

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 634450	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 4/16/2025
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NAME OF PROVIDER OR SUPPLIER MEDILODGE OF FARMINGTON	STREET ADDRESS, CITY, STATE, ZIP CODE 34225 GRAND RIVER AVE FARMINGTON, MI 48335
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F0000 SS=	INITIAL COMMENTS Medilodge of Farmington was surveyed for an Abbreviated survey on 4/16/25. MI00151260, MI00151909, MI00151473, MI00151501, MI00151564 Census=87	F0000		
F0684 SS= D	Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: This citation pertains to Intake MI00151473 Based on interview and record review, the facility failed to provide needed care and services to administer Total Parental Nutrition (TPN, a special formula given through a vein and provides nutrition) for one resident (R502) of one resident reviewed for TPN, resulting in weakness, fatigue, and a transfer to the hospital for dehydration and electrolyte replacement. Findings include:	F0684	F684 Quality Of Care Severity Level D Compliance Date 4/30/2025 Element 1 What Corrective action(s) will be taken: Resident 502 No longer resides in the facility. Element 2 How Facility will identify other residents having a potential to be affected by the practice and what corrective action will be taken All residents have a potential to be affected by the practice. Current residents residing in the facility were accessed by the licensed nurses to ensure that residents with changes in condition needs were being met on 04/17/2025. All residents identified are at risk for change in condition have been assessed by a licensed nurse. Element 3 What Measures will be put in place or what	5/8/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

05/08/2025

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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	<p>The State Agency received a complaint on 3/25/25 alleging the facility failed to provide R502 with their ordered TPN resulting in hospitalization.</p> <p>On 4/15/25, Clinical Record review revealed R502 had a past medical history of pancreaticobiliary (pancreas, gall bladder, and bile duct) cancer and was transferred from the hospital for status post paraoesophageal hernia surgery (restoring the normal anatomy of the esophagus and stomach by closing a defect in the diaphragm) and treatment of gastric outlet obstruction (blockage between the stomach and small intestine) and was dependent on nutritional support via Total Parental Nutrition (TPN). Admission Nursing assessment documented Alert (x4) times four (refers to a person's level of orientation, fully aware of their surroundings and identity).</p> <p>On 4/15/25 at 9:18 AM, a telephone interview with the complainant confirmed R502 was accepted to the facility to receive TPN. On Friday 3/21/25, R502 was transferred to the facility and informed the TPN was not available and would have to be ordered. The Doctor ordered Dextrose (sterile sugar water) Intravenously (IV) until the TPN was delivered. The TPN was delivered on Saturday 3/22/25, but there was delay in administering because they (facility) did not have the correct tubing (the incorrect tubing was sent from pharmacy). On Saturday 3/22/25, R502 complained of becoming weak and "not</p>		<p>systematic changes will you make to ensure that the deficient practice does not recur</p> <p>The quality assurance team reviewed the policy for Notification of Changes and deemed it appropriate on 04/17/2025.</p> <p>On this date 4/30/2025 or before their next scheduled shift, we will educate nurses on the Notification of Change Policy with a focus on the following:</p> <p>If a resident is admitted to the facility and is to receive TPN the nurse is to ensure the order had been received, reviewed, and signed by physician and faxed to pharmacy to be received in time for the resident admission.</p> <p>When a delay in order implementation is identified, the resident will be assessed for changes in conditions and provider notified.</p> <p>If the TPN is not available for administration the resident will be returned ton the hospital.</p> <p>System Change: The clinical IDT will complete rounds Monday through Friday to identify any change of conditions.</p> <p>Element 4</p> <p>How the corrective action(s) will be monitored to ensure the deficient practices will not recur, i.e, what quality assurance program, will you put in place</p> <p>The DON/designee will audit 5 resident with change in condition weekly to ensure that staff met the residents' needs x's 4 weeks then monthly thereafter until substantial compliance is met and audits are</p>	

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	<p>feeling right". Sunday morning, 3/23/25 R502 still had not received TPN and insisted on returning to the hospital.</p> <p>On 4/16/25 at 10:27 AM, a telephone interview with Registered Nurse (RN) "C" recalled Friday 3/21/25 around 3:30 PM, R502 arrived at the facility and was the Admission Nurse for R502 at which time, identified the ordered TPN was not at the facility. Per RN "C", orders for TPN are sent prior to arrival to ensure it will be available once the resident arrives. RN "C" said before R502 got off the stretcher they notified the Director of Nursing (DON) the TPN was not there and discussed sending the resident back to the hospital. The DON said to clarify with the Provider. Nurse Practitioner (NP) "G" was contacted informing the TPN was not at the facility and ordered IV Dextrose until TPN was delivered.</p> <p>On 4/15/25 at 11:29 AM, a telephone interview with Central Admissions (CA) "B" acknowledged R502 was clinically reviewed and accepted for TPN on 3/20/25. On 3/21/25 at 8:21 AM, the resident was officially accepted and the hospital arranged for transport at 2:00 PM. CA "B" said they had only been in the role for two weeks and this was their first admission with a TPN resident. CA "B" was unaware they were responsible for ordering the TPN hence why it was not at the facility at the time R502 arrived.</p> <p>On 4/15/25 at 12:13 PM, an interview with</p>		<p>discontinued by the QA committee.</p> <p>The audit period will be for 3 months, or until QAPI deems substantial compliance</p> <p>The Administrator is responsible for ongoing compliance</p>	

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	<p>LPN "E" revealed that they recalled on Saturday 3/22/25, the TPN was delivered, and RN "D" was called to administer. LPN "E" recalled RN "D" was not able to administer because the "blue key" on the IV tubing was incorrect and would not fit into the pump chamber. NP "G" was informed the equipment sent was not compatible and they were unable to provide TPN. NP "G" was notified and ordered to continue with IV fluids. LPN "E" commented R502 was so frustrated, "I understand why she insisted on being sent to the hospital. I couldn't blame her."</p> <p>On 4/15/25 at 1:23 PM, a telephone interview with RN "D" confirmed they were called by Nursing staff to administer the TPN for R502 and Pharmacy had sent the TPN in three different bags, provided two pumps and two different sized filter tubing. RN "D" said in their 27 years of Nursing, they had never seen TPN supplies like this and did not seem "normal". RN "D" was unsuccessful loading the tubing into the pumps and the supplies were incompatible. RN "D" notified on-call Manager RN "C" informing neither pump was compatible with the tubing sent by Pharmacy and R502 was unable to receive TPN. RN "D" said NP "G" was notified and ordered to continue IV fluids. Per RN "D", R502 should have been sent back to the hospital for TPN in their opinion.</p> <p>On 4/16/25 at 10:27 AM, RN "C" said they were contacted by night shift Nurses early</p>			

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	<p>morning on 3/22/25 informing the TPN was unable to be administered due to the equipment sent was incompatible. RN "C" said NP "G" was notified at least three times and told us (Nursing) they (R502) can run on Dextrose and wanted to continue with the same plan and instructed to keep R502 on IV Dextrose. When asked why R502 was not transferred back to the hospital, RN "C" remarked "My question was the same." RN "C" acknowledged it was not appropriate for R502 to remain without providing their TPN.</p> <p>Review of Nursing Progress note dated 3/23/25 10:30 AM " ...Resident request to go to hospital ..."</p> <p>On 3/23/25, R502 required hospitalization for weakness and fatigue related to dehydration and would require IV hydration and replacement of Potassium and Magnesium.</p> <p>On 4/16/25, requested medical records were obtained from the hospital and revealed on 3/20/25 R502's Potassium Level was 4.6 (millimoles per liter) mmol/L and had dropped on 3/23/25 to 2.7 mmol/L. Normal range for Potassium in adults is between 3.5 and 5.0 mmol/L.</p> <p>Review of laboratory records revealed on 3/21/25, R502's Magnesium level was 2.2mg/dl (milligram/deciliter) had dropped on 3/23/25 to 1.1 mg/dl. Normal range for Magnesium in adults is between 1.6-2.4 mg/dl.</p>			

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F0755 SS= D	<p>On 4/16/25 at 9:35 AM, The DON remarked themselves and RN "C" were "on the same page" and agreed R502 should have been sent back to the hospital sooner.</p> <p>On 4/16/25 at 11:43, NP "G" was contacted by phone for interview with no return call by the end of the survey.</p> <p>Pharmacy Srvcs/Procedures/Pharmacist/Records §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by:</p>	F0755	<p>F755 Pharmacy Services Severity Level D Compliance Date 04/30/2025 Element 1</p> <p>What corrective actions(s) will be taken</p> <p>Resident 502 is no longer resides in the facility</p> <p>element 2</p> <p>How facility will identify other residents having a potential to be affected by practice and what corrective action will be taken</p> <p>All residents with orders for TPN have a potential to be affected by the practice</p> <p>Current residents residing in the facility were assessed by licensed nurse to ensure that the current residents and all new admissions with TPN orders have pumps, tubing, and TPN solution to meet their needs on 04/17/2025.</p> <p>Element 3</p> <p>What ensures will be put in place or what</p>	5/8/2025

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	<p>This citation pertains to Intake MI00151473</p> <p>Based on interview and record review, the facility failed to ensure proper pumps and intravenous tubing was provided by Pharmacy to administer Total Parental Nutrition (TPN) (providing nutrition through a vein) per Physician orders for one resident (R502) of one reviewed for TPN resulting in R502 having concerns of weakness and fatigue resulting in hospitalization for dehydration and electrolyte replacement.</p> <p>Findings include:</p> <p>The State Agency received a complaint on 3/25/25 alleging the facility failed to provide R502 with their ordered TPN resulting in hospitalization.</p> <p>On 4/15/25, clinical record review revealed R502 was admitted to the facility on 3/21/25 and had a past medical history of pancreaticobiliary (pancreas, gall bladder, and bile duct) cancer and was transferred from the hospital for status post paraoesophageal hernia surgery (restoring the normal anatomy of the esophagus and stomach by closing a defect in the diaphragm) and treatment of gastric outlet obstruction and would require nutritional support via Total Parental Nutrition (TPN). Admission Nursing assessment documented Alert (x4) times four (refers to a person's level</p>		<p>systematic changes you will make to ensure that the deficient practice does not recur</p> <p>The Quality Assurance committee reviewed the policy for Parenteral Nutrition and deemed it appropriate on 04/17/2025.</p> <p>On this date 04/30/2025 or before their scheduled shift, we will educate Admission Directors and Nurse Managers on the Parenteral Nutrition Policy for the following:</p> <p>If a resident is admitted to the facility and is to receive TPN the nurse is to ensure the order has been received, review, and signed by the physician and faxed to the pharmacy to be received in time for the resident admission.</p> <p>Pharmacy will ensure needed supplies are sent with the TPN prior to resident admission.</p> <p>PharmScript Pharmacy is taken the TPN ordering and supply process through their QAPI and provided education to the staff to prevent future recurrence</p> <p>Element 4</p> <p>How the corrective action(s) will be monitored to ensure the deficient practices will not recur, i.e what quality assurance program will be put in place</p> <p>The DON/designee will audit 5 residents with TPN orders weekly to to ensure proper pumps and tubing is provided by the pharmacy and TPN is available upon admission for x's 4 weeks then monthly thereafter until substantial compliance is met and audits are discontinued by the QAPI committee.</p>		

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	<p>of orientation, fully aware their surroundings and identity).</p> <p>Record review revealed R502 arrived on Friday 3/21/25 at 3:15 PM and had an order for TPN.</p> <p>On 3/21/2025 at 4:12 PM, the Nursing progress note documented ..." TPN order faxed to (contracted pharmacy) they confirmed receiving it and stated it would be in the overnight shipment due to time being after 11am ..."</p> <p>On 3/22/25 at 5:57 AM, Nursing Progress note documented the TPN " ...Order needs clarification ..." and was not administered.</p> <p>On 3/22/25 at 11:00 PM, Nursing Progress note from Licensed Practical Nurse (LPN) "F" documented " ...awaiting pharmacy delivery for correct equipment ..."</p> <p>On 4/15/25 at 11:25 AM, a telephone interview with LPN "F" clarified the "correct equipment" from their note was in reference to two pumps and two filter lines that were not compatible. The "blue keys" on the tubing were not fitting into the pumps. LPN "E" called the Pharmacy on speaker phone, and was told they (Pharmacy) would be out to deliver the correct tubing.</p> <p>On 4/15/25 at 12:13 PM, an interview with LPN "E" confirmed on Saturday 3/22/25 night shift, Registered Nurse (RN) "D" was called to</p>		<p>The audit period will be 3 months or until QAPI deems substantial compliance</p> <p>The Administrator is responsible for ongoing compliance</p>	

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	<p>administer the TPN for R502. LPN "E" recalled RN "D" was not able to administer because the "blue key" on the tubing was incorrect and would not fit into the pump chamber. Around 7:30-8:00 PM, the Pharmacy was called and informed the equipment they sent was not compatible and the TPN could not be given.</p> <p>On 4/15/25 at 1:23 PM, a telephone interview with RN "D" detailed they were called by Nursing staff to administer the TPN for R502. RN "D" confirmed Pharmacy had sent two pumps and two different sized filter tubing. RN "D" said in their 27 years of Nursing, they had never seen TPN supplies like this and did not seem "normal". RN "D" was unsuccessful loading the tubing into the pumps specifically the "blue key" that inserts into both chamber pumps would not fit. It was incompatible. RN "D" notified on the on-call Manager RN "C" informing neither pump was compatible with the tubing sent by Pharmacy and R502 was unable to receive TPN.</p> <p>On 4/16/25 at 9:35 AM, the Director of Nursing (DON) acknowledged they were contacted on 3/22/25 by RN "C" sending a text message of a picture of the TPN bags and informed Nursing was not clear how to administer, and was unaware there were two pumps involved, at which time, the DON instructed to call the Pharmacy. The DON confirmed RN "C" was no longer at the facility but was involved with this incident and provided their phone number.</p>			

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	<p>On 4/16/25 at 10:27 AM, a telephone interview with RN "C" remarked they remembered the incident clearly because they were the on-call Nurse that weekend and was the admission nurse for R502.</p> <p>R502 arrived Friday 3/21/25 around 3:30 PM and identified orders for TPN. Realizing there was no TPN on site at the time they were admitted, I notified the Director of Nursing (DON) and Nurse Practitioner (NP) "G" informing we did not have the TPN and NP "G" ordered Intravenous (IV) 10% Dextrose until the TPN arrived. RN "C" called Pharmacy and was informed delivery of the TPN and equipment (pump and tubing) would arrive on the overnight delivery, which would be on 3/22/25 early morning, which it arrived around 2:00-3:00AM.</p> <p>RN "C" was then called by the night shift nurses informing that the TPN was delivered, but the equipment Pharmacy sent was not the correct tubing and it was incompatible. RN "C" stated they called the Pharmacy (from home) on the morning of Saturday 3/22/25 and told Pharmacy the tubing was not compatible and the TPN could not be administered. The Pharmacy said they would deliver new IV tubing Saturday 3/22/25.</p> <p>RN "C" said on Saturday 3/22/25 around 9:30 -10:00 PM, they were contacted by night shift Nursing and told the revised equipment was still incompatible and the TPN could not be</p>			

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	<p>administered. The Pharmacy was contacted again on 3/22/25 around 10:00 PM and they said they would come out Sunday 3/23/25 and replace the pumps.</p> <p>According to RN "C", the Pharmacy commented to them there was an Equipment Department and they were involved with such concerns, but they leave on Fridays and there is no weekend coverage.</p> <p>RN "C" followed up on Sunday 3/23/25 and was informed that R502 insisted on leaving and wanted to go back to the hospital and was transferred that morning.</p> <p>On 4/16/25, requested medical records were obtained from the hospital and revealed on 3/20/25 R502's Potassium Level was 4.6 (millimoles per liter) mmol/L and had dropped on 3/23/25 to 2.7 mmol/L.</p> <p>Normal range for Potassium in adults is between 3.5 and 5.0 mmol/L.</p> <p>Review of laboratory records revealed on 3/21/25, R502's Magnesium level was 2.2mg/dl (milligram/deciliter) had dropped on 3/23/25 to 1.1 mg/dl.</p> <p>Normal range for Magnesium in adults is between 1.6-2.4 mg/dl.</p> <p>On 3/23/25, R502 required hospitalization for weakness and fatigue related to dehydration and would require IV hydration in addition to</p>			

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	replacements of Potassium and Magnesium.				