STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235583	A. Building B. Wing	08/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Green View	1234 Golf Course Rd Alpena, MI 49707

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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. 49310 Based on observation, interview, and record review, the facility failed to ensure medications were safely administered in an environment of a residents choosing for one Resident (R191) of twelve residents reviewed for Residents' Rights. Findings include: During medication administration observation on 8/7/24 at 7:24 a.m., Registered Nurse (RN) E provided Resident #191 (R191) her prescribed medications while R191 was eating breakfast in the dining room with other residents. RN E placed the medications directly on the table next to R191 and exited the dining room without observing R191 take the medications. The Director of Nursing (DON) was interviewed on 8/7/24 at 10:30 a.m. The DON agreed medications should not be provided in the dining room unless a resident prefers to take his or her medications in the dining room. The DON said the resident preference for administration locale would be in the care plan if a resident wants medications administered in a public area such as the dining room. R191 was interviewed on 8/7/24 at 11:51 a.m. When asked about receiving medication while in the dining room, R191 said the nurses usually provide her with medications in her room. When asked how she felt about receiving medications while in the dining room, R191 replied, I don't want them in the dining room. I never want them in there. I want to get them in here [resident's room]. The policy Promoting/Maintaining Resident Dignity dated 10/26/23 read, in part: .It is the practice of the facility to protect and promote resident rights and treat each resident with respect and dignity as well as care for each resident in a manner and in an environment that maintains or enhances residents' quality of life by recognizing each resident's individuality . An undated, attached addendum for Residents' Rights read, in part: .(d) a patient or resident is entitled to privacy, to the extent feasible in treatment and in care for personal needs with consideration, respect, and full recognition of his or her dignity and individuality .

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 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** 49310 Based on observation, interview, and record review, the facility failed to ensure assistance was provided with donning a back brace for one Resident (R20) of four residents reviewed for range-of-motion and mobility. Findings include: Resident #20 (R20) On 8/5/24 at approximately 9:15 a.m., a Thoracolumbosacral orthosis (TLSO - a type of back brace) was observed on a chair in R20's room. R20 was sitting in a wheelchair talking on the phone and was not visibly wearing a different brace or device to stabilize or support the spine. On 8/5/24 at 12:47 p.m., the TLSO remained in the chair in R20's room. When asked about the TLSO, R20 said, I broke my back and I'm supposed to wear that when I'm out of bed, but I can't put it on by myself. R20 indicated she was admitted to the facility for skilled rehabilitation services after experiencing a fall at home that resulted in a spinal fracture. R20 was asked if the staff assisted with donning the brace. R20 said the therapist was assisting with the brace but skilled therapy had ended in July, and no one helped her put on the TLSO since. On 8/6/24 at 10:22 a.m., R20 was observed in her room using a walker to ambulate. R20 was not wearing the TLSO. R20 said, No one helps me put it on since therapy stopped. I'm supposed to wear it when I'm not in bed, but I can't buckle it by myself. On 8/6/24 at 10:26 a.m., the nurse manager, Registered Nurse D (RN D) was asked if R20 should be wearing her TLSO every day when out of bed. RN D said R20 always refuses to wear it [the TLSO]. RN D accompanied the surveyor to R20's room and asked R20 if she would like help with placing her back brace. R20 responded, yes - it's about time! Resident #20 (R20) was admitted to the facility on [DATE] with a spinal fracture. A Minimum Data Set (MDS) assessment dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 14 indicating R20 was cognitively intact. Section E did not code any behavioral concerns. Section E0800 of the MDS documented R20 did not exhibit rejection or refusal of care necessary to achieve R20's goals for health and well-being. R20 had a physician's order for TLSO brace with activity every shift. Transfer records from the hospital documented the need for R20 to wear the TLSO when out of bed. R20's care plans included an intervention for TLSO as ordered. There was no documentation of refusing to wear the TLSO in the care plan or in behavior tracking tasks. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Physical Therapist Assistant (PTA) and Occupational Therapist (OT) were interviewed on 8/06/24 at 10:53 AM. The OT reviewed R20's record and said skilled therapy did not have any documentation on R20's TLSO. The PTA said he worked with R20 for the duration of her skilled therapy, and confirmed he assisted her each day with applying the TLSO. The PTA said R20 wore the brace willingly and never refused to wear it for him. The PTA said R20 was unable to apply the brace independently and required assistance with placing the brace. When asked who was supposed to be aiding with the brace, the PTA said, nursing. The PTA and OT confirmed R20 should be wearing the brace every day when out of bed. The OT said occupational therapy and physical therapy ended on 7/23/24 and 7/26/24 so nursing should have been applying the brace each day since skilled therapy services ended. The Treatment Administration Record (TAR) revealed the order for the TLSO. The brace was signed out as being applied every day, each shift in August including 8/5/24 and 8/6/24 when the observations were made of R20 not wearing the brace. There were no documented refusals by R20 to wear the brace. RN A, the nurse who initialed the TAR indicating the TLSO had been applied on 8/5/24 and 8/6/24, was interviewed on 8/6/24 at 12:52 p.m. RN A confirmed he had not assisted R20 with applying the TLSO. RN A said, I've never assisted (R20) with application of the brace. When asked why he signed the TAR with his initials indicating the brace was applied, RN A said the Certified Nursing Assistants (CNAs) applied the TLSO. The tasks in R20's medical record did not include documentation by CNAs indicating R20 was assisted with placing the TLSO when out of bed. Progress notes in R20's record did not document the daily donning and doffing of the brace. A physician's progress note on 6/17/24 read, in part: .Generalized weakness. To wear TLSO brace when up . The Director of Nursing (DON) was interviewed on 8/7/24 at 10:38 a.m. The DON said the expectation is for staff to assist R20 with placement and removal of the TLSO. The policy Use of Assistive Devices dated 10/26/23 read, in part: .The purpose of this policy is to provide a reliable process for the proper and consistent use of assistive devices for those residents requiring equipment to maintain or improve function .facility staff will provide appropriate assistance .set up assistance, supervision, or physical assistance as needed .

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F 0689 Level of Harm - 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** 49302 Based on observation, interview, and record review, the facility failed to ensure a mobility bar was properly fixated to a bed frame for one resident (Resident #21) of 6 residents reviewed for accident hazards and bed safety. This deficient practice resulted in two separate falls from bed resulting in a concussion and a hip fracture requiring surgical intervention. Findings include: Resident #21 (R21): Review of R21's electronic medical record (EMR) revealed initial admission to the facility on [DATE] with diagnoses including chronic obstructive pulmonary disease (COPD), right foot amputation, and depression. Review of R21's most recent Brief Interview for Mental Status (BIMS) assessment revealed a score of 15, indicative of intact cognition. Review of the facility census revealed R21's most recent hospitalization was 7/30/24 - 8/5/24. On 8/6/24 at 10:38 AM, R21 was observed lying in bed with a fall mat placed on the floor on the left side of her bed and a mobility bar attached to the left side of the bed frame. When asked if she utilized the mobility bar, R21 replied, Yes, but it was broken when I fell . R21 stated her right hip was, very sore. Review of an Unwitnessed Fall Event Report written by Registered Nurse (RN) H, dated 5/30/24 read, in part: Nursing Description: heard yelling . I moved quickly to the end of b-wing and when I got there, I could tell it was coming from [R21's] room. I entered [the] room to find [R21] on the floor, laying on her back with her bilat [bilateral] knees bent, small scratch visible on left knee and left 5th finger . Immediate Action Taken: Kept her on the floor .tried to straighten bilateral legs to check hips, she yelled out in pain so I called [physician] and he ordered to ship her to ER [emergency room] . Review of the Predisposing Situation Factors on the Unwitnessed Fall Event Report revealed Other (describe) was selected via checkmark. Other Info read, in part: Predisposing equipment=Left side of rail was not locked, and it swung out of the way toward the head of the bed. On 8/7/24 at 8:10 AM, an interview was conducted with RN H regarding R21's fall on 5/30/24. RN H verified the mobility bar was not locked in the closed position at the time of the fall assessment. When asked if the instability of the mobility bar contributed to R21's fall, RN H replied, I would assume it did. Review of R21's ER discharge summary, dated 5/30/24, read, in part: (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Reason for visit: Fall . Diagnoses: Closed head injury . Review of an Unwitnessed Fall Event Report written by RN I, dated 6/19/24 read, in part: This nurse was walking down the hall and heard a garbage can tip over and a resident yelling for help. This nurse went to [R21's] room and saw resident laying on the floor next to her bed. Resident was bleeding from her R [right] forearm and R knee . Resident c/o [complains of] 10/10 pain . Review of the Predisposing Situation Factors on the Unwitnessed Fall Event Report revealed Equipment (describe in note) was selected via checkmark. No additional narrative was provided. Review of a progress note dated 6/20/24, read, in part: RTC [return to clinic] at 1500 [3:00 PM] . shouting out with pain during transfers and repositioning . Review of R21's ER discharge summary, dated 6/20/24 read, in part: Reason for visit: Fall, Leg Pain . Diagnoses: nondisplaced fracture of greater trochanter of right femur . referral was sent to orthopedic clinic for outpatient follow-up . Review of a Standards of Care (SOC) Meeting, dated 6/20/24 read, in part: .Initial SOC Fall note for fall occurring 6/19. Resident stated that she rolled out of bed and onto the floor .Fall resulted in 3 skin tears and increased pain in R [right] leg. Resident shipped to ER for evaluation . CT [computed tomography scam] shows r [right] hairline femur fracture . This is the second occurrence of resident rolling out of bed. Last fall 5/30. Resident mobility bar was unlocked and moved away when she rolled against it . Review of a progress noted dated 7/30/24 read, in part: Resident had appointment for ortho [orthopedics] .for previous fracture . The doctor stated a significant change in the fracture and that the resident needed to have surgery. Resident was transferred from ortho to ER to have surgery today . On 8/07/24 at 9:32 AM, an interview was conducted with Maintenance Director (MD) J who verified he oversaw mobility bar audits and maintenance. MD J verified he was notified of R21's faulty mobility bar after her second fall from bed which resulted in a hip fracture. MD J verified a spring was broken preventing the mobility bar from properly locking in place. On 8/7/24 at approximately 9:05 AM, an interview was conducted with the Director of Nursing (DON) who verified R21's mobility bar was not in working order at the time of both the 5/30/24 and 6/19/24 falls, the latter which resulted in a hip fracture. When asked why the mobility bar was not repaired after the first fall despite the documentation by RN H recognizing it as a predisposing environmental factor, the DON replied, I didn't realize the rail was not fixed after the first fall .I review the incident reports and that was just something I missed. The DON confirmed all residents with a mobility bar in place should have an active physician's order. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of R21's EMR did not reveal a physician order for a mobility bar at present date nor at the time of the falls. Review of facility policy titled, Proper Use of Bed Rails revised 10/24/22 read, in part: .if bed rails are used, the facility ensures correct installation, use, and maintenance of the rails . the facility will obtain a physician's order for the use of the specified bed rail and medical diagnoses, condition, symptom, or functional reason for use of the bed rail . The facility will assure the correct installation and maintenance of bed rails, prior to use. This includes: .conducting routine preventative maintenance of bed and bed rails to ensure they meet current safety standards and are not in need of repair . Review of the Manufacturer's User-Service Manual for the mobility bar read, in part: .Warning: Risk of Serious Injury or Death. Do not use this assist device until you have verified that it is locked in place. Injury to resident of caregiver may result if this procedure is not followed .

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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** 49310 Based on interview and record review, the facility failed to: 1. Document the rationale for declining gradual dose reductions for an antipsychotic medication for one Resident (R1) of five residents reviewed for unnecessary medications, and 2. Document the rationale and duration of PRN use of a psychotropic medication for one Resident (R6) of five residents reviewed for unnecessary medications. Findings include: Resident #1 (R1) A review of the physician's orders for R1 included an order for Abilify (an antipsychotic medication) 10 milligrams (mg) daily. A review of R1's medical record did not reveal any attempts at Gradual Dose Reduction (GDR) of the Abilify since R1 was admitted to the facility on [DATE]. A form Antipsychotic Gradual Dose Reduction Form dated 11/23/23 was in R1's record. The form documented the Antipsychotic medication to be addressed was Abilify for Bipolar disorder and hallucinations. A box was checked that read: a gradual dose reduction is contraindicated for the following reason: . but no documentation followed - the area to document the response was blank. R1's physician did not provide a written response documenting the reason for declining a GDR attempt for Abilify. Staff F was interviewed on 8/6/24 at 1:37 p.m. Staff F confirmed she was the social services designee and oversaw GDR of psychotropic medications. When asked when the last GDR of Abilify was attempted for R1, Staff F said a dose reduction had not taken place since she assumed the social services designee position in January 2023. Staff F was asked if the physician had attempted a GDR of the Abilify since R1 was admitted to the facility. Staff F replied, No, I don't think so. Staff F was asked if the physician had documented any rationale for not attempting a GDR or if there was documentation of clinical contraindication of a GDR. Staff F reviewed R1's medical record and said, I can't find any documentation. Staff F said a GDR for Abilify was submitted to the physician on 11/23/23 but the physician had declined the GDR request. Staff F was asked for the documented reasoning for declination. Staff F reviewed R1's medical record and confirmed there was no physician documentation indicating the physician's reason for not attempting a GDR. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Staff F was asked if the facility's contracted provider of psychiatric services was involved with R1's psychiatric needs and psychotropic medication. Staff F said contracted psychiatric services were not involved because R1 is followed by Community Mental Health (CMH). Staff F was asked the location of CMH documentation, facility communication, and collaboration with the facility regarding R1's Abilify and GDR history. Staff F reviewed R1's medical record and confirmed there was no documentation in the medical record from CMH. Staff F confirmed the medical record was the only place documented reasoning for declination of GDR attempts would be located. On 8/6/24 at 3:34 p.m., the Corporate Regional Nurse (CRN) provided a medication history for Abilify. The CRN said, No GDR's have been tried since (R1) was admitted in 2021 - (R1) has been on 10 milligrams [of Abilify] since (R1) has been here. The Director of Nursing (DON) was interviewed on 8/7/24 at 10:34 a.m. The DON said GDRs should be attempted every 6 months the first year of admission, then annually. The DON said physician documention of reasoning is required if a physician determines a GDR would be detrimental for a resident. The DON was asked where the physician documented a reason for declining a GDR for R1. The DON replied, He [the physician] didn't document a reason. The policy Use of Psychotropic Drugs and Gradual Dose Reductions dated 10/24/22 read, in part: .Residents who use psychotropic drugs receive gradual dose reductions .unless clinically contraindicated .The physician has documented the clinical rationale for why .attempted dose reduction at that time would be likely to impair the resident's function or increase distressed behavior . Resident #6 (R6) R6 was prescribed lorazepam (an antianxiety medication) every 8 hours PRN (as needed) for anxiety for 14 days. The most recent admitted R6 was 8/18/23. A review of the lorazepam order history revealed R6 was prescribed the lorazepam PRN since readmission to the facility at varying time intervals and varying durations of therapy without adequate indications for use or rationale provided by a physician. A Medication Regimen Review (MRR) by the consultant pharmacist dated 7/8/24 read, in part: .This resident currently has an order for lorazepam PRN .PRN psychotropic orders cannot exceed 14 days with the exception that the prescriber documents their rationale in the residents medical record and indicates the duration for the PRN order. Please consider ( )discontinue PRN lorazepam or ( ) If PRN lorazepam is to be continued, please write a new PRN order and include the duration of therapy and rationale for continued use . The physician response on the July MRR read in chart. Physician notes in R6's medical record from 8/18/23 through 8/7/24 did not reveal documented rationale by the physician for the PRN lorazepam nor did the documentation contain an indication of the duration of use for the PRN lorazepam. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Director of Nursing (DON) was interviewed on 8/7/24 at 10:21 a.m. The DON said R6's anxiety increased at bedtime. The DON stated, We've tried melatonin [a hormone that regulates the sleep cycle] and things like that, but it wasn't effective. (R6) can't sleep because of anxiety so we are using lorazepam to help her sleep. The DON was told R6 was currently being administered melatonin at night. The DON said the melatonin is not effective with assisting R6 with sleeping. When asked why R6 was being administered melatonin if it wasn't working, the DON responded, Good question! When asked why an antianxiety medication was being utilized in lieu of a hypnotic medication to assist with sleep, the DON did not provide an answer. The policy Use of Psychotropic Drugs and Gradual Dose Reductions dated 10/24/22 read, in part: .PRN orders for psychotropic drugs shall be used only when the medication is necessary .and for a limited duration i.e., 14 days. A. If the attending physician or prescribing practitioner believes it is appropriate for the PRN order to be extended beyond 14 days, he or she shall document their rationale in the resident's medical record and indicate the duration for the PRN order .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 49310 Based on observation, interview, and record review, the facility failed to ensure medications were appropriately administered for two Residents (R4 and R17) of four residents reviewed for infection control practices during medication administration. Findings include: During medication administration observation on 8/6/24 at 7:41 a.m., Registered Nurse (RN) A was preparing medications for Resident #4 (R4) at the medication cart. RN A picked up a plastic water cup by the lip of the cup with ungloved hands to set the cup on the med cart. RN A poured water into the cup they had just touched with bare fingers and gathered the medications and cup of water and entered R4's room. RN A placed the cup of water, a medication cup containing R4's medications, and an insulin syringe on R4's bedside table without a barrier. RN A handed R4 the medication cup containing the medication. When R4 attempted to place the medications from the cup into his mouth, three medications fell from the cup onto R4's bed. RN A picked up the medications with bare, ungloved fingers and placed the three medications back into the medication cup. RN A provided R4 the cup of water. R4 placed the rim of the cup RN A had touched with bare fingers to his mouth to swallow the medications including the three medications RN A had touched with his bare fingers. RN A administered medications to Resident #17 (R17). RN A obtained a water cup containing a flexible straw then adjusted the straw by bending the top of the straw (the portion that is placed in the mouth when drinking from a straw) with bare hands. RN A placed the portion of the straw they had just touched with bare, ungloved fingers into R17's mouth for the resident to drink. The Director of Nursing (DON) was interviewed on 8/7/24 at 10:30 a.m. When the medication administration observations were conveyed to the DON, the DON confirmed the actions by RN A were unacceptable. The DON said, It's not ok - it's an infection control issue. The policy Infection Prevention and Control Program dated 12/27/23 read, in part: .Licensed staff shall adhere to safe infection and medication administration practices . The policies Administration Procedures for All Medications and Oral Medication Administration, both dated 8/2020, read in part: .Medications will be administered in a safe and effective manner .Use a barrier to carry medication containers into the resident's room and to separate the supplies and the over-the-bed table or other surface .taking care to avoid touching the tablet or capsule .