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	10/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Lodge at Taylor	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 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47964 This citation pertains to intake number MI00145631. Based on observation, interview, and record review the facility failed to include one resident (R501) on the podiatrist list out of three residents reviewed for Activities of Daily Living (ADLS), resulting in R501 having overgrown toenails and resident dissatisfaction with foot care. Findings include: On 10/2/24 at 11:10 AM R501 reported that he was not seen by the foot doctor to have his nails trimmed and that he had to make his own outside appointment in August because the facility didn't put him on the podiatry list. An observation of bilateral feet revealed resident's great toenails had grown passed the end of toes. R501 further reported, I like my toenails kept short. Review of R501's Electronic Health Record (EHR) revealed admitted to the facility on [DATE] with pertinent diagnosis which included cerebral infarction, hemiplegia affecting left dominant side, and need for assistance with personal care. Review of a Minimum Data Set (MDS) assessment dated [DATE], revealed R501 had intact cognition and required set up for personal hygiene. Further review of R501's EHR revealed no podiatry consults since admission or documentation of nail care being administered. On 10/2/24 at 11:55 AM Social Worker (SW) E was interviewed and said the previous social worker did not send a complete referral to the podiatry group. R501 should have been seen by the podiatrist in August. On 10/2/24 at 4:00 PM the Director of Nursing (DON) was interviewed and did not provide any documentation of nail care for R501. The DON agreed the referral for podiatry should have been made. (continued on next page)

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

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled Nail Care revised 8/20/24 revealed in part .The purpose of this procedure is to provide guidelines for the care of a resident's nails for good grooming and health. 1. Assessment of resident nails will be conducted on admission and readmission to determine the resident's nail condition, needs, and preferences for nail care, if possible. Obtain history and preferences regarding podiatrist. Identify conditions that increase risk for foot or nail problems such as stroke. Routine nail care, to include trimming and filing, will be provided on a regular basis and as the need arises.

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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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. 22349 This citation pertains to intake MI00145907 and MI00146790. Based on observation, interview, and record review, the facility failed to ensure tube feeding (liquid nutrition) was administered in accordance to physician's orders for one (R510) of four residents reviewed for tube feeding resulting in R510's tube feeding being on hold for an undetermined amount of time, the amount of tube feeding administered being less than prescribed, and the potential for the resident to have insufficient nutrition, hydration, and weight loss. Findings include: On 10/2/24 at approximately 9:00 AM, R510 was observed laying in her bed with a tube feeding pump that was audibly alarming. The display screen on the tube feeding pump indicated the tube feeding was on hold. The display screen did not indicate how long the feeding had been on hold or how much tube feeding had been administered. R510 was unable to be interviewed due to severely impaired cognition and non-verbal status. The tube feeding bottle was identified as Jevity 1.5 Cal, 1,500 milliliter (ml) bottle and had the following documentation written on it; hung on 10/1/24 at 9:00 PM, rate = 73 ml/hr (73 milliliters per hour). The 1,500 ml bottle had approximately 550 ml of feeding infused. A review of R510's Electronic Health Record (EHR) indicated the resident had diagnoses that included anoxic brain injury (brain cell death due to oxygen deprivation) and required a feeding tube (a tube surgically inserted through the wall of the abdomen into the stomach to deliver liquid nutrition, hydration, and medication). On the 5/10/24, the physician ordered the following tube feeding orders; Jevity 1.5 Cal at 73 ml/hour to go up at 12:00 PM and run until 1,314 ml had been infused. A care plan for Enteral Feeding (tube feeding) revised on 1/22/24 included the following interventions: Administer enteral nutrition per orders. A care plan for Risk of altered Nutrition revised on 8/25/24 included the following interventions: Administer enteral nutrition per orders. On 10/2/24 at approximately 9:20 AM the Director of Nursing (DON) and R510's nurse, Licensed Practical Nurse (LPN) B were at R510's bedside and asked about R510's tube feeding. Neither LPN B or the DON could determine how long the resident's tube feeding was on hold or how much tube feeding (Jevity 1.5 Cal) had been infused over a 24-hour period. The DON said, The tube feeding bottle has documentation on it to indicate it was hung at 9:00 PM. The order is for 73 ml per hour. If the tube had been properly infusing for 12 hours, then about 876 milliliter should have been given to the resident by now. The bottle currently only has 550 ml infused, so the resident is about 300 ml short at this time. I will notify the physician and dietitian to determine how to correct this. The DON had reviewed R510's order and could not explain why the tube feeding was hung at 9:00 PM instead of at 12:00 PM in accordance with the physician's orders. On 10/2/24 at approximately 2:00 PM the DON reported that the physician had been notified that R510's tube feeding and hydration amount had not been met for this 24- hour period. The DON said that both nutrition and water boluses (large dose of formula infused over a short period of time) had been prescribed to the resident and the tube feeding infusion will be restarted the next day at 12:00 PM per the physician's original order. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to the facility's Feeding Tube policy revised on 6/30/22 in part reads; Feeding tubes will be used only as necessary to address malnutrition and dehydration, or when the resident's clinical condition deems this intervention medically necessary to maintain acceptable parameters of nutrition and hydration. Feeding tubes will be maintained in accordance with current clinical standards of practice, with interventions to prevent complications to the extent possible 7. Feeding tubes will be utilized according to physician's orders 11. e. Ensure that the administration of enteral nutrition is consistent with and follows the physician's orders 12. c. Periodic evaluation of the amount of feeding being administered for consistency with physician's orders.

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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. 22349 This citation pertains to intake MI00146210. Based on observation, interview, and record review, the facility failed to ensure appropriate tracheostomy (surgical opening created in the front of the neck into the trachea to help oxygen reach the lungs) care was provided to one of three residents (R510) reviewed for tracheostomy care resulting in R510 not receiving the prescribed amount of humidified oxygen due to unaddressed malfunctioning humidification equipment with the potential for respiratory complications. Findings include: On 10/2/24 at approximately 9:00 AM, R510 was observed laying in her bed with a tracheostomy covered with a trach collar (soft plastic mask that fits over the trach to deliver humidified oxygen). The trach collar tubing was connected to a compressor (machine that delivers humidification to oxygen) that was set on 0% (zero) humidification. The oxygen concentrator (machine that delivers oxygen) was set at 5 liters. The compressor's water bottle was leaking water and dripping down the outside of the trach tubing and trach collection bag. The trach collection bag and some of the trach collar tubing was lying in approximately 2 inches of water inside a plastic wash basin. The plastic wash basin was set in the lower drawer of the resident's bedside dresser. R510 was unable to be interviewed due to severely impaired cognition and non-verbal status. R510 did not appear to be in any distress. A review of R510's Electronic Health Record (EHR) indicated the resident had diagnoses that included anoxic brain injury (brain cell death due to oxygen deprivation) and required a tracheostomy for adequate oxygenation. According to the physician's orders dated 5/10/24, R510's trach collar orders were 5 L/ 28%. A care plan for Impaired Pulmonary/respiratory status related to tracheostomy initiated on 5/11/24 include the following interventions; Tracheostomy care per orders and as needed. On 10/2/24 at approximately 9:30 AM the Director of Nursing (DON) and Respiratory Therapist (RT) C were at R510's bedside and asked about the trach tubing lying in 2 inches of water in the plastic wash basin in the resident's bedside dresser. RT C said, It's not supposed to be like that. I don't know what happened. I did trach care earlier, and it wasn't leaking like this. Upon inspection of the resident's trach equipment RT C said the humidification setting was incorrect. RT C adjusted the humidification setting, re-adjusted the water bottle on the concentrator to stop the water from leaking out of the connection site and removed the plastic wash basin from the resident's dresser. R510's pulse oximetry was assessed and read 94 % (normal reading is 90-100%). R510 was not in any apparent respiratory distress. The DON said that if R510's trach equipment was leaking water the RT should have been notified immediately. The staff should not have just set the trach equipment inside a wash basin and let it continue to leak. It should have been addressed differently. We will be having an education immediately. According to the facility's policy for Tracheostomy Care last reviewed on 10/26/23 in part reads: The facility will ensure that residents who need respiratory care, including tracheostomy care and tracheal suctioning, is provided such care consistent with professional standards of practice, the comprehensive person-centered care plan and resident goals and preferences. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Compliance Guidelines: 1.The facility, in collaboration with the attending practitioner, must perform a comprehensive assessment of the resident's respiratory needs 3.Tracheostomy care will be provided according to the physician's orders, comprehensive assessment and individualized care plan such as monitoring for resident specific risks for possible complications, psychosocial needs as well as suctioning as appropriate 5. The facility will ensure staff responsible for providing tracheostomy care including suctioning are trained and competent according to professional standards of practice.

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or get specialized rehabilitative services as required for a resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47964 This citation pertains to Intake number MI00145631. Based on interview and record review the facility failed to provide Occupational Therapy (OT) sessions as ordered for one (R501) of three residents reviewed for physical rehab, resulting in missed therapy sessions and resident dissatisfaction. Findings include: On 10/2/24 at 11:10 AM R501 was observed sitting in his wheelchair in his room wearing a left palm protector. When R501 was questioned about his care in the facility R501 stated I didn't get all my OT sessions. I had surgery on my left forearm to lengthen the tendons going to my hand so that I could open my hand better. My hand isn't any better, about the same as before the surgery. R501 removed the left palm protector and demonstrated his left hand in a flexion contracture. R501 further stated I'm going to get therapy outside of this facility because they didn't do enough. Review of R501's Electronic Health Record (EHR) revealed admitted to the facility on [DATE] with pertinent diagnosis which included cerebral infarction, hemiplegia affecting left dominant side, and need for assistance with personal care. Review of a Minimum Data Set (MDS) assessment dated [DATE] revealed R501 had intact cognition. Review of R501's physician orders revealed Effective 5/16/24 OT 3-5x/week for 30 days. Review of the R501's OT evaluation revealed Frequency 3 to 5 times/week Duration 30 days Intensity Daily Cert period 5/16/24 -6/14/2024. Clinical impression/reason for skilled services: Patient recently had a surgery to fractionally lengthen his tendons on LUE (left upper extremity) 4/6/24. Patient requires PROM (passive range of motion) to stretch tendons to increase ROM and decrease risk of contractures. Patient demonstrates good rehab potential. Review of R501's OT service log revealed OT therapy provided one OT session for the week of 6/2/24 with no missed visits documented. Week of 6/9/24 resident unavailable 6/10/24, refused 6/11/24, OT provided on 6/2/24 and resident refused on 6/14/24. One session of OT was performed for the week of 6/9/24. On 10/2/24 at 12:30 PM Occupational Therapist D was interviewed and said R501 should have been seen by OT at least three times a week and there isn't a documented reason why R501 was only seen once a week. On 10/2/24 at 4:00 PM the Director of Nursing (DON) was interviewed and said therapy should be performed per orders and therapist plan of care. (continued on next page)

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled Rehabilitation Therapy and Services reviewed 1/1/22 revealed in part: . The facility is committed to providing quality therapy services .be pursuant to physician orders .be reasonable and necessary to improve a resident's current condition, to maintain the residents' current condition or to prevent or slow further deterioration of the resident's condition.