STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235541	A. Building B. Wing	03/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Lodge at Taylor	22950 Northline Rd Taylor, MI 48180

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34901 Based on interview and record review, the facility failed to notify the physician and report abnormally elevated blood sugar levels as ordered for one resident (R103) out of three residents reviewed for diabetes mellitus management, resulting in the physician not having the opportunity to timely participate in medical decisions regarding care and treatment. Findings include: A review of the clinical record documented Resident #103 (R103) was admitted into the facility on [DATE] and discharged on [DATE]. R103's diagnoses included dysphagia, end stage renal disease, acute respiratory failure with hypoxia, type 2 diabetes mellitus, unspecified convulsions, local infection of the skin and subcutaneous tissue, anoxic brain damage, resistance to multiple antimicrobial drugs, gastrostomy status (use of a feeding tube), and stage 4 pressure ulcer of sacral region. Record review of R103's Impaired metabolic status related to diabetes, hyperlipidemia care plan initiated on 1/11/24 documented the following intervention, monitor glucose levels per orders. A review of R103's physician orders documented in part to inject Humalog insulin (fast acting insulin) per sliding scale. For blood sugars above 401 call the physician. Order start date 1/11/24. Order end date 1/19/24. On 3/27/24 at 1:07 PM, License Practical Nurse (LPN) E said that nurses are to follow the guidelines for contacting the physician based upon whatever the physician ordered. If there were no orders written, nurses would usually contact the physician if the resident's blood sugar was below 70 or above 400. On 3/28/24 at 11:17 AM during an interview and record review with the Director of Nursing (DON), a review of R103's January 2024 Medication Administration Record documented that on January 17, 2024, at 12:00 AM and 6:00 AM, R103's blood sugar values were 459 and 436 respectively. The DON said the physician should have been notified about the hyperglycemia (high blood sugar). After reviewing R103's clinical record the DON stated, I don't see where they called the doctor. The DON added that hyperglycemia was a change in a resident's condition and because the resident was on a tube feeding, his blood sugars should be pretty consistent. (continued on next page)

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

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/28/24 at 1:00 PM during the exit conference, the Nursing Home Administrator and DON were asked if there was any additional documentation or information that the facility would like to provide prior to the end of the survey, and they reported there was not.

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F 0686 Level of Harm - 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** 34901 This citation pertains to Intake MI00143341. Based on interview and record review, the facility failed to implement adequate interventions in a timely manner for one resident (R103) deemed to be at very high risk for pressure ulcers out of five residents reviewed for wound care, resulting in the worsening of an existing stage 4 pressure ulcer. Findings include: It was reported to the State Agency that a resident was not receiving appropriate wound care treatment. On 3/27/24 at 11:08 AM, a Concerned Family Member for Resident #103 (R103) said R103 passed away on 1/31/24 because he was not receiving adequate wound care in the facility. A copy of R103's death certificate was provided. A review of the clinical record for R103 revealed an admission into the facility on [DATE] and discharged from the facility on 1/18/24. R103's diagnoses included gastrostomy status (feeding tube), tracheostomy, end stage renal disease, local infection of the skin and subcutaneous tissue, anoxic brain damage, resistance to multiple antimicrobial drugs (MRSA), and stage 4 pressure ulcer of sacral region. A Minimum Data Set assessment dated [DATE] documented severe cognitive impairment. A facility document titled, Nursing Admission Evaluation, dated 1/10/24 revealed R103 was dependent upon staff for bed mobility and toileting, 2+ persons assist for transfers, and was unable to follow commands and cooperate with transfers. Further review of R103's clinical record documented the following: 1. Braden Scale for Predicting Pressure Sore Risk, dated 1/11/24, score: 8.0 - Very High Risk (score of 9 or below). Moisture: constantly moist. (Interpretation: skin is kept moist almost constantly by perspiration, urine, etc. Dampness is detected every time patient is moved or turned.) 2. R103's hospital discharge summary dated 1/10/24 revealed the following: Wound Care Instructions: Sacrum-cleanse wound, apply skin protectant to peri wound, pack wound with Vashe (wound cleanser) moist gauze, cover with sacral adhesive foam. Change BID (twice daily) and prn (as needed). 3. R103's Skin and Wound Evaluation dated 1/10/24 revealed in part the following: Type: pressure Stage: 4: full-thickness skin and tissue loss Location: Sacrum Present on Admission (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Wound measurements. Length: 7.4 cm (centimeter) Width: 5.2 cm Depth: 4.5 cm % Slough: 50 % of wound filled Exudate: Moderate amount of serosanguineous Secondary dressing was to include dry dressing and silicone. A review of R103's Skin and Wound Evaluation dated 1/17/24 documented a significant increase in the size of the resident's sacral wound in seven days. 4. R103's Skin and Wound Evaluation dated 1/17/24 revealed in part the following: Type: pressure Stage: 4: full-thickness skin and tissue loss Location: Sacrum Present on Admission Wound measurements: Length: 12.3 cm Width: 13.1 cm Depth: 5.2 cm % Slough: 60 % of wound filled Exudate: Moderate amount of serosanguineous Secondary dressing was to include foam dressing and silicone. Review of R103's care plans documented in part the following: 1. Focus: Resident has episodes of bowel incontinence related to generalized weakness, impaired mobility, depression, diabetes, diuretic use, functional incontinence, unable to feel urge to have BM (bowel movement), unable to verbalize need to toilet. Date Initiated: 1/12/2024. Interventions: Administer medication as ordered. Assist resident with toileting needs. Check at regular intervals and change as needed. Initiated 1/12/24. Resident's family request that his brief be open and not fastened while in bed. Initiated 1/18/24. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	2. Focus: Resident is at risk for impaired skin integrity related to confined to a bed all or most of the time, diabetes, impaired cognition, incontinent of bowel, needs assistance with Activities of Daily Living, receiving dialysis, requires staff assistance to reposition, cancer diagnosis, chronic end-stage renal disease, depression, edema, uses devices that can cause pressure (oxygen/trach tubing, indwelling catheter tubing, feeding tube). Date Initiated: 1/11/2024. Interventions: Apply protective barrier cream after incontinent episodes. Administer medications as ordered. Assist resident with turning and repositioning as needed. Initiated 1/11/24. 3. Focus: Resident has impaired skin integrity as evidenced by: (Stage 4 to sacrum present upon admission) related to confined to a bed all or most of the time, diabetes, impaired cognition, incontinent of bowel, needs assistance with Activities of Daily Living, receiving dialysis, requires staff assistance to reposition, cancer diagnosis, chronic end-stage renal disease, depression, edema, uses devices that can cause pressure (oxygen/trach tubing, indwelling catheter tubing, feeding tube). Date Initiated: 1/11/2024. Interventions: Administer treatment(s) per orders. Apply protective barrier cream after incontinent episodes. Assist resident with turning and repositioning as needed. Initiated 1/11/24. Low air loss mattress. Initiated 1/12/24. During an interview and record review on 3/27/24 at 2:45 PM, Wound Care Nurse, Licensed Practical Nurse (LPN) C said R103 was admitted with a sacrum wound. LPN C stated, The family was very intent on the wound being cleaned and remaining clean. We treated his sacral wound as we would normally do. I spoke with the family a lot while he was here. LPN C added if anything was wrong with the dressing integrity after a resident with a sacral wound had a bowel movement the dressing needed to be changed. The following documents for R103 were reviewed with LPN C: January 2024 Medication Administration Record (MAR), January 2024 Treatment Administration Record (TAR), nursing progress notes, and Certified Nurse Aide (CNA) documentation of R103's bowel movements. A review of the January 2024 MAR documented the following orders: 1. Dakins (1/4 strength) External Solution 0.125 % (Sodium Hypochlorite) (a wound care solution). Apply to sacrum topically one time a day for wound care. Start date: 1/11/24. Discontinue date: 1/17/24. This sacral dressing change was administered at 9:00 AM on the following dates: 1/11/24, 1/12/24, 1/13/24, 1/14/24, 1/15/24, 1/16/24, and 1/17/24. None of these scheduled dressing changes were documented as administered by Wound Care Nurse, LPN C. 2. Dakins (1/4 strength) External Solution 0.125 % (Sodium Hypochlorite). Apply to sacrum topically one time a day for wound care cleanse with wound cleanser pat dry apply iodosorb gel (an antimicrobial gel) to peri wound and pack Dakins soaked gauze into wound in a wet to dry manner cover with silicone border. Start date: 1/18/24. Discontinue date 1/19/24. This sacral dressing change was administered at 1:30 PM on 1/18/24. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	A review of R103's nursing progress notes documented additional dressing changes occurred on the following dates and times: 1/11/24 at 7:39 PM, 1/13/24 at 3:38 PM, 1/14/24 at 8:22 AM, 1/15/24 at 12:45 AM, 1/15/24 at 6:50 AM, 1/16/24 at 9:10 AM, and 1/16/24 at 5:58 PM. Through review of documentation the dressing changes on 1/13/24 and 1/14/24 were not performed by the wound care nurse. According to LPN C, the prn dressing changes should have been documented on the TAR or MAR and they were not. According to CNA documentation, R103 had a diarrheal bowel movement on 1/12/24 at 2:54 PM. LPN C stated, We don't have any documentation to support that his dressing was changed at that time. As a wound care nurse, I would expect his dressing to be changed because of the watery diarrhea. I'm 100% sure that his dressing was changed. I know it wasn't documented. It needed to be documented. A medium size bowel movement was recorded on 1/18/24 at 1:57 AM. The only dressing change recorded on 1/18/24 was at 1:30 PM. LPN C said the silicone foam was a waterproof bandage, and the integrity of the bandage would remain intact even if the resident experienced diarrhea. LPN C said she always used the silicone foam when she changed R103's dressing even if it was not on the wound care order. The addition of the silicone foam was not added to R103's orders until 1/18/24. An interview and record review were conducted with the Director of Nursing (DON) and LPN C on 3/28/24 at 11:17 AM. A review of R103's hospital discharged orders included: Sacrum-cleanse wound, apply skin protectant to peri wound, pack wound with vashe moist gauze, cover with sacral adhesive foam. Change BID and prn. LPN C indicated that Dakins and vashe are similar and sacral adhesive foam was a silicone foam. LPN C stated, Our first (wound care) order was incomplete because it left off the (silicone adhesive) barrier. The packaging for the silicone foam dressing was reviewed and indicated it was for the management of exuding wounds (wounds leaking fluid). On 3/28/24 at 11:40 AM, when Physician M was queried why R103's wound care order was changed from twice daily to once daily, he stated, I usually don't change the order on wound care (from the hospital). Physician M added it might have been a default order. On 3/28/24 at 12:51 PM, the DON provided documentation that indicated a silicone dressing was used as a treatment for R103 on 1/17/24. The DON acknowledged that the silicone dressing was not added to R103's wound care order until 1/18/24. The DON said the wound care nurse did not complete all R103's dressing changes. On 3/27/24 at 12:30 PM, a document titled, Certification of Vital Record and Certificate of Death, dated 2/8/24 was reviewed and revealed in part the following: -Decedent's Name: (R103) -date of death : 1/31/24 -Enter the chain of events - diseases, injuries, or complications - that directly caused the death: (a.) Septic Shock - Approximate interval between onset and death: days (b.) Infected Sacral Decubitus Ulcer - Approximate interval between onset and death: 14 days (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	-Manner of death: Natural The Death Certificate designated the approximate beginning of the chain of events that led to R103's death as 1/17/24. A review of the facility policy titled Pressure Injury Prevention and Management, dated 1/1/22, documented in part the following: - The facility shall establish and utilize a systematic approach for pressure injury prevention and management, including prompt assessment and treatment; intervening to stabilize, reduce or remove underlying risk factors; monitoring the impact of the interventions; and modifying the interventions as appropriate. - Interventions will be based on specific factors identified in the risk assessment, skin assessment, and any pressure injury assessment (e.g., moisture management, impaired mobility, nutritional deficit, staging, wound characteristics). On 3/28/24 at 1:00 PM during the exit conference, the Nursing Home Administrator and DON were asked if there was any additional documentation or information that the facility would like to provide prior to the end of the survey, and they reported there was not.

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34901 This citation pertains to Intake MI00143095. Based on interview and record review, the facility failed to ensure a physician's assessment accurately reflected current diabetes mellitus status for one resident (R102) out of three residents reviewed for blood sugar management, resulting in the potential for delayed execution of appropriate medical treatments and medical needs. Findings include: It was reported to the State Agency that the facility was not properly monitoring the resident's diabetes. On 3/27/24 at 12:54 AM, R102 was observed awake and in her room. R102 said she was not on any diabetic medications now because her blood sugars have been better. A review of the clinical record for Resident #102 (R102) documented an initial admitted [DATE] and readmitted [DATE]. R102's diagnoses included type 2 diabetes mellitus with diabetic peripheral angiopathy (reduced circulation of blood to a body part other than the brain or heart). A Minimum Data Set assessment dated [DATE] documented intact cognition. Further review of R102's clinical record revealed in part the following: 1. R102's February 2024 Medication Administration Record (MAR) documented to monitor R102's blood sugars three times a day. Start date 2/10/24. Discontinue date 2/27/24. R102 was prescribed 24 units of Lantus (long-acting insulin) at 9:00 PM and Humalog (fast-acting insulin) with meals as needed according to the blood sugar readings. Humalog coverage was administered when R102's blood sugars were 151 or above. - The 8:00 AM blood sugars ranged from 82 to 312 mg/dl. Five out of the 17 blood sugars were above 150 mg/dl. - The 12:00 PM blood sugars ranged from 84 to 302 mg/dl. Six out of the 17 blood sugars were above 150 mg/dl. - The 5:00 PM blood sugars ranged from 94 to 400 mg/dl. Eight out of the 17 blood sugars were above 150 mg/dl. 2. R102's March 2024 MAR documented to monitor R102's blood sugar levels two times a day for two weeks. R102's scheduled insulin and additional insulin coverage had been discontinued. - The 8:00 AM blood sugars ranged from 100 to 238 mg/dl. Twelve out of the 14 blood sugars were above 150 mg/dl. (continued on next page)

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- The 4:00 PM blood sugars ranged from 143 to 280 mg/dl. Twelve out of the 14 blood sugars were above 150 mg/dl. 3. R102's lab results documented a Hemoglobin A1c of 7.9% on 2/12/24. 4. Physician N note of 2/12/24: Diabetes mellitus type 2. Patient had episode of hypoglycemia this morning, resolved with juice. Recent A1c at 8.6%. Monitor for any hypoglycemia. 5. Physician N note of 2/21/24: Diabetes mellitus type 2. Patient had episode of hypoglycemia this morning, resolved with juice. Recent A1c at 8.6%. Monitor for any hypoglycemia. 6. Physician N note of 3/13/24 (created on 3/18/24): Diabetes mellitus type 2. Patient had episode of hypoglycemia this morning, resolved with juice. Recent A1c at 8.6%. Monitor for any hypoglycemia. On 3/27/24 at 1:02 PM, Unit Manager, Licensed Practical Nurse (LPN) O said they were monitoring R102's blood sugars just to see if she was running high to determine if she needed insulin. R102's March 2024 blood sugar levels were reviewed with LPN O and using the resident's previous insulin sliding scale as a reference point, LPN O acknowledged that R102 would have received 2-4 units of insulin coverage several times. LPN O indicated that Physician N would have evaluated R102's blood sugar levels. When the notes from Physician N dated 2/12/24, 2/21/24, and 3/13/24 were reviewed with LPN O, she stated, This is concerning. On 3/27/24 at 4:34 PM during an interview and record review, the Director of Nursing (DON) said they did 14 days of blood sugar monitoring on R102 when she returned from the hospital to see where the resident's baseline blood sugars were. After reviewing Physician N's notes of 2/12/24, 2/21/24, and 3/13/24, the DON said the physician's notes look like a copy and paste. The Physician should have evaluated her blood sugars, assessed the resident, and adjusted the plan of care as needed. The DON acknowledged that according to the physician's notes this was not done. On 3/28/24 at 10:32 AM, Physician N said R102 was having some issues with low blood sugar episodes while in the hospital. R102 was dropping below the hundreds right before her discharge, and they recommended to hold her insulin. When queried about the current monitoring of R102's diabetes, Physician N stated, From what I remember she was stable. I wasn't aware of any acute episodes regarding her diabetes. When queried about the repetitiveness of his clinical notes on R102 related to diabetes, Physician N stated if a disease is chronic and stable, obviously that (information) is carried from note to note. When queried about the evaluation of the blood sugar monitoring performed on R102 four times a day for two weeks, Physician N said he should be contacted by the facility if the blood sugars are low or high. Physician N stated, I will follow-up with the DON (Director of Nursing) and see what they have for her and straighten things up. (continued on next page)

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/28/24 at 10:19 AM, a policy was requested that governed physician visits. The facility provided Section 483.30(b) Physician Visits from the State Operations Manual Appendix PP, which documented in part the following: The intent of this regulation is to have the physician take an active role in supervising the care of the residents. Physician visits should not be superficial visits but must include an evaluation of the resident's condition and total program of care, including medications and treatments, and a decision about the continued appropriateness of the resident's current medical regimen. On 3/28/24 at 1:00 PM during the exit conference, the Nursing Home Administrator and DON were asked if there was any additional documentation or information that the facility would like to provide prior to the end of the survey, and they reported there was not.