menus and that they must look on the wall as to what is on the menu. They complained they do not have menus in their rooms. The group was asked if they could order from an alternative menu if they didn't like what they were served, and the entire group complained that there was a time cut off for making a second choice. The group was asked to explain what the time limit meant, and they complained that they have to pick by certain times in advance for a second choice. For example, the night before for breakfast. The group was asked if they changed their mind once the meal was served could they get something different and the group quickly responded, NO. They complained that the staff say it's too late for that. On 8/21/24, at 8:09 AM, a breakfast tray observation revealed the following items: 1 small scoop of eggs which appeared to be too moist as they were unable to be forked off the plate; hash brown patty with the center not crispy and slightly soggy; 1 piece of buttered wheat toast; a small bowl of corn flakes, 1 cup of milk, 1 cup of coffee that was luke warm, 2 sugar, 1 jelly and 3 dry creamer packs. There was no salt nor pepper provided. On 8/21/24, at 9:18 AM, Registered Dietician (RD) S was asked to explain food choices for the residents. RD S offered that there is an always menu they can select options from. RD S was asked if there were any rules with the always menu and RD S offered, they can talk to staff but unsure how they ordered from the alternative menu. RD S was alerted the residents would like fresh fruits and that they all complained about the taste and appearance of the confetti eggs. RD S was asked what type of eggs the facility provides and RD S stated, we have fresh and powdered eggs. On 8/21/24, at 1:51 PM, just prior to exit, two residents were in the hallway and were overheard making complaints about the lunch served that day. The overheard complaints were did you eat the lunch today? I didn't and No, it was junk I didn't eat either. On 8/21/24, at 2:30 PM, a record review of the facility provided Lunch and Dinner Alternatives document revealed Lunch requests must be made no later than 8:30 am Dinner requests must be made no later than 2:30 PM If a request is placed after cut off time, a sandwich of cook's choice will be served instead . Please note that depending on demand this menu could be subject to change and sometimes we may be out of a certain product. We strive to make you happy and will re-stock ASAP. A second document revealed Ala Carte Menu Great Alternatives for you to choose from Breakfast: breakfast requests must be in by 7 PM the evening before Hot Cereal- Oatmeal or cream of wheat served with syrup or brown sugar as requested Cold Cereal-Fruit loops, cheerios, or corn flakes Eggs-Scrambled, Hard Boiled or Fried with Toast and Jelly. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the recipe for CONFEET EGGS 1 0Z (ounce) . Whole liquid egg . 3 1/4 Quart GREEN PEPPERS, CHOPPED . 3/4 Cup DICED SWEET RED PEPPERS . 3/4 cup .COMBINE EGG, GREEN PEPPER, AND SWEET RED PEPPER. STIR UNTIL VEGETABLE ARE EVENLY DISTRIBUTED . Portion Size: 1/4 CUP .

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37668 Based on observation, interview and record review, the facility failed to: 1. Properly label and date food and food products, 2. Dispose of expired food and food products, 3. Thoroughly dry dishes prior to stacking, and 4. Ensure air gap for ice machine drainage pipe, resulting in the potential for cross-contamination and foodborne illness. These deficient practices have the potential to affect 37 residents who receive food from the kitchen. Findings Include: During a tour of the facility kitchen on [DATE], beginning at 9:04 AM, the following items were noted: - Kitchen Aid stand mixer was uncovered and not in use. When the mixer was tilted back, chunks of dried food substances were observed. - The floor appeared dirty with a build up of unknown substances and dirt behind the tables, oven, and near the walls. A palpable film of grease was present on the interior lip of the stove/oven hood. Visible cobwebs and dust were observed in various areas of the interior of the oven/stove hood. - Open and Undated bottle of Apple Cider Vinegar. When queried if the product is supposed to be dated by dietary staff, Dietary Staff R indicated it was. Dietary Staff R confirmed the Apple Cider Vinegar was not dated and indicated they would need to discard it. A tour of the tall refrigerator in the main kitchen area was completed with Dietary Manager G. The following items were identified in the refrigerator: - Three open and undated 46-ounce (oz) containers of Thickened Lemon Water. Manager G was asked if the containers of thickened water are supposed to be dated when opened and confirmed they should be. Manager G did not provide further explanation but indicated the product was not able to be used and they would dispose of the product. - A 20 oz container of Apple Butter with Opened: [DATE]; Expired: [DATE] written on the container. When queried if the Apple Butter was expired, Manager G confirmed it was. When asked why the food product was still in the refrigerator, Manager G did not provide an explanation but indicated they would dispose of it. - A gallon of 2% milk with no open date on the container. When queried if milk is supposed to be dated when opened, Manager G verbalized is should be. When asked why it was not dated, an explanation was not provided. A tour of the dry storage area was completed with Dietary Manager G. The following items were identified: - Open 16 oz container of mustard with the date, Use by [DATE] on it. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- Open 32 oz container of Vanilla with the date, Use by [DATE] on it. Dietary Manager G was asked about the mustard and Vanilla and verbalized the food products should have been thrown away on the date indicated on the packages. - A box of bananas was noted on a shelf in the dry storage room. The box had a black substance in it and the peel on one banana was split open. When queried regarding the bananas, Manager G disposed of the banana with the split peel and indicated the facility would be receiving their delivery the following day. The dishwashing and drying area was toured with Dietary Manager G. Cups with visible water and moisture were stacked on top of each other on a rack. When asked, Dietary Manager G revealed the area where the cups were stacked were for clean dishes. When queried regarding the visible water and moisture present in the stacked cups, Dietary Manager G stated, Not okay. Will have to rewash. Under the three-compartment sink, in the main area of the kitchen, the drain cover in the floor was pushed to the side, off the drain hole and a PVC pipe was positioned directly in the drain hole. A second, small piece of PVC pipe was connected to the PVC pipe positioned in the drain with a zip tie. The second piece was pushed to the side and appeared to be a makeshift stand for the drainage pipe. There was no air gap observed. Dietary Manager G was queried what the drainage pipe was for and why the drain cover was not in place over the drainage hole and replied, Not sure. When queried how long the pipe had been like that, Manager G and Staff R revealed it had been that way for quite a while but were unable to provide a specific timeframe. Dietary Manager G proceeded to move the drain cover back in place over the drainage hole. The PVC drainage pipe was then positioned directly on top of the drain cover with no air gap present. When queried what the pipe was for, Director G indicated they were unsure. Further visual inspection of the area under the three-compartment sink revealed multiple cobwebs in the area and in the corner. On [DATE] at 12:00 PM, an interview and observation of the kitchen drainage pipe and drain cover was completed with Maintenance Director J. When queried regarding the drainage pipe being positioned directly on top of the drainage grate with no air gap, Maintenance Director J stated, That is from the ice machine. When queried regarding the smaller PVC pipe connected to the drainage pipe with a zip tie, Maintenance Director J moved the smaller piece of PVC pipe around the pipe and stated, I think they put it to the side because it (drainage pipe) started sagging. Maintenance Director J proceeded to point out where the drainage pipe was attached to the wall and was sagging in areas. When queried regarding the drain cover being moved off the hole and the drainage pipe being positioned directly inside the drainage hole and why the drain cover was not secured, Maintenance Director J was unable to provide an explanation. An interview was completed with Maintenance Director J on [DATE] at 11:06 AM. Maintenance Director J indicated they worked on the drainage pipe and stated, Resecured it and made sure it has a downslope. It has an air gap now. When asked if the drainage pipe should have an air gap, Maintenance Director J stated, Yes. Maintenance Director J was then asked if they completed rounds in the kitchen and replied, Yes. When asked why the drain cover was moved to the side with drainage pipe was positioned in the drain hole when they are completing rounds in the kitchen, Maintenance Director J replied, Needed to be reattached. No further explanation was provided. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	An interview was completed with the facility Administrator and Director of Nursing (DON) on [DATE] at 4:00 PM. When queried regarding observations in the kitchen of undated/outdated food products, drain cover, drainage pipe/lack of air gap, cobwebs/dirt, grease, and cups stacked with visible water/moisture, the Administrator and DON verbalized understanding of concerns and indicated the concerns would be addressed. Review of facility policy/procedure entitled, Kitchen Sanitation (Reviewed/Revised: [DATE]) revealed, The food service area shall be maintained in a clean and sanitary manner . 1. Kitchens, kitchen areas and dining areas shall be kept clean, free from litter and rubbish . 2. Utensils, counters, shelves and equipment shall be kept clean, maintained in good repair . Review of facility policy/procedure entitled, Food Receiving and Storage (Reviewed/Revised: [DATE]) revealed, Foods shall be received and stored in a manner that complies with safe food handling practices . 1. Food Services . will maintain clean food storage areas . 7. Foods stored in the refrigerator or freezer will be covered, labeled and dated ('opened on and 'use by' date). Whole produce will have a received date and freshness will be monitored by texture and appearance and discarded as appropriate .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235416	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Sterling	500 School Rd Sterling, MI 48659

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37668 Based on observation, interview and record review, the facility failed to implement and operationalize a comprehensive infection control program encompassing outcome and process surveillance, resulting in a lack of accurate and comprehensive infection control tracking including potential infections, surveillance and data monitoring/analysis, appropriate Personal Protective Equipment (PPE) use, lack of implementation of water management sample recommendations, contamination of linens, and the likelihood for spread of microorganisms and illness to all 37 facility residents. Findings include: An interview and review of facility Infection Control (IC) data was completed with IC Registered Nurse (RN) B and the Director of Nursing (DON) on 8/21/24 at 1:12 PM. When queried regarding process surveillance for January 2024, IC RN B provided six audit forms for hand hygiene as well as Verification Checklist-Therapy Gym Cleaning completed by Therapy Staff and Verification Checklist-Kitchen Observation forms completed by Dietary Manager G. Review of the hand hygiene audit forms revealed two of the audits were completed by Dietary Manager G for Dietary Staff and four audit forms were completed by facility nurses for Certified Nursing Assistants (CNA). When queried what shifts audits were completed, IC RN B revealed all the audits were completed on the day or afternoons shifts. An explanation was not provided when asked why audits were not completed on midnight shift. IC RN B was asked what is one of the most important things that people can do to prevent the spread of infection, IC RN B replied, Washing hands. With further inquiry regarding the facility process/procedure for process surveillance including what audits were completed on a monthly basis, IC RN B revealed they do not do hand hygiene audits every month but do complete surveillance monthly. When asked if laundry was completed in the facility, IC RN B confirmed it was. When queried if they completed process surveillance/audits of laundry facilities/procedures, IC RN B replied they do not do official audits. With further inquiry regarding how they determine if linen is processed, stored, and handled in a manner to prevent contamination and the spread of microorganisms, IC RN B verbalized they go in the laundry room but do not have an official audit. IC RN B was then queried regarding the facility policy/procedure related to Enhanced Barrier Precautions (EBP) and if Personal Protection Equipment (PPE) should be utilized when providing care for an indwelling urinary catheter, and stated, Yes, should. IC RN B then revealed they were aware staff had not worn PPE when providing care to a resident with EBP in place. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility Outcome Surveillance data for January 2024 was reviewed with IC RN B at this time. IC RN B provided a handwritten form titled, Line Listing of Resident Infections, a printed Order Listing Report for Antibiotic Orders and an infection map. The number of resident infections included on the line list did not match the number of infections indicated on the mapping tool. When queried regarding the discrepancy, IC RN B reviewed the data and indicated they missed marking infections on the map. The line listing for January 2024 did not include any carry over infections from December 2023. However, a review of the December 2023 Line Listing of Resident Infections revealed there was one carry over infection into January 2024. Further review of the January 2024 Line Listing of Resident Infections included six Residents and seven infections including four Healthcare Acquired Infections (HAI). There were no residents with signs/symptoms of infections not receiving antimicrobial treatment included on the tracking/surveillance form. The Order Listing Report included two Residents not included on the Line List of Resident Infections. Per the Order Listing Report, the Residents not listed on the Line List of Resident Infections were receiving nystatin powder (anti-fungal medication) and rifaximin (antibiotic medication used to treat irritable bowel syndrome, travelers' diarrhea, and to reduce the risk of overt hepatic encephalopathy-liver dysfunction) with the indication for liver. When queried how they track and complete surveillance of residents with signs/symptoms of infection for identification and prevention of spread who are not receiving treatment, IC RN B replied, Not tracking signs/symptoms of potential infections. When asked why not, IC RN B indicated they track actual infections that are treated. With further inquiry related to outcome surveillance, IC RN B revealed they do not include residents who have orders for nystatin powder because it is not a real infection. When queried if a fungal infection on the skin is transmittable to others, IC RN B and the DON confirmed it could be. When queried if everyone with the common cold and/or other sign/symptoms of gastrointestinal illness always receives antimicrobial treatment, IC RN B verbalized they do not. When asked, IC RN B and the DON confirmed the pathogens/illnesses are able to be transmitted to others and cause illness. IC RN B and the DON verbalized understanding of the importance of surveillance and tracking of potential illness and signs/symptoms of infection. Review of the Monthly Analysis and Summary/QAPI Committee Infection Prevention/Control Report for January 2024 specified there were three HAI infections. IC RN B was then queried regarding their role in the facility water management plan including monitoring for and preventing the spread of waterborne pathogens including legionella and revealed they were not involved in the water management plan. With further inquiry, IC RN B stated, Maintenance does the water testing and would let know me if we have any issues. IC RN B was asked how frequently water testing is completed and stated, Not sure. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility water management plan was requested at this time. Maintenance Director J provided the facility Water Management Plan binder. The binder included Legionella water sampling testing results titled, Certificate of Analysis. The collection dates of Legionella testing since the last annual survey were dated: 10/11/23, 4/15/24 and 7/23/24. The results for each date included Pre and Post results from the Central Bathroom. The form did not detail the source of the water from the central bathroom. When queried what pre and post meant, Maintenance Director revealed they obtain samples before and after allowing the water to run. The sample dated as collected 10/11/23 detailed a positive result of 0.4 CFU/mL (Colony-Forming Units/milliliter) of Legionella species was identified and grown in the Post water sample. The Certificate of Analysis testing result form detailed, Action Criteria for Legionella . Detectable, but < 1 . Suggested Remedial Action: Potable Water: 2 . Implement action 1. (Review routine maintenance program recommended by the manufacture of the equipment to ensure that the recommended program is being followed. The present of barely detectable number of Legionella represents a low level of concern.) Conduct follow-up analysis after a few weeks for evidence of further Legionella amplification. The level of Legionella represents little concern, but the detected indicated that the system is a potential amplifier of Legionella . When queried if they were aware of the positive water testing results with Legionella growth, both the DON and IC RN B verbalized they were unaware of the result. When queried what actions were taken and if follow-up analysis of the water was completed, both the DON and IC RN B indicated they did not know. Maintenance Director J was contacted by the DON and returned. When asked about the positive Legionella testing results collected 10/11/23 and actions taken following the results including follow up testing, Maintenance Director J verbalized retesting was not completed beyond routine testing and indicated they did not need to complete follow up testing. When queried regarding the Remedial Actions included on the Certificate of Analysis test results, Maintenance Director J did not provide further explanation. When queried why only the central bathroom was tested and why water samples were not obtained, an explanation was not provided. The DON confirmed remediation actions should have been completed and stated, It's a learning experience. When queried regarding respiratory illness signs and systems and potential Legionella infection, IC RN B and the DON verbalized understanding of the importance of coordination and active involvement of the IC Nurse in the Water Management program. Review of facility provided policy/procedure entitled, Infection Prevention and Control Program (Reviewed/Revised: 12/27/23) revealed, The facility has established and maintains an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections . 3. Surveillance: a. A system of surveillance is utilized for prevention, identifying, reporting, investigating, and controlling infections and communicable diseases . b. The Infection Preventionist serves as the leader in surveillance activities, maintains documentation of incidents, findings, and any corrective actions made by the facility and reports surveillance findings . 12. Linens . staff shall handle, store, process, and transport linens to prevent spread of infection . 16. Water Management: a. A water management program has been established as part of the overall infection prevention and control program . (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the facility provided policy/procedure entitled, Water Management Program (no date) detailed, It is the policy of this facility to establish water management plans for reducing the risk of Legionella and other opportunistic pathogens in the facility's water systems . 1. A water management team has been established to develop and implement the facility's water management program, including facility leadership, the Infection Preventionist, maintenance employees, safety officers, risk and quality management staff, and Director of Nursing . 3. A risk assessment will be conducted by the water management team annually to identify where Legionella and other opportunistic waterborne pathogens could grow and spread in the facility's water systems . 39059 Linen: On 8/19/24, at 12:34 PM, CNA P was observed exiting the linen closet with a pile of clean linen in their right arm. The linen was touching their uniform and was uncovered. CNA P entered into room [ROOM NUMBER] and exited without the linen. CNA P gathered washcloths/clean linen and was asked what they planned to do with the 2 piles of linen they had carried into room [ROOM NUMBER] and CNA P offered, I'm changing her. Enhanced barrier: On 8/20/24, at 11:10 AM, Resident #20 was sitting in their wheelchair in their room which was an enhanced barrier room. They had a urinary catheter. CNA P entered the room to answer their call light. Resident #20 offered they wanted to sit in their recliner. Moments later, CNA P entered the room pushing a Hoyer lift with a bed pad in their right hand that was touching the Hoyer lift. CNA Q entered to assist. CNA Q placed gloves on but no gown. CNA P did not place gloves or a gown. The two CNA's assisted the resident into the recliner with their uniforms touching the bed and also the recliner. Once the resident was sitting in the recliner. CNA P entered the bathroom and placed gloves on, removed the urinary catheter bag and placed onto the recliner. CNA P then entered the bathroom and returned with paper towels and a graduate with the same gloves on. CNA P emptied the urine into the graduate and wiped the catheter bag tubing with a paper towel before they dumped it into the toilet. CNA P still did not place on a gown. On 8/20/24, at 11:45 AM, a record review of Resident #20's electronic medical record revealed an admission on 3/13/2024 with diagnoses that included muscle weakness, Chronic Obstructive Pulmonary Disease and [NAME] Prostactic Hyperplasia. A review of the physician orders revealed Use enhanced barriers while performing high-contact activity with the resident . Order Status Active Order Date 07/18/2024 . On 8/21/24, at 11:00 AM, the Director of Nursing (DON) was alerted of the lack of Personal Protective Equipment (PPE) during care of Resident #20 and the DON offered that they should have had PPE on and that Infection Control Nurse had already started education.