STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235486	A. BUILDING _____ B. WING _____	03/12/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MEDILODGE OF RICHMOND	34901 DIVISION RD RICHMOND, MI 48062

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0725 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	**Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains in part to MI 477. Based on observation, interview and record review, the facility failed to ensure sufficient staff were available for resident care needs (including showers and incontinence care) and care was provided timely and/or documented when completed for five sampled residents (R902, R903, R904, R905, R906) and two anonymous residents reviewed for Activities of Daily Living (ADL) care, nurse staffing concerns and call light response resulting in unmet care needs and dissatisfaction with care and the potential for additional residents with unmet care needs. Findings include: On 03/12/20 at 9:20 AM, Nurse B was asked about meeting the care needs of the residents and reported two nurses had given notice (quit)related to some recent changes and that sometimes they need to work through lunch to get things done. On 03/12/20 at 9:28 AM, a Certified Nursing Assistant (CNA) A was asked how they meet the care needs of the residents and reported it depends on how busy they are and how many residents they take care of. CNA A reported they were assigned to care for 15 residents and so was the other CNA. CNA A reported two CNAs were assigned to the two halls today and they usually work with two CNAs and one nurse to cover the (up to) 30 residents on the two halls. On 03/12/20 at 9:33 AM and 1:20 PM, a visitor C who requested anonymity for themselves and their resident (Resident D) reported staffing concerns and felt they could use more staff as a rule. Visitor C reported they were worried about how it would go if they were not looking after Resident D (who has Dementia and confusion). Visitor C reported there was a time when the resident had multiple trips to the bathroom and they had to care for the resident by themselves as the resident was having trouble standing, walking and wiping after incontinence on their own. They reported going out into the hall to look for help when it had not come in 45 minutes and saw no staff in the hall. Visitor C further noted having only one CNA on the midnight shift and worried that staffing was going to be an ongoing issue. Anonymous Resident D was observed to be in bed, with the head of the bed up and resting with their eyes closed. Visitor C reported Resident D had come in for physical therapy and recently had a decline in the ability to care for themselves. On 03/12/20 at 9:40 AM, CNA E stated on query about the care of the residents, We have run with a split (third CNA) but there are two for now. CNA E reported theirs was one of the harder/busier sets to work in (28 residents were noted). On 03/12/20 at 9:49 AM, LPN F reported the facility had normal day time staffing at one nurse for up to 30 residents. On 03/12/20 at 11:07 AM, R902 was observed to be seated in their wheelchair, with oxygen in place via a nasal cannula. R902 was asked about care needs being met at the facility and reported, staff were not caring for their urinary catheter every shift, their pain was not always controlled, medications were late, showers were missed and sometimes had to wait for help up to three hours at night. R902 reported having to call 911 in the past because they felt they didn't get the help they needed. R902 also commented feeling at times staff were not very gentle during care and felt like a rag doll and was not sure if this was because the staff felt rushed. A review of the clinical record for R902 revealed: An admission into the facility on [DATE] with [DIAGNOSES REDACTED]. A Minimum Data Set (MDS) assessment dated [DATE] revealed R902 to be alert to self, time, place and able to make independent decisions in regard to daily life. The MDS further noted the need for extensive assistance of one or two persons for bed mobility, transfer, locomotion, dressing, hygiene, bathing and toilet needs. The care plan revealed, The resident needs activities of daily living assistance related to weakness, [MEDICAL CONDITION] (heart failure), [MEDICAL CONDITION]. Date Initiated: 06/07/2019. Revision on: 06/07/2019. A review of the shower documentation for the last thirty days prior to 03/12/20 indicated a shower was given on 2/17, 2/24 and 2/28. This documents three showers out of a possible eight were given. No refusals were documented. On 03/12/20 at 12:28 PM, Anonymous Visitor G was asked about care at the facility and reported: a concern for nurse to resident ratios of 1:24 and 1:30; a nurse crying during their shift; the same nurse with concerns about not being able to adequately care for residents; and care not provided nor changes in condition monitored. On 03/12/20 at 12:43 PM, CNA I was asked about meeting the care needs of the residents and reported, We have our ups and downs. We have a high turn over rate. I don't think it is okay for one person to take care of 15 residents a day. I think it is all about ratios and numbers. You try your best. Sometimes there are too many things to do. On 03/12/20 at 1:05 PM, a resident (Resident J) who requested not to be identified was asked if their needs were being met and care was provided as they thought it should, Resident J reported it takes 30 to 45 minutes at times for staff to answer call lights. A review of the clinical record for Resident J revealed: An admission into the facility in 2014 and [DIAGNOSES REDACTED]. A Minimum Data Set (MDS) assessment dated [DATE] revealed impaired cognition and the need for extensive assistance of one or two persons for bed mobility, transfer, locomotion, dressing, hygiene, bathing and toilet needs. On 03/12/20 at 1:10 PM, R904 was observed to be in bed wearing oxygen via a nasal cannula. R904 was asked about care concerns and reported in the first week they were at the facility, when they put the call bell on, staff were not timely. R904 reported it happened at different times of the day and one time waited a half an hour to get help to the bathroom. R904 asked, What if something happens to me in the middle of the night. R904 commented that staffing seems pretty short at times and staff report the beepers (pagers) do not always work or were not available. A review of the clinical record for R904 revealed: An admission into the facility on [DATE] and [DIAGNOSES REDACTED]. A Minimum Data Set (MDS) assessment dated [DATE] revealed R904 with intact cognition and the need for limited assistance of one person for transfer and dressing. The care plan revealed, The resident needs activities of daily living assistance. Date Initiated: 02/20/2020. Revision on: 02/21/2020. A review of the electronic record shower documentation for the last thirty days prior to 03/12/20 indicates a shower was not documented as given since admission. No refusals were documented. On 03/12/20 at 1:30 PM, R903 was observed seated in their wheelchair wearing oxygen via a nasal cannula. R903 was asked about their care needs being met by staff at the facility and reported, they had been a nurse and felt they knew what level of care should be provided. R903 indicated some shifts are good, some aren't .It's the few bad ones that make it uncomfortable. One person put me to bed without my O2 (oxygen). Some times I wake up and my (O2) concentrator is shut off. Midnights and afternoons shift were reported as the worst for being short staffed. A review of the clinical record for R903 revealed and admission into the facility on [DATE] and [DIAGNOSES REDACTED]. The MDS assessment dated [DATE] indicated moderately impaired cognition and the need for extensive assist of one or two persons for bed mobility, dressing, hygiene, toilet needs and bathing. The nursing care plan revealed: The resident needs activities of daily living assistance related to: Activity Intolerance. Date Initiated: 02/08/2018 Revision on: 09/07/2018. A review of the shower task documentation for the last thirty days prior to 03/12/20 revealed one shower/bed bath was documented on 02/27/20. The shower days were indicated to occur on Thursdays and Sundays. The documentation reveals one of eight shower was documented and or completed. On 03/12/20 at 2:13 PM, CNA L was asked about the care needs of the residents not being met and reported finding residents upon starting their rounds who appeared not to have been changed timely after incontinence of bowel and urine. CNA L also reported having worked a night shift where they were the only CNA to care for around 30 residents. On 03/12/20 at 2:23 PM, CNA M reported they were working a double (16 hours) and

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

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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F 0725 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	(continued... from page 1) had done this before. On 03/12/20 at 2:44 PM, the Director of Nursing (DON) was asked about care and staffing concerns presented by the residents and reported R902 may not always use the call light but instead will call out when help is needed and may be forgetful of medications received. The daily assignment sheet for 03/12/20 was reviewed with the DON and it was noted that a nurse was not assigned to the 200 and 300 wing on the night shift. The DON confirmed a nurse had not yet been assigned. This left three nurses on the night shift (7 PM to 7 AM) where five had been scheduled for the day (7 AM to 7 PM) shift. The DON was asked about staffing needs and reported they do try to make sure there are enough staff to cover and not let areas go short of staff. The DON reported nursing managers and restorative aides could fill in for lunches and when no nurse is available. On 03/12/20 at 3:28 PM, the Staffing Coordinator (Staff O) was asked about staffing at the facility and stated, It has been an up and down pattern. At the end of last August it was pretty bad. It got slightly better in October and November. The number of nurses dropped in November and we lost a few more in December. We are hurting for nurses. We just lost a bunch on the night shift. We actively hire and expect to have a career fair at the the end of April. We don't currently use any agency staff. CNAs are easier and not too much of a problem. The problem is usually nights, but I hate to mandate. Having just one nurse or CNA is difficult at night. There is no more (extra) pay to work the night shift. We lose more staff from the night shift. We are having an issue with one or two call-ins (no shows) a day. They are getting burned out. Staff O was asked about the concerns of a visitor not seeing any one in the hall and reported a concern, When I go looking for them they're not there. The daily assignment sheet for 03/12/20 was reviewed with Staff O and it was noted that a nurse was not assigned to the 200 and 300 wing nor the 800 wing. Staff O indicated the 800 unit would be covered by the nurse assigned to the 6 and 700 units. The 100/400 unit nurse would cover the 200/300 unit. On 03/12/20 at 4:16 PM, Resident council minutes and staffing concerns were reviewed with R905 and R906. R905 was seated in a wheelchair and required support of their arm and leg on one side and did not move them independently. R906 was seated in a wheelchair with oxygen in place via a nasal cannula. Both residents reported there were not enough staff to get you to the bathroom on time. R906 spoke more clearly than R905 and R905 nodded in agreement. R905 appeared to understand questions asked. R906 confirmed the complaints and concerns of Anonymous Resident J by name independent of query about this resident. When asked directly about care concerns and not being assisted to the toilet in a timely manner R905 reported they have missed showers with a nod Yes and pointed to their lap with a circular motion while nodding their head and said Yuck. R906 confirmed the complaint by residents of missed showers and every day complaints about missed showers and longer wait times for care. The 2/12/20 Resident Council Minutes revealed concerns with an unkind nurse, call light response time, beds not getting made, sheets not changed, melted ice cream and a request to have a certain CNA at night. The 01/19/20 Resident Council Minutes revealed concerns with an unkind nurse, call light response time and melted ice cream. The 12/12/20 Resident Council Minutes revealed, unkind nurse. R906 did not have information for this concern. These concerns were identified as old business with action taken as resident council concern form. R905, R906 and Anonymous Resident J were identified as having attended the resident council meetings. A review of the clinical record for R905 revealed: An admission into the facility on [DATE] and a re-admission on 3/11/19 and [DIAGNOSES REDACTED]. A Minimum Data Set (MDS) assessment dated [DATE] revealed R905 to have impaired cognition and the need for extensive assistance of one person for bed mobility, transfer, locomotion, dressing, hygiene, bathing and toilet needs. The care plan revealed, (R902) needs activities of daily living assistance related [MEDICAL CONDITION](stroke). Date Initiated: 08/20/2018. Revision on: 08/21/2018. A review of the bladder elimination documentation for the last thirty days prior to 03/12/20 indicates 10 episodes of incontinence and 50 where R905 was continent. A review of the shower documentation for the last thirty days prior to 03/12/20 indicates a shower was given on 2/14, 2/17 and 2/20. This documents three showers out of a possible eight were given. No refusals were documented. A review of the clinical record for R906 revealed: An admission into the facility on [DATE] and a re-admission on 3/10/20 and [DIAGNOSES REDACTED]. A Minimum Data Set (MDS) assessment dated [DATE] revealed R906 to have intact cognition and independent for bed mobility, transfer, locomotion, dressing, hygiene, bathing and toilet needs. A review of the shower documentation for the last thirty days prior to 03/12/20 indicates a shower was given on 2/28. No additional shower documentation was noted. On 03/12/20 at 4:39 PM, Nurse P was asked about meeting care needs at the facility and reported, nurses have quit and some of them have said they feel the facility does not care enough to schedule the nurses needed. Nurse P was asked about having only three nurses listed on the schedule for the night shift and stated, We are scheduled that way at least weekly. We have verbalized our concerns. Nurse P further reported making short cuts in charting because they did not have enough time to chart everything including administered medication. On 03/12/20 at 5:00 PM, a review of concerns with staffing and care provided was conducted with the Administrator. The Administrator acknowledged that there was a concern with staff taking home the pagers/beepers. The Administrator reported they had an all staff meeting about answering call lights and how to respond to residents within your scope of practice. The Administrator also confirmed that the facility does not have a system that can print out or keeps a log of call lights. A review of the Assignment sheet for 03/12/20 revealed a census of 118. Five nurses were scheduled for the day shift 7 AM to 7 PM and three nurses were scheduled for the night shift A review of the assignment sheet for 03/06/20, 03/07/20, 03/08/20, 03/10/20 and 03/11/20 indicated the three night nurses cared for 39 residents each. Punches for two of three nurses confirmed attendance on 3/11 and on 3/10 only two nurses after 10:30 PM. Of three nurses scheduled on 03/07 and 03/08 one punch was not received possibly leaving two nurses. On 03/06 punches were received for two of three nurses scheduled. A review of the Master Nursing schedule for March indicated 29 days were scheduled with three or less nurses. A policy related to staffing or ADL care was not provided. A policy related to staffing or ADL care was not provided.