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	334100	A. BUILDING _____ B. WING _____	2/27/2025

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F0000 SS=	INITIAL COMMENTS Medilodge of East Lansing was surveyed for an Abbreviated survey on 2/27/2025 . Intakes: MI00149947, MI00150109, MI00150188, MI00150221, MI00150267, MI00150359, MI00150371, MI150393. Census: 72	F0000		
F0657 SS= D	Care Plan Timing and Revision §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by:	F0657	Element 1 Resident 7 continues to reside in the facility. The skin care plan was reviewed and updated to include the correct classification and staging of current wounds and include appropriate interventions to prevent and promote healing of wounds by the Director of Nursing/Designee by 3/14/25. Element 2 A one-time audit of current residents with wounds was completed to ensure their skin care plans have the correct classification and staging of current wounds and they include appropriate interventions to prevent and promote healing of wounds. This was completed by the Director of Nursing/Designee by 3/14/25. Element 3 The QAPI Committee has reviewed the Comprehensive Care Plan policy and has deemed it to be appropriate by 3/14/25. The Director of Nursing and/or designee educated the Wound Care Nurse and the licensed nurses on the Comprehensive Care	3/14/2025

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

Electronically Signed | 03/20/2025

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.

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	This citation pertains to intake number MI00149947 Based on observation, interview, and record review the facility failed to ensure for one out of seven residents (Resident #7) a comprehensive care plan, including revisions, were in place for prevention and promotion of pressure ulcer healing. Findings Included: Per Resident #7's (R7) electronic medical record (EMR) R7 was admitted to the facility on 8/1/2024. Diagnoses included right and left knee contractures. In an observation, and attempt to interview, on 2/27/2025 at 9:46 AM, R7 was observed in bed. R7 was observed to have contractures to both arms, both hands and fingers, neck, and was not able to communicate. R7's feet/heels were observed to be lying on the mattress with nothing in between R7's feet/heels and the mattress in order to offload the pressure from the mattress. Offloading boots (boots with air in them that prevents heels from touching the bed mattress and relieves pressure of the heels) were noted to be on the floor in front of R7's closet. An approximately 5 x 5 centimeter (cm) circle dark area was observed on the side of R7's left outer foot. During an observation on 2/27/2025 at 10:25 AM, it was observed that R7 had a pressure ulcer located on the left trochanter (left hip bone), and a coccyx pressure ulcer was also observed. The offloading boots were not on R7's feet. On 2/27/2025 at 10:45 AM, Certified Nurse Aid (CNA) "C" stated that she did not know the schedule for R7's offloading boots, a stated that she could see the boots where on the floor, but		Plan policy by 3/14/25 with emphasis on ensuring skin care plans have correct classification and staging of wounds and that they include appropriate interventions to prevent and promote healing of wounds. Nurse Aides were educated on checking resident kardex□s and ensuring interventions are in place. This was completed by the Staff Development Coordinator/Designee by 3/14/25. Wounds will be reviewed weekly in standard of care meeting to ensure wounds are classified and staged correctly, care plans are updated and appropriate interventions are in place to prevent and promote wound healing. Element 4 The Director of Nursing/designee will audit Skin care plans of residents with wounds weekly x4 weeks then monthly thereafter to ensure wounds are classified and staged correctly and interventions are in place to prevent and promote healing of wounds. Results will be reviewed monthly by the QAPI Committee until substantial compliance is achieved. The Administrator is responsible to maintain compliance.	

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	did not put them on or off of R7 because she assumed the restorative aids did that. CNA "C" did not put the boots on R7 prior to leaving R7's room. Record review of R7's care plans revealed R7 was to, "To have padded boots (offloading boots) on feet at all times.", dated 2/17/2025. In an interview on 2/27/2025 at 10:52 AM, Certified Occupational Therapy Assistant (COTA) "D" stated that the CNAs were responsible for making sure R7's offloading boots were on him at all times. In an interview on 2/27/2025 at 12:58 PM, Licensed Practical Nurse (LPN) "E" stated that if R7's offloading boots were documented on his care plan to be on him at all times then, "Yes" the boots should be on him at all times, and said the CNAs were responsible in ensuring they were on him. In an observation on 2/27/2025 at 1:00 PM, R7 was observed without the offloading boots on, a pillow was between both legs, but both of R7's feet, heels, and sides of his feet were observed resting on the mattress. During the 1:00 PM observation CNA "F" stated she knew R7 had the boots, but said sometimes R7 would wear them and other times he would not. CNA "F" she did not really know. Record review of a "Wound Evaluation" dated 2/17/2025 revealed R7 had a picture taken of a darkened area on the outer side of his left foot. The picture revealed a dark circle which was documented to be 3.23 cm x 3.07 cm x 1.46 cm (area, length, width) in measurement. The dark circle was documented to be a hematoma (blood collected under the skin from broken blood			

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	vessels due to trauma or injury). Per the "Resident Assessment Instrument 3.0" (RAI) manual dated October 2023, version 1.18.11 page M-27, a Deep Tissue Injury (DTI) is identified by a "Purple or maroon area of discolored intact skin due to damage of underlying soft tissue..." The manual further revealed, "Deep tissue injuries may sometimes indicate severe damage. Identification and management of deep tissue injury (DTI) is imperative." The observation of the picture of the side of R7's left foot revealed a DTI and not a hematoma, as there was no documentation of trauma or injury to R7's left foot. Record review of a wound assessment dated 2/25/2025, revealed R7 had a wound to the left trochanter (hip). The wound measured at 27 x 5.7 x 6.1 x <0.1 cm (area, length, width, depth), meaning the wound was an open wound with depth. However, the wound was documented to be a blister. Upon observation of the picture the wound bed was not visible due to eschar (a type of dead tissue that forms a dry, black, or brown covering over wounds) and therefore was unstagable (the wound bed cannot be observed due to being obscured by the dead tissue). Upon reference to the RAI manual on page M-8 the manual revealed, "Pressure ulcers that have eschar...tissue present such that the anatomical tissue cannot be visualized or palpated in the wound bed, should be classified as unstagable..." Record review of R7's progress notes dated 2/16/2025 revealed, "...Left hip appears to beworsening (sic), wound is deeper with increased drainage and borders less taut. Cleansed and dressing changed..." Therefore, the wound was not a blister.			

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	Review of a "Wound Evaluation" dated 10/29/2024, revealed R7 had a stage 4 pressure ulcer to his coccyx (butt bone) that was measured to be 0.48 x 1.07 x 0.65 x 0.1 cm. The evaluation revealed the wound was facility acquired (it happened at the facility). Review of another "Wound Evaluation" dated 2/25/2025, revealed R7's coccyx pressure ulcer measured 11.32 x 4.48 x 3.73 x 0.4 cm, and the bed of the wound was covered with slough (dead tissue that is typically white, yellowish, debris, and remnants of tissue) making the wound bed not visible rendering the wound unstagable. The evaluation revealed the wound was documented to be a stage 4. Per the RAI manual, "Pressure ulcers that have slough (yellow, tan, gray, green or brown)...tissue present such that the anatomical tissue cannot be visualized or palpated in the wound bed, should be classified as unstagable..." Review of an active care plan dated 8/1/2024 and revised on 2/20/2025 revealed, "Resident (R7) is at risk for impaired skin integrity related to Cerebral Hemorrhage, Respiratory Failure, and Contractures. Stage 4 pressure wound to coccyx, Blister to rear left trochanter, hematoma to left lateral foot" The care plan had an intervention for R7 to have, "...Padded boots on feet at all times", dated 2/17/2025. There were not further updated interventions to the care plan. In an interview on 2/27/2025 at 1:36 PM, Registered Nurse (RN) "G". who was the wound nurse, stated R7's left lateral (side) foot was a hematoma which was a blister, discolored tissue. RN "G" stated she thought maybe it was a DTI. RN "G" said R7 was to have the boots on his feet at all times, and said the boots were an intervention on R7's care plan. RN "G" said all			

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	staff CNAs and Nursing were supposed to be sure the boots were on R7 at all times, and assure his feet were elevated off the mattress. RN "G" stated that R7's left trochanter wound should have been documented as an unstagable pressure ulcer and not a blister. RN "G" further stated that there were no added interventions to R7's care plan for pressure ulcers other than the boots, upon the development of the pressure ulcers. RN "G" stated that in her opinion she did not know that she would have added any other interventions to R7's care plans, nor could she think of any interventions that should have been added for pressure ulcer preventions and/or treatment. RN "G" said as far as R7's coccyx pressure ulcer, he must have been left on his back to long. RN "G" said no root cause analysis, Interdisciplinary Team, care conferences were conducted regarding R7's pressure ulcers in order to determine the cause of R7's skin breakdown. In an interview on 2/27/2025 at 2:15 PM, Director of Nursing (DON) "B" stated R7 did not tolerate being up in any chair, and stated R7's Kardex (CNA document for providing care) did reveal for the CNAs to have R7's boots on him at all times.			
F0686 SS= D	Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of	F0686	Element 1 Resident 7 wounds were reviewed by the Director of Nursing, Wound Nurse and wound care provider by 3/14/25 and it was determined re classification of wounds was appropriate. Coccyx Wound was reassessed on 3/13/25 by the wound care provider and determined that the wound needed to be reclassified again back to a stage 4 due to the resolving of slough in the wound bed from the previous week. Skin /Wound evaluations and care plan was updated to reflect the correct	3/14/2025

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	practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: This citation pertains to intake number MI00149947. Based on observation, interview, and record review the facility failed to provide for one out of three residents (Resident #7) care and services to prevent and promote healing of pressure ulcers resulting in worsening wounds. Findings Included: Per Resident #7's (R7) electronic medical record (EMR) R7 was admitted to the facility on 8/1/2024. Diagnoses included right and left knee contractures. In an observation, and attempt to interview, on 2/27/2025 at 9:46 AM, R7 was observed in bed. R7 was observed to have contractures to both arms, both hands and fingers, neck, and was not able to communicate. R7's feet/heels were observed to be lying on the mattress with nothing in between R7's feet/heels and the mattress in order to offload the pressure from the mattress. Offloading boots (boots with air in them that prevents heels from touching the bed mattress and relieves pressure of the heels) were noted to be on the floor in front of R7's closet. An approximately 5 x 5 centimeter (cm) circle dark area was observed on the side of R7's left outer foot. During an observation on 2/27/2025 at 10:25 AM, it was observed that R7 had a pressure ulcer located on the left trochanter (left hip bone), and a coccyx pressure ulcer was also observed. The		classification and staging of current wounds and include appropriate interventions to prevent and promote healing of wounds. Element 2 A one-time audit of current residents□ with wounds was completed to ensure the wounds are classified and staged correctly and the care plans are updated and include appropriate interventions to prevent and promote healing of wounds. Any wounds not classified correctly were immediately re classified and care plans updated. This was completed by the Director of Nursing/Designee by 3/14/25. Element 3 The QAPI Committee has reviewed the Pressure Ulcer Prevention and Management policy and has deemed it to be appropriate by 3/14/25. The Director of Nursing and/or designee educated the Wound Care Nurse and the licensed nurses on the Pressure Ulcer Prevention and Management policy by 3/14/25 with emphasis on correct classification and staging of wounds and ensuring that the care plans are updated and they include appropriate interventions to prevent and promote healing of wounds. Nurse Aides were educated on checking resident kardex□s and ensuring interventions are in place. This was completed by the Staff Development Coordinator/Designee by 3/14/25. Wounds will be reviewed weekly in standard of care meeting to ensure wounds are	

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	offloading boots were not on R7's feet. On 2/27/2025 at 10:45 AM, Certified Nurse Aid (CNA) "C" stated that she did not know the schedule for R7's offloading boots, and stated that she could see the boots were on the floor, but did not put them on or off of R7 because she assumed the restorative aids did that. CNA "C" did not put the boots on R7 prior to leaving R7's room. Record review of R7's care plans revealed R7 was to, "To have padded boots (offloading boots) on feet at all times.", dated 2/17/2025. In an interview on 2/27/2025 at 10:52 AM, Certified Occupational Therapy Assistant (COTA) "D" stated that the CNAs were responsible for making sure R7's offloading boots were on him at all times. In an interview on 2/27/2025 at 12:58 PM, Licensed Practical Nurse (LPN) "E" stated that if R7's offloading boots were documented on his care plan to be on him at all times then, "Yes" the boots should be on him at all times, and said the CNAs were responsible in ensuring they were on him. In an observation on 2/27/2025 at 1:00 PM, R7 was observed without the offloading boots on, a pillow was between both legs, both of R7's feet, heels, and sides of his feet were observed resting on the mattress. During the 1:00 PM observation CNA "F" stated she knew R7 had the boots, but said sometimes R7 would wear them and other times he would not. CNA "F" she did not really know. Record review of a "Wound Evaluation" dated 2/17/2025 revealed R7 had a picture taken of a darkened area on the outer side of his left foot.		classified and staged correctly, care plans are updated and appropriate interventions are in place to prevent and promote wound healing. Element 4 The Director of Nursing/designee will audit residents with wounds weekly x4 weeks then monthly thereafter to ensure wounds are classified and staged correctly, care plans are updated and interventions are in place to prevent and promote healing of wounds. Results will be reviewed monthly by the QAPI Committee until substantial compliance is achieved. The Administrator is responsible to maintain compliance.	

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	The picture revealed a dark circle which was documented to be 3.23 cm x 3.07 cm x 1.46 cm (area, length, width) in measurement. The dark circle was documented to be a hematoma (blood collected under the skin from broken blood vessels due to trauma or injury). Per the "Resident Assessment Instrument 3.0" (RAI) manual dated October 2023, version 1.18.11 page M-27, a Deep Tissue Injury (DTI) is identified by a "Purple or maroon area of discolored intact skin due to damage of underlying soft tissue..." The manual further revealed, "Deep tissue injuries may sometimes indicate severe damage. Identification and management of deep tissue injury (DTI) is imperative." The observation of the picture of the side of R7's left foot revealed a DTI and not a hematoma, as there was no documentation of trauma or injury to R7's left foot. Record review of a wound assessment dated 2/25/2025, revealed R7 had a wound to the left trochanter (hip). The wound measured at 27 x 5.7 x 6.1 x <0.1 cm (area, length, width, depth), meaning the wound was an open wound with depth. However, the wound was documented to be a blister. Upon observation of the picture the wound bed was not visible due to eschar (a type of dead tissue that forms a dry, black, or brown covering over wounds) and therefore was unstagable (the wound bed cannot be observed due to being obscured by the dead tissue). Upon reference to the RAI manual on page M-8 the manual revealed, "Pressure ulcers that have eschar...tissue present such that the anatomical tissue cannot be visualized or palpated in the wound bed, should be classified as unstagable..." Record review of R7's progress notes dated			

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	2/16/2025 revealed, "...Left hip appears to beworsening (sic), wound is deeper with increased drainage and borders less taut. Cleansed and dressing changed..." Therefore, the wound was not a blister. Review of a "Wound Evaluation" dated 10/29/2024, revealed R7 had a stage 4 pressure ulcer to his coccyx (butt bone) that was measured to be 0.48 x 1.07 x 0.65 x 0.1 cm. The evaluation revealed the wound was facility acquired (it happened at the facility). Review of another "Wound Evaluation" dated 2/25/2025, revealed R7's coccyx pressure ulcer measured 11.32 x 4.48 x 3.73 x 0.4 cm, and the bed of the wound was covered with slough (dead tissue that is typically white, yellowish, debris, and remnants of tissue) making the wound bed not visible rendering the wound unstagable. The evaluation revealed the wound was documented to be a stage 4. Per the RAI manual, "Pressure ulcers that have slough (yellow, tan, gray, green or brown)...tissue present such that the anatomical tissue cannot be visualized or palpated in the wound bed, should be classified as unstagable..." Review of an active care plan dated 8/1/2024 and revised on 2/20/2025 revealed, "Resident (R7) is at risk for impaired skin integrity related to Cerebral Hemorrhage, Respiratory Failure, and Contractures. Stage 4 pressure wound to coccyx, Blister to rear left trochanter, hematoma to left lateral foot" The care plan had an intervention for R7 to have, "...Padded boots on feet at all times", dated 2/17/2025. There were not further updated interventions to the care plan. In an interview on 2/27/2025 at 1:36 PM, Registered Nurse (RN) "G". who was the wound			

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	nurse, stated R7's left lateral (side) foot was a hematoma which was a blister, discolored tissue. RN "G" stated she thought maybe it was a DTI. RN "G" said R7 was to have the boots on his feet at all times, and said the boots were an intervention on R7's care plan. RN "G" said all staff CNAs and Nursing were supposed to be sure the boots were on R7 at all times, and assure his feet were elevated off the mattress. RN "G" stated that R7's left trochanter wound should have been documented as an unstagable pressure ulcer and not a blister. RN "G" further stated that there were no added interventions to R7's care plan for pressure ulcers other than the boots, upon the development of the pressure ulcers. RN "G" stated that in her opinion she did not know that she would have added any other interventions to R7's care plans, nor could she think of any interventions that should have been added for pressure ulcer preventions and/or treatment. RN "G" said as far as R7's coccyx pressure ulcer, he must have been left on his back to long. RN "G" said no root cause analysis, Interdisciplinary Team, care conferences were conducted regarding R7's pressure ulcers in order to determine the cause of R7's skin breakdown. In an interview on 2/27/2025 at 2:15 PM, Director of Nursing (DON) "B" stated R7 did not tolerate being up in any chair, and stated R7's Kardex (CNA document for providing care) did reveal for the CNAs to have R7's boots on him at all times.			