STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235600	A. Building B. Wing	07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Montrose Inc	9317 W Vienna Rd Montrose, MI 48457

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28101 This Citation pertains to Intake Number MI00143098 Based on interview and record review the facility failed to treat one resident (Resident #111) of 3 residents reviewed for residents' rights with dignity resulting in Resident #111 having feelings of frustration and mental anguish. Findings include: Resident #111 (R111): Review of R111's face sheet dated 6/27/24 revealed she was a [AGE] year-old female admitted to the facility on [DATE] and had diagnoses that included: adjustment disorder with anxiety, heartburn, muscle weakness, shortness of breath and dependence on oxygen. R111 was her own responsible party. Review of R111's Interdisciplinary Progress Note dated 2/14/24 at 3:41 AM revealed a note written by the Director of Nursing (DON) This nurse has been in resident's room multiple times. The process of obtaining medications form the pharmacy has been explained to her each time. She continues to put her call light on asking for her alprazolam (antianxiety medication). She is demanding that a staff person stay in her room until the medication arrives. It has been explained that putting on her light on this frequently will not hurry the process. Multiple calls to on call APP (physician group). During an interview with the DON on 6/27/24 at 3:10 PM the note she wrote in R111's medical record on 2/14/24 at 3:41 AM was reviewed. The DON recalled that they have ongoing issues with their pharmacy getting C2 (controlled substance prescriptions) filled. The DON said they have had multiple discussions with pharmacy and have not come up with a solution to allow them to receive these medications timely. The DON was aware R111 went about 24 hours in the facility without receiving her antianxiety medications. She recalled not instructing staff to stay with R111 despite R111 being very distressed. The DON was asked what she did to assist R111 with her anxiety due to the lack of medication availability. The DON could not find any documentation that indicated the facility provided any comfort measures. During an interview with R111 on 7/2/24 at 1:55 PM, R111 recalled not getting her alprazolam (antianxiety medication) on admission. R111 said it made me feel, horrible, like I am in a different world, I do crazy things when I do not get that medication. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R111's Medication Administration Record (MAR) for February 2024 revealed, Alpraxolam Oral tablet 0.25 mg, give 1 tablet by mouth two times a day for anxiety start date 02/14/2024 0600 The first dose provided was the evening of 2/14/24. R111 was admitted on [DATE] with hospital discharge orders for Alpraxalam 0.25 mg twice a day.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22347 This Citation pertains to Intake Number MI00136915. Based on interview and record review, the facility failed to ensure an environment free of abuse (verbal and physical) for four residents (Resident #117, Resident #118, Resident #119 and Resident #120), of 8 residents reviewed for abuse, resulting in verbalizations of anger, hostility, threats of violence, and physical and verbal abuse from Resident #102. Findings Include: Review of the facility Admission packet given to all residents and/or Power of Attorneys at the time of admission (un-dated), stated Federal and/or State law gives you the right to remain at the center (the facility) once admitted , and not be transferred or discharged against your will, except for the following: The health and/or safety if the resident or other individuals in the center are endangered. Review of the electronic medical record and per interview done with the Director of Nursing/DON on 6/27/24 at approximately 2:00 PM, revealed that Resident #102 verbalized abusive behaviors and physical abuse with a total of 4 facility residents prior to being discharged to an AFC home on 5/16/23 on the following dates: 08/26/21 (with Resident #117) , 09/17/21 (with Resident #118), 10/11/21 (with Resident #118), 12/31/21 (with Resident #119), 02/17/22 (with Resident #119) and on 05/09/23 (with Resident #120). Resident #102: Review of the Face Sheet, Minimum Data Set (MDS, resident assessment tool), Physician, Nursing and Social Service progress notes dated 1/11/21 through 5/9/23, revealed Resident #102 was [AGE] years old, with moderately to severe cognitive impairment, was not his own person had a guardian in place, required assistance with all Activities of Daily Living (ADL), and required staff supervision due to behaviors. The resident's diagnoses included, cerebral palsy, dysphagia (difficulty swallowing), epilepsy, hydrocephalus with a shunt, abnormal gait, repeated falls, restlessness and agitation, pain, anxiety, bipolar disorder, and depression. Review of the electronic medical record/EMR done on 6/27/24 at approximately 2:00 p.m., accompanied by the DON, revealed the resident was initially admitted to the facility on [DATE], discharged on [DATE], readmitted on [DATE], readmitted on [DATE] and discharged to an AFC facility on 5/16/23. The resident had predatory sexual tendencies, according to the facility documentation. Review of the resident's Predatory Sexual tendencies care plan dated 11/1/22 (the last abusive incident the facility reported was on 5/9/23), stated (The resident's) guardian, she admits to (Resident #102) predatory sexual tendencies, and is unwilling to take him home because she has daughters at home, but she is willing to have him stay in this facility where we have a population of at risk individuals. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's Aggressive care plan dated 1/29/21 (prior to first reported abusive incident at the facility), stated The resident can be verbally aggressive r/t (related to) behavioral issues, can exhibit inappropriate social behavior of screaming/verbal noises/words. Review of the resident's Aggressive care plan dated 1/29/21, intervention dated 9/17/21 (sexual abuse incident with Resident #118 on 9/17/21), stated Observe resident when he is out of room and or in common area. Resident should not be in touching distance from other residents. Review of facility documentation dated 8/26/23 (dated the date of the resident's first abusive allegation at facility), stated Prior to admission to (the facility), (Resident #102) was residing in an AFC and some of the admission documentation received from his prior AFC includes, He will hit the wall and deny it, He scratches himself and will scratch his face and blame staff, the patient has acted on command auditory hallucinations in the past lighting his hair on fire and it may be possible that his striking face and scratching the back of his hand is a symptom of depression. Incidents of abusive behaviors: 1. On 8/26/21, an altercation between Resident #102 and Resident #117 occurred. Resident #120 accused Resident #117 of hitting him in the eye. The facility investigation dated 9/2/21, found this allegation to not be substantiated. Review of the resident's EMR investigation dated 9/2/21, stated (Resident #102) has current care plans for verbal aggression, exhibiting inappropriate social behavior, mental delay and having delirium and acute confessional episodes. Resident #102 was not transferred to the ER for a psychotic evaluation at the time. 2. On 9/17/21, an altercation between Resident #102 and Resident #118 occurred. Resident #118 had a BIMS (cognitive assessment score, 10 being alert) of 0. Resident #118 was sitting in a common area and a Nursing Assistant/CNA (no longer at facility) observed his hands between the residents (#118) legs; Resident #102 was left in a common area without staff supervision. Review of the facility investigation (un-dated), stated (Resident #118) was seated and it appeared that he (Resident #102) had his hand between her legs on top of her clothing. Abuse was not substantiated by the facility, and the police were not notified of this incident. Resident #102 was not transferred to the ER for a psychotic evaluation at the time. 3. On 10/11/21, a second altercation between Resident #102 and Resident #118 occurred. Resident #118 was hit by Resident #102 on the buttocks, staff observed the incident (no longer at facility). Review of the investigation dated 10/19/21, stated (Staff member) observed (Resident #102) strike (Resident #118) on her buttocks. Resident #102 was sitting in his doorway of his room and hit Resident #118 as she went by (could have caused a fall with injury). Review of the investigation dated 10/19/21, stated Abuse within this resident-to-resident incident is unsubstantiated; police were not notified of the incident. Resident #102 was not transferred to the ER for a psychotic evaluation at the time. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. On 12/31/21, an altercation between Resident #102 and Resident #119 occurred. Review of the facility investigation dated 1/10/21, stated (Resident #102) was in the common area with another resident (Resident #119) and was using the f-word. As (Resident #102) was removed (by staff) from the common area, (Resident #102) stated to (Resident #119) that he was going to get a knife from his uncle and stab her. Abuse within this incident is unsubstantiated; law enforcement was not notified as there is no suspicion of a crime. Resident #102 was not transferred to ER for a psychotic evaluation at the time. 5. On 2/17/22, a second altercation between Resident #102 and Resident #119 occurred. Review of the facility investigation (undated), stated Resident's (#102 and #119) were passing in the hallway, on the way to their rooms, when (Resident #119) unprovoked, doubled her fist, shaking it at (Resident #102), saying I just want to punch you in the face. Immediate intervention was to send (Resident #119) to the emergency room for a psychiatric evaluation. No abuse identified within this investigation. 6. On 5/9/23, an altercation between Resident #102 and Resident #120 occurred. Resident #120 had a BIMS (cognitive assessment score, 10 being alert) of 0. Review of the facility investigation dated 5/17/23, stated on 5/9/23 (Resident #102) was observed in an attempt to pull (Resident #120's) shirt down in an effort to view her breasts while she appeared to be sleeping in the short-term dining room (common area). (Resident #120's) husband remained with (Resident #120) throughout the night. Review of the facility witness statement dated 5/9/23, stated I walked through the dining room and noticed that resident (Resident #102) was wheeling towards (Resident #120). (Resident #120) was reclined back sleeping. The second time I walked through the dining room, which was only seconds later, he (Resident #102) was pulling (Resident #120's) shirt down and trying to look at her breasts. (Resident #102) refused to stay in his room, so I ended up laying her down in bed. The facility was able to substantiate (Resident #102's) attempt to pull (Resident #120's) shirt down in an effort to view her breasts. However, (Resident #102) was not able to view her breasts and did not make physical contact with her breasts. Therefore, sexual abuse with this incident is unsubstantiated. Resident #102 was not transferred to ER for a psychiatric evaluation regarding this incident. At this point after 6 incidents, the facility discharged Resident #102 to an AFC home on 5/16/23. Review of the facility Resident Rights policy dated 1/10/24, revealed the facility had the responsibility to protect all residents from verbal, physical, sexual and mental abuse. The policy stated, Prospective residents will be screened to determine whether the facility has the capability and capacity to provide the necessary care and services for each resident admitted . The facility will make efforts to ensure all residents are protected from physical and psychosocial harm, as well as additional abuse: increased supervision of the alleged victim and residents. Coordination with QAPI: Measures to verify the implementation of corrective actions and timeframe's and tracking patterns of similar occurrences.

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F 0686 Level of Harm - Minimal harm or potential for 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** 28101 This Citation pertains to Intake Number MI00141964. Based on observations, interviews and record review the facility failed to implement standards of care and care planning for pressure relief and implement interventions to keep a pressure ulcer free from contamination for one resident (Resident #115) of 3 residents reviewed for pressure ulcers, resulting in Resident #115 having chronic wound contamination (urine and feces) and a lack of consistent pressure relief for 3 unstageable pressures and pressure ulcers worsening. Findings include: Resident #115 (R115): Review of R115's face sheet dated 6/27/24 revealed that he was a [AGE] year-old male, admitted to the facility on [DATE] and had diagnoses that included: chronic respiratory failure with hypoxia, cerebral infarction (brain injury), aphasia (language communication disorder), dependence on respirator, pressure ulcer of sacral region, unstageable. He was not his own responsible party. Review of R115's Activities of Daily Living (ADL) care plan dated 11/08/23 revealed interventions that included, bed mobility 2-person assist, toileting 2-person assist, transfers 2-person assist. R115 was observed on 6/27/24 in bed on his back. The only float repositing device in use was under both calves floating his heels. Registered Nurse (RN) K and Licensed Practical Nurse (LPN) J came in to reposition R115 and allow the Surveyor to see R115's skin. R115 was turned on his left side, when his brief was pulled back his buttock was saturated with brown liquid. No dressing was visible, the wound edges and inside were coated and it was not possible to determine size/depth. RN K and LPN J put the soiled brief back in place, placed a wedge cushion under R115's buttock deep enough to have contact with his sacrum and place both calves back in contact with the cushion used to float his heels. The left calf was again in contact with the heel floating device. The nurses said they would have the caregivers clean him up and after he was clean, they would apply a dressing to his buttock. When asked if the devices being used were removing pressure from the R115's pressure ulcers they determined the wedge cushion should be up higher to avoid contact with the sacral pressure ulcer but did not do anything to remove pressure on R115's left calf pressure ulcer. R115 was observed in bed on 7/1/24 at 12:30 PM, he was again on his back and his left calf was again in contact with the heel floating device. No other positioning devices were observed in use. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R115 was observed in bed on 7/1/24 at 1:27 PM, he had a wedge positioning device on his right side pushed under at the level of his sacral pressure ulcer and his left calf was again resting on the heel floating device. Certified Nurse Aides (CNA's) M and L turned R115 on his left side and pulled back his brief. The dressing on his buttock was soaked with brown liquid and there was no visible date. The CNA's went to LPN N to request help. The 3 staff cleaned R115, and the LPN replaced the dressing on R115's buttock after cleaning it. Staff were asked how often R115 soils his buttock wound they indicated that every time they turn him, he is usually soiled due to his tube feeding makes him stool constantly and R115 did not have a catheter and cannot let them know when he needs to urinate. When R115 was cleaned up the CNA's took two wedge cushions and place them just under his hips deep enough to float his sacral wound and took 2 towel rolls they brought into the room and placed them above and below the dressing on his left calf. This allowed the calf wound and the heels to float. During an interview with the Director of Nursing (DON) on 7/1/34 at 2:40 PM the surveyor inquired as to how the staff were using the positioning devices to float R115 pressure ulcers and expressed concern as observations were made with the devices in contact with the pressure ulcers and devices were not always being used. The DON said she would start educating staff today to float R115's pressure ulcers. The surveyor again requested all wound documentation and wound care planning with R115 guardian. Concern was expressed that R115's sacral wound was observed soiled with feces and urine and staff are indicating that would is chronically soiled. Review of R115's impaired skin integrity care plan dated 11/8/23 revealed he had unstageable pressure ulcers on his sacrum, right trochanter (hip) and left medial calf. No start dates for these unstageable pressure ulcers were listed. Interventions included: assist resident with turning and repositioning as needed starting 12/29/23, Pressure redistribution mattress to bed started 6/28/24 and provided incontinence care as needed started 6/28/24. Review of the facility timeline of wound measurements and treatment changes for R115's, 3 stageable pressure ulcers for the last two months showed his sacral wound and wound on his right trochanter improved at times and increased in size at times. The unstageable wound on his left calf had gone from 8.69 cm x 2.15 cm Area 13.9 on 5/2/24 to 11.3 cm x 3.6 cm Area 28.88 on 6/26/24. (significant decline in healing). During an interview on 7/2/24 at 11:19 AM, that included State Surveyor S, R115's Physician N, Nurse Practitioner (NP) P the DON and Assistant Director of Nursing (ADON) O the facility timeline was reviewed and observations of lack for pressure relief and the resident being soiled with urine and feces was shared. The DON again confirmed that she had started training staff on proper pressure relief, but the care plan had not been updated as to the expectation of frequency of pressure relief or how the pressure relieving devices were to be utilized. There was no indication the facility had addressed pressure relief concerns or incontinence care concerns of the contamination of the pressure ulcer on R115's sacrum had been reviewed with R115's guardian. The DON indicated that because R115 was on a special pressure ulcer relieving surface they were meeting R115's pressure relieving needs. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R115's specialty mattress manual revealed an area light lighted by the DON that read, BED LINES: Use flat sheets, knitted stretch-fit sheets, or deep -pocket fitted sheets. Use as few layers of linens or underpads beneath the patient as possible to allow best possible envelopment immersion and pressure management performance. The document ended with the statement, Wound Care: (Name of product) is only one element of care in prevention and treatment of pressure ulcers. Frequent repositioning, proper care, routine skin assessment, wound treatment and proper nutrition are but a few of the elements required in the prevention and treatment of pressure ulcers. As there are many factors that may influence the development of a pressure ulcer for each individual, the ultimate responsibility in the prevention and treatment of pressure ulcers is with the healthcare professional. The DON provided the Surveyor with R115's specialty mattress instruction manual on 7/2/24 at approximately 2:30 PM. The surveyor again asked how this mattress being used and floatation devices not being used properly makes R115's wound avoidable and the DON did not have any response. The DON did not verbalize any of the instructions she said she provided to staff for pressure relief or provide and updated pressure relieve care plan for R115. Review of Fundamentals of Nursing ([NAME] and [NAME]) 10th edition revealed, Repositioning (turning) patients is a consistent element of evidence-based pressure injury prevention (EPUAP, NPIAP, PPPIA, 2019a). The twofold aim of repositioning should be to reduce or relieve pressure at the interface between bony prominence and support surface (bed or chair) and to limit the amount of time the tissue is exposed to pressure (Maklebust and [NAME], 2016). Elevating the head of the bed to 30 degrees or less decreases the chance of pressure injury development from shearing forces (WOCN, 2016). Change the immobilized patient's position according to tissue tolerance, level of activity and mobility, general medical condition, overall treatment objectives, skin condition, and comfort (EPUAP, NPIAP, PPPIA, 2019a). A standard turning interval of 1.5 to 2 hours does not always prevent pressure injury development; repositioning intervals are based on patient assessment. Some patients may need more frequent position changes, while other patients can tolerate every-2-hour position changes without tissue injury. When repositioning, use positioning devices to protect bony prominences (WOCN, 2016). [NAME], [NAME] A.; [NAME], [NAME] Griffin; Stockert, [NAME] A.; Hall, [NAME]. Fundamentals of Nursing - E-Book (p. 1255). Elsevier Health Sciences. Kindle Edition.

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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** 28101 This Citation pertains to Intake Number MI00142716. Based on interview and record review the facility failed to provide adequate supervision and assistance for one resident (Resident #113) of 3 residents reviewed for falls resulting in Resident #113 falling and sustaining a serious laceration requiring hospitalization . Findings include: Resident #113 (R113): Review of R113's face sheet dated 7/2/24 revealed she was a [AGE] year-old female admitted to the facility on [DATE] and had diagnoses that included: Chronic respiratory failure with hypoxia, congestive heart failure, muscle weakness, difficulty in walking, liver disease, dependent on supplemental oxygen, and dependent on other enabling machines. Review of R113's Activities of Daily Living (ADL) care plan dated 3/17/23 revealed she required the assistance of 1-2 people for bed mobility, personal hygiene, for toilet use at bed level (bed pan). Transfers required assistance of 2 with a mechanical lift. Required a sponge bath as a full bath or shower could not be tolerated. Review of R113's fall care plan, dated 3/17/23, revealed interventions that included: call light in reach, bed in low position when not providing care. Review of R113's incident and accident report, dated 5/12/23 at 9:00 PM, revealed, R113 was found in her room laying on her right side next to the bed. Predisposing Physiological Factors, the boxes were checked for confused, incontinent. Predisposing Environmental the box was checked for bed height. Witnesses listed 6 staff. None of the staff witnessed the event. No statements were made to indicate who had provided care or when care had last been provided. During an interview with the Nursing Home Administrator (NHA) on 7/2/24 at 9:00 AM, R113 incident and accident report for 5/12/23 at 9:00 PM was reviewed. The report did not have any statements related to R113's care prior to the fall and all 6 staff listed on the report indicated they did not witness the fall. The NHA said she did not investigate the fall because the resident said she was attempting to get out of bed and go to the bathroom. The resident did not return so she did not have any additional information. The NHA said she did not have any additional information related to R113's fall. The NHA said only one staff person listed in the report still worked at the facility. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview with the Director of Nursing (DON) on 7/2/24 at 10:27 AM the DON provided a fall assessment for R113, dated 5/13/23 at 3:14 AM, that indicated R113 had not had any care during the 3 hours prior to her fall out of bed and there was no indication what care was provided or what R113 was like 3 hours prior to the fall. The DON confirmed that the standard of care for dependent residents is to provide care every 2 hours at a minimum. The DON said she did not investigate the fall. The DON said the Registered Nurse that completed the incident report and fall assessment no longer worked for the facility. The DON said the only staff person listed on the incident and accident report still working for the facility was Certified Nurse Aide (CNA) I. Review of R113's fall assessment dated [DATE] at 3:14 AM reveal no indication of who did the assessment. The injury description was right knee r/t laceration. What was resident doing prior to the fall listed attempting to self-transfer. Last time care was provided was 1800 (3 hours prior to her fall). No information was available to determine who provided her care or what care was provided. Review of R113's progress note dated 5/12/23 at 9:45 PM revealed, Called to resident's room for reports of resident observed on floor. Upon entering the room resident was noted laying on the floor, on her right side, next to the bed. Blood noted in a puddle under her leg. VS (vital signs) obtained. Mentation check and at baseline. ROM (range of motion) checked at baseline. Resident assisted from the floor to her wheelchair by 4 staff members. Right knee noted to have a large laceration that was bleeding heavily. Pressure applied by CNA (certified nurse aide) while RN (Registered Nurse) obtained wound care supplies. Knee irrigated with normal saline. Nonstick dressing applied. Wrapped with kerlex. ABD (absorbent dressing) applied to reinforce when the bleeding was noted through the dressing. More ABD applied and secured with an ace wrap for more pressure applied. EMS (emergency medical services) called and transported resident to (name of hospital) Review of R113's progress note, dated 5/12/23 at midnight, revealed, Notified by nursing the resident was sent to the hospital due to uncontrolled bleeding from a 6-8-inch laceration to the right knee. This note was electronically signed by a nurse practitioner. During a telephone interview on 7/2/24 at 2:37 PM, CNA I recalled working the night R113 was found on the floor. He recalled assisting getting her off the floor. He could not recall who the staff were that worked that night and he did not recall who provided R113 with care that night. The only thing he recalled clearly was that her bed was all the way up and he kept asking why the bed was all the way up. CNA I said R113 did not say she put the bed up when he asked. CNA I said he was concerned that someone left her bed up when they last did care. CNA I said he remembered that resident because there was a lot of blood. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235600	A. Building B. Wing	07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Montrose Inc	9317 W Vienna Rd Montrose, MI 48457

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 0689 Level of Harm - Actual harm Residents Affected - Few	Review of R113's hospital medical consult, dated 5/13/23 at 9:57 AM, revealed, Yesterday patient states she fell out of bed, however she cannot remember how or why she fell . She was brought to the ER (emergency room) for confusion and R (right) knee laceration. In ED (emergency department) patient was found in a fib (abnormal heartbeat) with RVR rapid ventricular response. She was given a bolus of amiodarone and went into VT (ventricular tachycardia) with hypotension. Pt shocked x 1 and went into SR (sinus rhythm) and then a fib with controlled rate. Currently pt in a fib with controlled rate. Patient does have h/o (history of) a fib and Eliquis (blood thinning medication) was held during previous admission 2* (secondary to) GI (gastrointestinal) bleed, unsure when this was resumed. Pt also found to have significant electrolyte imbalance, which are being replaced. She is anemic (low blood iron) and hypotensive (low blood pressure). IVR (intravenous fluids) are being started and PRBCs (packed red blood cells) have been ordered. Her right knee is being sutured at time of evaluation. Patient currently confused on why she needed to come to the hospital for just a fall. She denies any chest pain, pressure or tightness. She denies R (right) knee pain. She does have occasional SOB (shortness of breath) that is worse when she tries to move in bed. Review of R113's hospital medical record for her emergency room admission on 5/12/23 at 9:49 PM revealed she discharged on [DATE] at 2:22 PM. Review of R113's discharge summary for this hospitalization revealed. Pt (patient) was admitted s/p (status post) fall for AMS (altered mental status), multiple medical problems, PT (patient) was intubated at one time. Pt had been transferred out of ICU (intensive care unit) but was transferred back yesterday afternoon for respiratory acidosis. She was receiving respiratory support via AVAPS (ventilator). Per the nursing pt had sudden severe bradycardia followed by PEA (Pulseless Electrical Activity) ROSC (return of spontaneous circulation) was unable to be achieved and pt passed away.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49083 This Citation pertains to Intake Number MI00143607. A complaint was filed with the State Agency that alleged the facility was not providing adequate tracheostomy (surgical opening into the windpipe to allow air to flow in and out) care. Based on observation, interview, and record review, the facility failed to assure that staff maintained infection control prevention ((sterile technique), while performing tracheostomy suctioning for one resident (Resident #122) of one resident reviewed for tracheostomy care, leading to the likelihood for increased risk of respiratory infection. Findings include: Resident #122 (R122): On 7/2/24, A clinical record review revealed R122 was admitted to the facility on [DATE] with diagnoses that included: hypertension, heart failure, kidney disease, left cerebellar stroke, dysphagia (difficulty swallowing food or liquid) required a PEG tube (percutaneous endoscopic gastrostomy, surgical procedure inserting a tube into the stomach to provide nutrition), chronic respiratory failure with hypoxia (low blood oxygen) required airway management via a tracheostomy and dependent on supplemental oxygen. R122's most recent Brief interview of Mental Status (BIMS) score totaled 2/15 indicating severe impaired cognition. On 7/2/24 at 9:50 AM, R122 was observed alert, lying in bed, breathing via a tracheostomy attached to supplemental oxygen. R122 was nonverbal but maintained eye contact when spoken to. R122 required suctioning of the tracheostomy and an observation of this procedure was conducted with Licensed Practical Nurse (LPN) H. LPN H was observed donning unsterile gloves, touching the outside of the glove box, and removed a single-use sterile tracheal suctioning tube from the package. LPN H lubricated tip of catheter with sterile water then proceeded to insert into the airway. When asked if sterile gloves were to be used for tracheal suctioning, LPN H replied sterile gloves were not required. LPN H inquired if I wanted them to don sterile gloves, they could. Surveyor replied to perform the procedure as they were instructed per facility policy. LPN H continued to suction R122 without maintaining sterile technique. On 7/2/24 at 11:50 AM, An interview was conducted with the Facilities Infection Control and Nurse Educator Registered Nurse (RN) C and informed tracheal suction was observed without donning sterile gloves. RN C confirmed the facilities policy states suctioning requires sterile technique and sterile gloves are required for the procedure. The facility provided education materials from a Tracheostomy Care Inservice conducted in May 2024, and confirmed that the education endorsed .using the dominant hand for suctioning must be sterile . When questioned why the nursing checklist indicated clean gloves, RN C said that was the vendors checklist, not sure why it said clean, but the facility follows sterile technique. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/2/24 at 1:30 PM, The Director of Nursing (DON) was interviewed and was informed by RN C of the concerns and confirmed suctioning of tracheotomies, must maintain sterile technique. The DON identified this was a concern and will be reinforcing education to the nursing staff. Review of the facilities policy titled; Tracheostomy Care-Suctioning Procedure. Dated 10/30/2022 documented: .Using sterile technique, open the suction catheter kit and put on sterile gloves. Consider the glove on your dominant hand sterile, and the non-dominant hand clean .