STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235541	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/18/2024
NAME OF PROVIDER OR SUPPLIER: The Lodge at Taylor		STREET ADDRESS, CITY, STATE, ZIP CODE: 22950 Northline Rd Taylor, MI 48180	

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 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39958 This citation pertains to intake MI00145283. Based on interview and record review, the facility failed to provide accurate resident identifying documents and medical records upon emergent transfer to the hospital for one resident (R101) of three residents reviewed for emergency transfer, resulting in resident identification and medical information not being sent with EMS (Emergency Medical Service) personnel to the hospital and the potential for unmet care needs upon transfer. Findings include: Review of an Admission Record revealed, R101 readmitted to the facility on [DATE] and discharged [DATE] with pertinent diagnosis which included End Stage Renal, Type 2 Diabetes and Dysphagia. Review of a Minimum Data Set (MDS) assessment dated [DATE] revealed R101 had cognitive impairment with a Brief interview for Mental Status (BIMS) score of 9 out of 15. Review of a SBAR Communication Form and progress note dated 6/9/24 revealed, R101 was transferred to the hospital by EMS due to mental status change and blood pressure monitoring. In an interview on 7/18/24 at 9:49 a.m., Licensed Practical Nurse (LPN) A reported when a resident is discharged to the hospital; the physician is called to get an order, SBAR is completed, the SBAR and face sheet are sent to the hospital with the resident. In an interview on 7/18/24 at 10:31a.m., the Director of Nursing (DON) reported there was a concern with R101's discharge. The DON reported two nurses worked together to send R101 to the hospital. The DON then reported one of the nurses printed out the wrong paperwork and gave it to EMS. The hospital called hours later and informed the facility that the paperwork they received had another resident's information and not R101's. In an interview on 7/18/24 at 11:23 a.m., the Nursing Home Administrator (NHA) reported a past noncompliance was completed for the incident involving R101. The NHA reported incorrect paperwork was sent to the hospital for R101. The NHA reported the paperwork went through the facility, EMS and the hospital before the incorrect information was noticed. (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

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	07/18/2024

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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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During the onsite survey, past noncompliance (PNC) was cited after the facility implemented actions to correct the noncompliance which included: 1. Two nurses to verify the correct paperwork, nurses to initial and a copy of the paperwork to be placed in the unit managers mailbox. 2. Face sheet with photo to be sent with transfer paperwork. 3. Charge nurse to call ER prior to transfer to give report. 4. Charge nurse to contact DON/On-Call Manger to notify of transfer. 5. All resident EMR to be reviewed to ensure a current photo is in place, as resident allows. 6. DON/Designee will audit discharge to ensure substantial compliance. Results of these Audits will be brought to the QAPI Committee for review monthly. 7. Nursing staff educated on the new process. The facility was able to demonstrate monitoring of the corrective action and maintained compliance.

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

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F 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39958 This citation pertains to intake MI00145597. Based on interview and record review, the facility failed to implement interventions for a hypoglycemia (blood glucose/sugar) for one resident (R103) out of three residents reviewed for change in condition, resulting in R103 being hospitalized for hypoglycemia and subsequent death. Findings include: Review of an Admission Record revealed, R103 admitted to the facility on [DATE] and discharged [DATE] with pertinent diagnosis which included End Stage Renal and Type 2 Diabetes. Review of a Minimum Data Set (MDS) assessment dated [DATE] revealed R103 had no cognitive impairment with a Brief interview for Mental Status (BIMS) score of 15 out of 15. Review of a progress note with a date of [DATE] at 2:07 p.m. revealed, At 8:05 am Resident was found by another staff member to be unresponsive. code blue started. Team started performing CPR immediately. 911 was contacted. CPR continued for about 15 minutes until EMS arrived. EMS continued CPR for about 15 minutes. resident regained the pulse. EMS transported resident to hospital. DON and unit manager made aware.MD notified. family member made aware (sic). Review of vital signs revealed, R103 had a blood glucose of 35 on [DATE] at 8:10 a.m. Review of Physician orders revealed R103 had the following orders: If blood sugar less than (70) administer OJ, Food or glucose gel per manufacturer recommendation. Recheck in 15 minutes if no improvement notify MD as needed. May obtain blood glucose as needed if symptoms of hypo/hyperglycemia & notify MD as needed Notify MD if BS less than 70 or 250 or greater. Observe resident closely for signs & symptoms of hypoglycemia and hyperglycemia Hypoglycemia Symptoms: Confusion; Dizziness; Feeling shaky; Hunger; Headaches; Irritability; Pounding heart; Racing pulse; Pale skin; Sweating; Trembling; Weakness; Anxiety Hyperglycemia Symptoms: Increased thirst; Headaches; Trouble concentrating; Blurred vision; Frequent urination; Fatigue; Weight loss. Every shift. Insulin Glargine Solution 100 UNIT/ML Inject 20 unit subcutaneously two times a day for diabetes. Review of a July Medication Administration Record (MAR) revealed R103 received Insulin Glargine 20 units given at 6:00 a.m. on [DATE]. There was no documentation for Glucagon (medication to increase blood glucose levels) administration. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	In an interview on [DATE] at 10:16 a.m. Registered Nurse (RN) B reported arriving to work at 7:00 a.m. on [DATE]. RN B reported R103 was found unconscious and had a low blood glucose level. RN B reported she did not give R103 any morning medications and that R103 received insulin at 5:00 a.m. from another nurse. RN B then reported they started CPR, EMS arrived and R103's pulse returned. R103 was then sent to ER. In an interview on [DATE] at 10:21 a.m., the Director of Nursing (DON) confirmed R103 had a blood sugar of 35 and received 20 units of Lantus at 6:00 a.m. The DON then reported Licensed Practical Nurse (LPN) C was the night nurse who administered the Lantus to R103 at 6:00 a.m. In an interview on [DATE] at 12:32 p.m., the DON reported the facility has a best practice medication guide that includes hypoglycemia. The DON then reported R103's blood glucose of 35 was documented at 8:10 a.m. and the EMS arrived at 8:20 a.m. The DON was asked if the nurse administered Glucagon per the diabetic protocol. The DON stated, I don't see where we gave it to her. I don't know if they had time before EMS arrived. In an observation on [DATE] at 12:34 p.m., the backup medication list was reviewed with the DON. The list revealed 2 vials of Glucagon was included in the backup medication system. In an interview on [DATE] at 12:37 p.m., RN B reported they were about to give R103 Glucagon, but EMS arrived. When asked if the Glucagon was pulled from the backup system RN B stated, No. In an interview on [DATE] at 1:19 p.m., the DON was asked about expectations for administering Glucagon for blood glucose under 70. The staff should give Glucagon if EMS has not arrived. The DON then reported the EMS usually has arrived by then. The DON reported it takes 15 minutes for Glucagon to work and stated, It probably would not have helped. Review of Hospital records dated [DATE] at 8:44 a.m. revealed, R103 arrived at the ER with a chief complaint of cardiac arrest. EMS arrived at the facility and found R103 to be hypoglycemic. Labs revealed a glucose level of 13. Review of a Diabetic Protocol with no date documented the following: If the blood glucose reading is 70 mg/dl or below, the nurse should utilize the hypoglycemic protocol per the practitioner's orders. Treatment of hypoglycemia should not be delayed before notifying the practitioner. Blood glucose (BG) less than 70 and resident is unable or unwilling to take nutrition orally, immediate action/treatment give glucagon 1mg subcutaneously, 3 mg intranasal or 1 mg intermuscular.