STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235650	A. Building B. Wing	08/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Milford	555 Highland Ave Milford, MI 48381

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 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** 32568 Based on observation, interview, and record review, the facility failed to provide nursing care and services according to professional standards of practice for one (R203) of one resident reviewed for tube feeding. Findings include: On 8/12/24 at 10:18 AM, R203 was observed lying in bed. R203 was receiving nutrition via a PEG (Percutaneous Endoscopic Gastrostomy) tube (a tube surgically placed into the stomach to deliver nutrition). The PEG tube pump was running at 45 milliliters per hour (ml/hr) and the bottle of formula was dated 8/12/24. On 8/13/24 at 9:01 AM, R203 was observed lying in bed. R203 was receiving nutrition via a PEG tube. The PEG tube pump was running at 45 ml/her and the bottle of formula was dated 8/13/24. A review of R203's clinical record revealed R203 was admitted into the facility on [DATE] and readmitted on [DATE] with diagnoses that included: prostate cancer, chronic kidney disease, and ST elevation myocardial infarction (STEMI), and gastrointestinal hemorrhage. A review of an Minimum Data Set (MDS) assessment dated [DATE] revealed R203 had intact cognition and had a feeding tube. A review of R203's Physician's orders revealed no order for tube feeding that indicated the prescribed formula, rate, and feeding instructions until 8/13/24, five days after R203 was readmitted into the facility. It should be noted that R203's tube feeding was observed to be administered on 8/12/24 and 8/13/24. There was an active order with a start date of 8/9/24 to Cleanse (PEG) tube site with soap and water daily and as needed. Apply drain sponge as needed. site may be left open to air if clean and no drainage. A review of R203's August 2024 Treatment Administration Record (TAR) indicated this order was completed on 8/9/24, 8/10/24, 8/11/24, and 8/12/24 as evidenced by an electronic signature from the nurse who carried out the order. On 8/13/24 at approximately 10:30 AM, an observation of R203's PEG tube site was conducted with the Wound Care Coordinator, Licensed Practical Nurse (LPN) 'A'. LPN 'A' lifted R203's gown and revealed a dressing applied to R203's PEG tube site. The dressing was dated 8/9/24, four days earlier. LPN 'A' removed the dressing which was soiled with thick, caramel colored drainage. It should be noted that it was documented on the TAR that R203 received treatment to the PEG tube site daily since his readmission on 8/9/24. (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: 235650	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Milford	555 Highland Ave Milford, MI 48381

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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	On 8/13/24 at approximately 10:50 AM, an interview was conducted with the Director of Nursing (DON). When queried about how often PEG tube sites should be monitored, cleaned, and dressed, the DON reported at least daily. At that time, the DON was asked when R203's tube feeding order was put into place. The DON reported he would look into it. On 8/13/24 at 11:05 AM, the DON followed up and reported the PEG site dressing should have been changed according to physician's orders and the nurse should not have signed out that it was done if it was not. The DON further said the order for R203's tube feeding was not entered until that day, 8/13/24, but the nurse wrote the order in the progress note on admission on 8/8/24. When queried as to how the nurses knew what tube feeding to administer each day since 8/8/24 and how it was known whether or not R203 received daily tube feeding, the DON did not offer a response.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34208 Based on observation, interview, and record review, the facility failed to accurately assess wounds, perform wound care treatments, coordinate with a comprehensive wound care team consisting of a wound care practitioner, document treatment plans, and implement physician's orders for wound care treatments for two residents, (R#'s 101 and 305) of three residents reviewed for skin impairments, resulting in verbalized complaints, fear of staff competency and infection, and R101 voluntarily leaving the facility for wound care at the hospital. Findings include: R101 On 8/13/24 at 2:09 PM, a review of R101's closed record revealed they admitted to the facility on [DATE] and discharged [DATE]. R101's diagnoses included: cutaneous abscess of buttock, and hidradenitis suppurativa, a chronic inflammatory skin disorder characterized by painful nodules, abscesses, and scarring. R101's post-operative records from the hospital revealed they underwent incision and drainage of multiple buttock, back, thigh, and perianal abscesses with significant abscess cavities under the skin and, .extensive purulent material and tunneling The paperwork further revealed R101 had three penrose drains (a straight, flexible tube that drains fluid from a surgical site) placed to the wound. A review of a Nursing Admission Evaluation dated 5/21/24 was reviewed and revealed R101 admitted with a right buttock surgical wound. Neither the evaluation nor the nursing admission note dated 5/21/24 made any mention of the presence of wound drains. It was further noted the first practitioner note entered into the record by Nurse Practitioner G made no mention of the drains or the treatment to be applied to the wound, the note only read, .Wound Care consult for ongoing wound management . Continued review of R101's closed record revealed a Skin & Wound Evaluation dated 5/22/24 and documented R101 had a, 22. Other skin impairment specified on the form as rose pin, it was unclear what was meant by a rose pin wound. The form contained 21 types of wounds the assessing nurse could have checked including, 10. Hidradenitis Suppurativa (R101's diagnoses), or, 20. Surgical. It was of note, the assessment did not include any mention of the three wound drains. R101's Treatment Administration Record (TAR) was reviewed and revealed an order dated 5/24/24 (three days after admission and the day R101 left the facility) to monitor the wound drains. It was further discovered two orders were written on 5/22/24 for treatment to R101's buttocks that both read, .Cleanse with wound cleanser. Pat dry. Apply Bordered Foam as directed to buttock . It was noted both orders on the TAR were blank and not signed off as having been completed on 5/22/24. A review of Dr. 'H's progress note dated 5/23/24 was reviewed and read, .I am evaluating .today for an admission history and physical. Patient has a history of hydradenitis <sic> suppurativa and was hospitalized and treated for a right gluteal abscess status post incision and drainage .patient says he felt he got good wound care here .but today his nurse did something different and he is not sure he is getting the best wound care .all wounds to be managed by the wound care team here at the facility . It was noted Dr. 'H's progress notes did not indicate the type of wound care treatment or how often the treatment was to be done, nor did the note indicate the presence of drains. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of a progress note dated 5/24/24 at 10:05 PM was conducted and read, Lodger Requested to Leave Stating He Does Not Feel He Is Receiving the Care He Needs for His Surgical Wound. This Nurse Offered to Change the Dressing, Lodger Declined Stating I Have Made Up My Mind, I Am Returning to the Hospital, They Know How to Properly Care for My Wound .He Is Driving Himself to the Hospital . <sic> On 8/13/24 at 1:20 PM, an interview was conducted with Wound Care Nurse 'A'. Nurse 'A' was asked if there was a wound care physician, physician's assistant or nurse practitioner at the time of R101's admission and said there was not. Nurse 'A' then said they assessed R101 on admission, placed the treatment orders and Dr. 'H' signed off on them. They were asked about the presence of drains and confirmed R101 admitted with drains. They were asked why this was not documented and had no explanation but said it should have been noted. They were then asked about the missed treatment on 5/22/24 and said it should have been done by R101's assigned nurse. They further reported R101 told them on 5/23/24 they were concerned with the nurses ability/competency to care for their wounds and they reported the concern to Dr. 'H'. Nurse 'A' confirmed R101 left the faciity on [DATE]. On 8/14/24 11:03 AM, an interview was conducted with Dr. 'H' regarding R101. They were asked about the documentation for the specific treatment of R101's wounds and said they deferred to the facility's wound care team and did not document specific treatment orders in their progress notes. They were asked if they were aware at the time of R101's admission the Wound Care Team only consisted of Nurse 'A' and said they were aware the facility was challenged with finding a wound care physician. Dr. 'H' was then asked about the documentation of the presence of drains and agreed it was missed. Dr. 'H' further reported R101 did express to them their concerns about the treatment of their wounds and said it was reported to the facility's Administrator and Director of Nursing. An interview via telephone was conducted with R101 on 8/13/24 at 2:35 PM. They were asked about their stay at the facility and said, It was a disaster. R101 further reported they had surgery and were sent to the facility for wound care. They said the only nurse who seemed like they knew what they were doing was the first nurse, Nurse 'A'. They further reported no one seemed comfortable doing the treatments and the day before they left (5/23/24) the nurse sprayed something on their wound that caused it to, burn like crazy. R101 was asked if any treatments were missed and said they did not recall. R101 said they spoke to the doctor and they needed answers about the staff's competency to care for their wounds. They said they were told someone would come and speak to them but no one ever did. They said they were fearful of an infection and decided to return to the hospital. 38271 R305 On 8/12/24 at approximately 10:47 a.m., R305 was observed in their room, standing up next to their bed. R305 was observed to have a dry dressing on each knee that appeared to be worn and losing their adhesive properties. Neither dressing on their knees were dated and appeared to be worn. A worn dry dressing dated 8/10/24 was observed on R305's right elbow. R305 was queired if they had fallen and they indicated they had and had scraped their knees and elbow. On 08/12/24 at approximately 3:33 p.m., R305 was observed in their room, lying down in a low bed. R305 still had on the dry dressings on both knees with the edges of the dressings starting to become unattached. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/13/24 at approximately 8:55 a.m., R305 was observed in their room, lying in their bed. R305 was observed to have a dry dressing on their right knee that was still undated with no dressing on their left knee with an uncovered pink skin abrasion. R305's right elbow had a dry dressing dated 8/10/24. On 8/13/24 at approximately 10:46 a.m. R305 was observed in their room, lying in their bed. R305 was observed to have a dry dressing on their right knee that was undated and no dressing on their left knee with an uncovered pink skin abrasion. R305's right elbow had a dry dressing dated 3/10/24. R305 was queried if any staff had changed their dressing and they reported that nobody had. R305 was queired what happened to their dressing on their left knee and they indicated it had fallen off the previous day and that nobody had applied a new dressing. On 8/12/24 the medical record for R305 was reviewed and revealed the following: R305 was initially admitted to the facility on [DATE] and had diagnoses including Dementia and Type 2 Diabetes Mellitus. A Nursing progress note dated 8/10/24 revealed the following: At approximately 0100 (1:00 a.m.), lodger noted to be laying on his right side on the floor, in front of bathroom door, with knees bent up to waist. Lodger assessed for injury, abrasion noted to right knee, and skin tear noted to right elbow. Lodger denies hitting his head, and AROM (active range of motion) noted to all 4 extremities. Writer asked lodger what had happened and lodger states he was trying to move the mat. No mat located in room by writer. Neuro (neurological) checks complete and noted to be WNL (within normal limits) for lodger. Lodger noted to be incontinent of urine at this time. Lodger assisted to his feet per 3 staff, and assisted onto toilet. Lodger then assisted onto bed per 3 staff. On Call provider notified, and DON (Director of Nursing) notified. Will notify family in a.m. A Fall assessment dated [DATE] titled Fall-Initial-V2 was reviewed and revealed the following: Date of fall-8/10/24 New orders related to the fall: [Yes] 9a. Describe New Physician Orders-Clean right knee abrasion and right elbow skin tear with soap and water, apply TAO (triple antibiotic ointment) and dry dressing daily . Further review of R305's medical record did not reveal any noted transcribed Physician orders for R305's right knee abrasion and right elbow skin tears noted in the fall assessment dated [DATE]. A review of R305's August 2024 treatment administration record (TAR) did not reveal any treatments administered to R305's right knee or right elbow were documented as having been completed. On 8/14/24 at approximately 9:03 a.m., during a conversation with the Director of Nursing (DON), the DON was queried regarding the process for transcribing orders and they reported that the facility Nurse should have transcribed the Physician's orders for R305's dry dressing skin abrasions but did not and did not date knee dressing. The DON indicated they would input the orders for R305's dry dressings into the the electronic medical record so it can be completed by the Nurse and documented per the Physician's orders. On 8/14/24 a policy addressing the procedures for non-pressure wound care was requested from the facility Administrator and they reported they did not have a policy/procedure guide for non-pressure wounds.

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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 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** 32568 Based on observation, interview, and record review, the facility failed to timely assess pressure ulcers present on admission into the facility in a timely manner, and implement preventative measures to maintain skin integrity for one (R203) of two residents reviewed for pressure ulcers. Findings include: On 8/12/24 at 10:18 AM, R203 was observed lying on his back in bed. Two pairs of heel protector boots were observed in the room, on a chair and on the floor, not applied to R203's feet. R203's feet were pressed against the foot board of the bed. A low air loss mattress was observed. R203 reported he had sores on his feet. A review of R203's clinical record revealed R203 was admitted into the facility on [DATE] and readmitted on [DATE] with diagnoses that included: prostate cancer, chronic kidney disease, and ST elevation myocardial infarction (STEMI). A review of an Minimum Data Set (MDS) assessment dated [DATE] revealed R203 had intact cognition, required substantial/maximum assistance for bed mobility and transfers, did not walk, and had three unstageable pressure ulcers (obscured full-thickness skin and tissue loss) that were present on admission. On 8/13/24 at 9:01 AM, R203 was observed lying in bed. R203 reported staff applied heel protector boots on that day, but they did not always put them on. Further review of R203's clinical record revealed the following: A review of a Nursing Admission Evaluation dated 7/22/24, that was not complete and in progress revealed R203 was admitted with pressure ulcers to the left toe, left heel, right toe, and right heel with eschar (dead or devitalized tissue). A review of a Nursing Evaluation Summary progress note dated 7/22/24 written by the Director of Nursing (DON) and MDS Coordinator revealed, .Unstageable heel ulcers bilateral and necrotic areas noted on both great toes . A review of a History of Physical completed by Physician 'E' revealed no documentation of R203's pressure ulcers. Further review of all evaluations conducted by the facility's medical providers (Physician 'E' and Nurse Practitioner - NP 'G') revealed no documentation that R203 had pressure ulcers or an evaluation of the pressure ulcers. A review of a Skin assessment dated [DATE] revealed R203 had existing pressure ulcers to the bilateral heels and great toes. It was documented that boots and offloading in place. A review of R203's Wound Evaluations and Skin & Wound Evaluations revealed R203's feet were not assessed by LPN 'A' until 8/9/24 when he was readmitted into the facility from the hospital. R203 was transferred to the hospital on 7/29/24 and 7/31/24 and returned the same day and was admitted to the hospital from 8/4/24 through 8/8/24. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Skin & Wound Evaluations for R203 on 8/9/24 and 8/12/24 revealed R203 had an unstageable pressure ulcers to the left and right heels that were present on admission, filled with 100 percent eschar; and deep tissue injuries (DTIs) to the left and right great toes that were present on admission. A review of R203's Physician's Orders revealed orders dated 7/22/24 for treatment to the bilateral heels and toes for unstageable ulcers. An order for offloading boots on at all times while in bed was ordered on 7/22/24 and discontinued on 7/22/24. However, R203 continued to have pressure ulcers to his bilateral great toes and heels. A review of a Nursing Evaluation Summary progress note dated 8/8/24 revealed R203 was admitted into the facility on that day. It was documented that R203's BL (bilateral) heels have necrotic (dead) tissue. On 8/13/24 at approximately 10:30 AM, R203's feet were observed with Wound Care Coordinator, Licensed Practical Nurse (LPN) 'A'. At that time, R203 had heel protector boots on. An observation of R203's right foot revealed a black area to the great toe, a black area on the outer bottom part of the heel, and a second darkened area on the back of the heel. An observation of R203's left foot revealed a black area to the tip of the great toe and a black area described by LPN 'A' as all eschar located on the inner part of the heel. LPN 'A' reported that R203 needed a bed extender. On 8/13/24 at approximately 10:50 AM, an interview was conducted with LPN 'A'. When queried about how often she assessed residents' wounds, LPN 'A' reported she conducted wound assessments every week on Monday. When queried about why there was no documented assessment of R203's pressure ulcers to the heels and toes until 8/9/24, LPN 'A' reported R203 did not have any wounds until he returned to the facility from the hospital on 8/8/24. When queried about the MDS assessment, nursing admission assessment, skin assessment, and treatment orders that indicated R203 had pressure ulcers to his bilateral heels and great toes, LPN 'A' did not offer a response. On 8/13/24 at 1:16 PM, an interview was conducted with the DON. When queried about the facility's process for assessing residents' pressure ulcers, the DON reported they were assessed by LPN 'A' and the wound provider weekly. LPN 'A' reported the wound provider started working in the facility two weeks ago and did not come to the facility on [DATE]. The DON reported any assessment completed by LPN 'A' was documented in the electronic medical record. When queried about why R203's pressure ulcers were not assessed until 8/9/24 when he was admitted with them on 7/22/24, the DON reported he had to look into it. At that time, any evaluations of R203's pressure ulcers conducted by a medical provider was requested. No additional information was provided prior to the end of the survey.

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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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32568 Based on observation, interview, and record review, the facility failed to ensure a thorough and accurate assessment was done upon admission, physician's orders for an indwelling urinary catheter were in place, and the catheter was securely anchored for one (R204) of three residents reviewed for urinary catheters. Findings include: On 8/12/24 at 10:25 AM, R204 was observed sleeping in a chair in the room where his wife resided. R204's was observed with tubing from a urinary catheter exiting the bottom of his long pajama pants. The urinary catheter drainage bag was observed hung on R204's walker which was next to the resident and therefore the tubing was stretched from the pant leg to the walker. On 8/13/24 at 10:25 AM, R204 was observed ambulating with a walker. Tubing from the urinary catheter was observed coming out of the bottom of R204's pant leg and attached to the drainage bag that was attached to the bottom of the walker making contact with the floor. The tubing was observed dragging on the floor as R204 walked. On 8/13/24 at approximately 10:50 AM, an interview was conducted with the Director of Nursing (DON) who was present on the unit during the above observation. When queried about whether R204's catheter was anchored properly, the DON reported he could get a leg bag (a smaller drainage bag that is worn on the leg when you are up out of bed). When queried about what orders and monitoring should be in place for residents admitted with indwelling urinary catheters, the DON reported there should be physician's orders for the catheter. At that time, the DON was asked if the appropriate orders and monitoring were done for R204. The DON reported he would look into it. On 8/13/24 at approximately 11:30 AM, the DON reported R204 did not have an order for the indwelling urinary catheter. A review of R204's clinical record revealed the following: R204 was admitted into the facility on [DATE] for respite care. R204 received hospice services. A review of a Nursing Admission Evaluation for R204 revealed documented vital signs from his previous admission on 5/24/24. The evaluation indicated R204 was continent of urine and did not indicate that R204 had an indwelling urinary catheter. The evaluation was dated 8/11/24, two days after R204 was admitted into the facility. A review of the Certified Nursing Assistant (CNA) task for catheter care indicated R204 received catheter care on 8/13/24. There was no documentation that R204 received catheter care prior to that date. A review of R204's physician's orders revealed no physician's orders for R204's catheter until 8/13/24 which included an order to ensure the catheter was anchored in place. There was no care plan initiated until 8/13/24 for catheter care. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of R204's progress notes indicated no notes that indicated R204 had an indwelling urinary catheter. A review of R204s CNA task for Urinary Continence revealed CNAs documented R204 was continent of urine twice on 8/10/24 and 8/11/24, and once on 8/12/24 and 8/13/23. The task included a section to check Continence Not Rated due to Indwelling Catheter. In response to the question, What was the toileting bladder activity?, two CNAs documented, Used bed pan/commode/urinal/toilet despite R204 having a urinary catheter. Three CNAs documented R204 toileted himself. A review of a facility policy titled, Catheter Care Procedure - Urinary dated 2/28/23, revealed, in part, the following: .Residents with indwelling catheters will be provided catheter care in accordance with current clinical standards. This may include: .every shift .with each bowel movement .as needed and per request . Leg bags may be utilized for ambulatory residents .Catheters should be secured to prevent pulling and damage to the urethral meatus. This may be accomplished by .utilizing the appropriate drainage device (leg bag or catheter bag) .Catheters should be emptied every shift or as needed .urinary output should be recorded per facility protocol .

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32568 Based on observation, interview, and record review, the facility failed to ensure appropriate care was provided to prevent dislodgement of a PEG (Percutaneous Endoscopic Gastrostomy) tube (a tube surgically placed into the stomach to deliver nutrition), physicians orders for nutrition and hydration were in place, and care to the PEG tube site was provided according to physician's orders for one (R203) of one resident reviewed for tube feeding, resulting in the PEG tube being torn from R203's stomach requiring a hospital transfer, the potential for poor nutritional and hydration status, pain, infection and skin breakdown. Findings include: On 8/12/24 at 10:18 AM, R203 was observed lying in bed. R203 was receiving nutrition via a PEG tube. The PEG tube pump was running at 45 milliliters per hour (ml/hr) and the bottle of formula was dated 8/12/24. On 8/13/24 at 9:01 AM, R203 was observed lying in bed. R203 was receiving nutrition via a PEG tube. The PEG tube pump was running at 45 ml/her and the bottle of formula was dated 8/13/24. A review of R203's clinical record revealed R203 was admitted into the facility on [DATE] and readmitted on [DATE] with diagnoses that included: prostate cancer, chronic kidney disease, and ST elevation myocardial infarction (STEMI), and gastrointestinal hemorrhage. A review of an Minimum Data Set (MDS) assessment dated [DATE] revealed R203 had intact cognition and had a feeding tube. A review of a Transition of Care form from the hospital dated 8/8/24 revealed R203 had a primary diagnosis of dehydration and prerenal azotemia (caused by decreased blood flow to the kidneys which can be caused by dehydration or blood loss from a hemorrhage). Instructions for 250 cc (cubic centimeters) of free water flushes every 4 hours was included in the discharge instructions. A review of R203's Physician's orders revealed no order for tube feeding that indicated the prescribed formula, rate, and feeding instructions until 8/13/24, five days after R203 was readmitted into the facility. The orders entered on 8/13/24 indicated R203 was to receive 250 ml (milliliters) of free water, five days after R203 was readmitted into the facility. There was an active order with a start date of 8/9/24 to Cleanse (PEG) tube site with soap and water daily and as needed. Apply drain sponge as needed. site may be left open to air if clean and no drainage. A review of R203's August 2024 Treatment Administration Record (TAR) indicated this order was completed on 8/9/24, 8/10/24, 8/11/24, and 8/12/24 as evidenced by an electronic signature from the nurse who carried out the order. On 8/13/24 at approximately 10:30 AM, an observation of R203's PEG tube site was conducted with the Wound Care Coordinator, Licensed Practical Nurse (LPN) 'A'. LPN 'A' lifted R203's gown and revealed a dressing applied to R203's PEG tube site. The dressing was dated 8/9/24, four days earlier. LPN 'A' removed the dressing which was soiled with thick, caramel colored drainage. On 8/13/24 at approximately 10:50 AM, an interview was conducted with the Director of Nursing (DON). When queried about how often PEG tube sites should be monitored, cleaned, and dressed, the DON reported at least daily. At that time, the DON was asked when R203's tube feeding order was put into place. The DON reported he would look into it. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Medilodge of Milford		STREET ADDRESS, CITY, STATE, ZIP CODE 555 Highland Ave Milford, MI 48381	

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/13/24 at 11:05 AM, the DON followed up and reported the PEG site dressing should have been changed according to physician's orders and the nurse should not have signed out that it was done if it was not. The DON further said the order for R203's tube feeding was not entered until that day, 8/13/24, but the nurse wrote the order in the progress note on admission on 8/8/24. When queried as to how the nurses knew what tube feeding to administer each day since 8/8/24 and how it was known whether or not R203 received daily tube feeding, the DON did not offer a response. A review of R203's progress notes revealed the following: A Nursing Evaluation Summary dated 8/8/24 revealed R203 was readmitted into the facility. It was documented R203 was on peg-tube feeding but only mentioned the type of formula and the rate. A Nurses' Note dated 7/29/24 noted, Therapy was working with resident when peg tube accidentally was torn out. Small trauma to opening noted, stomach contents draining .911 called .transferring to (hospital) for eval and treatment . A progress note written by NP 'G' on 7/30/24 noted, .Chief Complaint .PEG tube traumatically pulled out and replaced .PEG tube traumatically pulled out while working with therapy by accident the other day. Went to the ER (emergency room) and it was replaced . An Alert Note dated 7/31/24 noted, .CNA (Certified Nursing Assistant) called writer to room because his (R203) peg tube dressing was wet .(R203) c/o (complained of) abdominal pain, abdominal contents coming out of site .transfer to hospital . R203 returned to the facility the same day after the PEG tube was replaced. On 8/13/24 at 9:52 AM, the Administrator and DON were asked to provide any incident reports and/or investigations for R203. The Administrator reported there were no investigations or incident reports for the resident. A review of a Physical Therapy (PT) Treatment Encounter Note dated 7/29/24 revealed, R203 was seen by Physical Therapy Assistant (PTA) 'F'. PTA 'F' documented, .Patient's feeding tube came out of his abdomen after amb (ambulation) . On 8/13/24 at approximately 12:41 PM, an interview was conducted with PTA 'F'. When queried about what happened with R203's PEG tube on 7/29/24, PTA 'F' reported she worked with the resident on ambulation using a gait belt. PTA 'F' reported the gait belt was positioned off of the PEG tube site. PTA 'F' further reported R203 was tired and wanted to lay down. PTA 'F' assisted R203 to sit at the side of the bed and when he laid down she heard a suction and his stomach was wet and the PEG tube was completely out. PTA 'F' reported she did not know what happened. She remembered the tubing was long and that she used a gait belt but was unable to say how it was traumatically pulled out. On 8/13/24 at approximately 12:52 PM, an interview was conducted with the DON. When queried about whether the incident of R203's PEG tube being traumatically pulled out during therapy was investigated, the DON reported he would have to check with therapy. On 8/13/24 at approximately 1:23 PM, the DON followed up and stated, Therapy said they don't think it was anything they did to cause the PEG tube to be traumatically pulled out. The DON reported he did not investigate it from a nursing standpoint. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of a facility policy titled, Feeding tubes, revised on 6/30/22, revealed, in part, the following: .Feeding tubes will be utilized according to physician orders .

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Obtain a doctor's order to admit a resident and ensure the resident is under a doctor's care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48680 Based on observation, interview and record review the facility failed to ensure a physician and/or physician extender evaluated and assessed a new/worsened pressure ulcer for one (R85) of two residents reviewed for pressure ulcers, resulting in the lack of pressure ulcer assessment by the physician, and the potential for inconsistent and timely documentation of wound status, and/or decline of the wound. Findings include: On 8/12/24 at 12:21 PM, R85 was observed in room appeared to be resting. When R85 was asked how they were doing and stated that their bottom was hurting and could not get comfortable due to the pain, other than that R85 was content. A record review revealed that R85 was admitted to the facility on [DATE] with diagnoses of Parkinson's diseases, pressure ulcers of sacral region and muscle weakness. R85 had a brief interview for mental status score of 15, indicating an intact cognition. A further review of the chart revealed that R85's wound care orders had been updated that morning 8/12/24. A review of the status of the wound, revealed no progress note from a provider since 2/2024. On 8/13/24 at 12:00 PM the Wound care nurse was interviewed and asked what wound care company they used. The Wound care nurse explained they just got a new provider two weeks ago. When further questioned on who was the provider was used prior too two weeks ago, the Wound care nurse stated, We have not had a provider for several months. The doctors were supposed to put in their own notes or assessments of the wounds after we round on their patients weekly. The wound care nurse was then asked about R85 and if they could provide the notes for the wound. The wound care nurse stated she would look and get back with this surveyor. On 8/14/24 at around 10 AM, the Medical director was interviewed by another surveyor and stated that she did not do progress notes on wounds, but put her notes in to follow up with the wound care team. The Medical director was then asked who did the wound care team consist of at the facility. She stated the Wound care nurse since the facility just got a new provider recently. The Medical director was informed of no progress notes or physician follow up with the wound care for R85. The Medical director stated, Correct, there is one now. No additional information was provided by the exit of survey.

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34208 Based on interview and record review, the facility failed to ensure labs were obtained timely for one resident (R40) of one resident reviewed for labs, resulting in the potential for unmet medical care needs. Findings include: On 8/12/24 at 1:20 PM, a review of R40's clinical record revealed a note entered into the record on 7/8/24 by Nurse Practitioner (NP) 'G' that read, .Check a CMP (comprehensive metabolic panel, a routine blood test that measures 14 different substances in a blood sample) and CBC (complete blood count, a blood test to look at a wide range of conditions) to monitor fluid volume status . A note entered into R40's record by Nurse 'I' on 7/19/24 at 10:48 AM was reviewed and read, .Resident asked nurse why his blood work from 7/8/24 still hadn't been completed yet, Dr. ('H') in the building at the time and resident asked her about it. Dr. ('H') ordered for blood work to be reordered STAT today . Continued review of R40's record revealed a note entered into R40's record by Nurse 'I' on 7/23/24 at 12:00 PM that read, .Resident stated that he still had not gotten bloodwork <sic> drawn from 7/19/24, nurse saw phlebotomist in building and asked why it was not done yet and to have it completed today. Labs drawn today . A review of R40's physician's orders was conducted and revealed orders dated 7/8/24 and 7/19/24 for a CBC and a CMP. It was noted the orders each had a status of Completed. On 8/13/24 at 2:52 PM, a review of R40's facility provided lab results were reviewed and only included CBC and CMP results collected on 7/22/24 and reported to the facility on [DATE]. No results were provided for labs ordered on 7/8/24 or 7/19/24. On 8/14/24 at 9:30 AM, an interview was conducted with the facility's Director of Nursing and they acknowledged the labs were not drawn and sent on 7/8/24 or 7/19/24. A review of a facility policy titled, Laboratory and Diagnostic Guidelines revised 10/2023 was conducted and read, Policy: This guideline is set up to track the timely completion, reporting and monitoring of laboratory and diagnostic tests, results, and notifications which are used to monitor resident status and/or therapeutic medication levels .

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38271 Based on observation, interview and record review the facility failed to follow infection control guidance for one resident (R306) of three residents reviewed for urinary catheters. Findings include: On 8/12/24 at approximately 10:43 a.m., R306 was observed in their room, lying in their bed. R306's catheter draining bag was observed located not below the bladder (indicating a risk for urine to backflow up into the bladder causing infection). R306 was noted not to have any signage on their door that indicated staff were to apply enhanced barrier precautions (EBP) when providing direct care to them. R306 was queired if staff were wearing any protective gowns when caring for them and they indicated nobody had. On 8/12/24 at approximately 3:32 p.m., R306 was observed in their room, lying in their bed. R306's catheter draining bag was still observed high and located not below bladder. R306's door was still noted to not contain any information that staff were to apply EBP. On 8/13/24 at approximately 8:54 a.m., R306 was observed in their room lying in their bed. R306's door was still not observed to have any signage informing staff that they were to don EBP when providing care to R306. On 8/13/24 at approximately 1:13 p.m., Physical Therapy Assistant F (PTA F) was observed providing therapy services to R306 in their room. PTA F was queired if they had used enhanced barrier precautions while doing therapy with R306 and they indicated they did not because they did not see a sign on 306's door. PTA F then reported that R306 should have had an EBP sign on their door because they had a catheter. On 8/12/24 the medical record for R306 was reviewed and revealed the following: R306 was initially admitted to the facility on [DATE] and had diagnoses including Contact with and suspected exposure to Covid-19 and Hemiplegia and Hemiparesis following Cerebral vascular disease affecting right non-dominant side. A Physician evaluation dated 8/9/24 revealed the following: This is an [AGE] year-old admitted to [name of facility] on 8/8/24 from [name of hospital] due to bright red blood per rectum. GI (Gastrointestinal) was consulted. Symptoms improved spontaneously. Lower GIB (gastrointestinal bleeding) suspected due to hemorrhoids, as family reports that patient has had recurrent episodes of bright red blood per rectum and work up found hemorrhoids to be the culprit Hospital course was complicated by large volume urinary retention requiring foley catheter, severe constipation, and E.coli UTI (urinary tract infection). A review of R306's Physician orders did not reveal any orders for enhanced barrier precautions. A review of R306's careplan did not reveal any plan of care for enhanced barrier precautions. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/13/24 at approximately 1:16 p.m., Registered Nurse C (RN C) was queried regarding R306's indwelling catheter and then not being provided EBP by the facility staff and they reported that R306 needed to have EBP due to the catheter and that they should have a sign on the door and a Physician's order. At that time, an observation of R306's room was conducted with RN C and they indicated they did not have a sign and would have to put one on the door to alert staff and implement an order in for EBP since R306 had an indwelling catheter. On 8/13/24 a facility document titled Enhanced Barrier Precautions was reviewed and revealed the following: Policy: It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms (MDRO) .b. Even if the resident is not known to be infected or colonized with a MDRO, an order for enhanced barrier precautions will be obtained for residents with any of the following: II. Indwelling medical devices (e.g., central lines, urinary catheters .3. a. Make gowns and gloves readily available near or outside of the resident's room .e. Provide education to residents and their visitors about enhanced barriers precautions