STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235036	A. BUILDING _____ B. WING _____	03/04/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MEDILODGE OF ROCHESTER HILLS, INC	1480 WALTON BLVD ROCHESTER HILLS, MI 48309

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 0600 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to Intake MI 485 Based on observation, interview and record review, the facility failed to ensure resident to resident physical abuse did not occur for two (R#801 and R#802) of eight residents reviewed for abuse, resulting in R#801 pushing R#802 and causing them to fall. Findings include: Review of a Facility Reported Incident (FRI) reported to the State Agency included an allegation of resident to resident physical abuse. According to the FRI, on 11/25/19 R#801 was observed to have pushed R#802 who fell as a result of being pushed. The conclusion of the FRI read, The facility concluded that (R#801) did push (R#802), however, did not rule the interaction to be abuse. On 3/4/20 at 12:45 PM, R#801 was observed lying in bed. R#801 was asked if they remembered pushing R#802. R#801 indicated they remembered the incident. R#801 stated, she (R#802) was pestering me. R#801 went on to explain they had pushed R#802 and R#802 fell . R#801 stated, I shouldn't have done it. On 3/4/20 at 12:56 PM, R#802 was observed sitting in a chair in the hallway with a lunch tray on a bedside table in front of her. R#802 was asked if they remembered being pushed by R#801. R#802 continued to talk in a very fast manner, on subjects not related to what was being asked, jumping from one subject to another. Review of R#801's clinical record revealed R#801 was admitted into the facility on [DATE] with [DIAGNOSES REDACTED]. According to the most recent quarterly Minimum Data Set (MDS) assessment dated [DATE], R#801 scored 13/15 indicating intact cognition. The MDS assessment also indicated R#801 was independent with most activities of daily living (ADL's). Review of R#802's clinical record revealed R#802 was originally admitted into the facility on [DATE] and readmitted [DATE] with [DIAGNOSES REDACTED]. According to the most recent quarterly MDS assessment dated [DATE], R#802 scored 4/15 indicating severely impaired cognition. The MDS assessment also indicated R#802 required minimal assistance of staff for ADL's. Care Plans for R#801 were reviewed and revealed the following: A care plan for Resident is alert with confusion and is able to make his needs known. He ambulates with a steady gait . Ambulated ad lib on the unit with supervision for safety . initiated 5/5/18 and revised on 5/9/18. A care plan for The resident uses [MEDICAL CONDITION] medications r/t (related to) dx (diagnosis) of [MEDICAL CONDITION] and Anxiety. Dx also includes Dementia, for which resident requires guidance with daily decision making. He exhibits hallucinations at times, picking at the air or items that are not there. May become irritable with overstimulation, and need to be guided to quiet area . observe for irritability or difficulty coping with excessive activity or congestion esp (especially) during shift change or around hyperverbal residents. Guide to quiet area for de-escalation calming environment, ie., assigned room or easy chair . initiated 5/7/18 revised 12/5/19. Progress notes for R#801 revealed the following: A Pertinent Charting-Behavioral note dated 11/25/19 read, Behavior Displayed: this resident noted pushing another resident in the hall causing the other resident to fall. Precipitating factors/events: other resident talking, hall with several other residents . A nursing note dated 11/25/18 read, Writer observed resident in his room at 5:00 p.m. Inquired about the incident earlier in the shift. He replied she was pestering me, when asked about what triggered the altercation. Had a discussion with the resident re (regarding): appropriate handling of his feelings and he nodded understanding. Resident has a history of becoming agitated in crowds and there were several residents and staff in the center area of the hallway at shift change when the altercations occurred . A Social Services note dated 11/26/18 read, Resident visited. he recalled negative interaction with another resident from the previous day. He said she kept going on and on and on, so I pushed her . and she fell . I didn't mean to make her fall . they tell me she's okay. Discussed alternate actions to pushing someone who might be bothering him, such as walking away. He agreed that would have been a better choice . A Psychiatric note dated 1/27/18 read, .SW (Social Worker) requesting patient be seen d/t altercation. Per SW patient is known to throw punches in the air but lately has been making drop kicks in the air. Patient was seen in his room he was seated up on his bed . Writer discussed recent behaviors. He feel the other patient was antagonizing him and he reacted . A Psychiatric note dated 2/10/20 read, SW requesting to be seen as f/u (follow up) after pt (patient) was aggressor in altercation from [DATE] by pushing another resident causing them to fall. Writer was notified, the last few days prior to her (sic) injection pt is experiencing more sx (symptoms). Per behavioral meeting. Resident has had 7 documented instances of exhibiting hallucinations, picking at the air or items that are not there in the past 14 days. Resident has had 2 documented instances of aggression towards others in the past 14 days . On 3/4/20 at 1:29 PM, an interview with Certified Nursing Assistant (CNA) 'B' was conducted. CNA 'B' explained R#801 usually kept to himself. That R#801 would walk up and down the hall fast, or punch the air with his arms. On 3/4/20 at 1:37 PM, an interview with Unit Manager (UM) 'C' was conducted. UM 'C' explained R#801 would pray at his bedside, jump up and down or go to a corner and punch his arms when he was excited or agitated. On 3/4/20 at 2:15 PM, an interview with SW 'D' was conducted. SW 'D' explained R#801 usually would self recreate, sanded the furniture in his room or prayed at bedside. He enjoyed group activities, but sometimes would jump up and walk out. SW 'D' went on to explain R#801 had a long term order for an antipsychotic mediation that was injected monthly. The injection was changed, after the altercation on 11/25/18, to every 28 days instead of 30 days due to increased behaviors at the end of the 30 days. Review of physician orders [REDACTED]. On 3/4/20 at 3:58 PM, an interview with the Administrator was conducted. The Administrator explained she had conducted the investigation into the resident to resident altercation. The Administrator went on to explain R#802 was hyperverbal and they were monitoring to ensure she was not affecting any other residents. R#801's care plan had been updated to monitor during times of overstimulation. The Administrator was queried about the conclusion of the FRI that there was no abuse. The Administrator explained she did not believe R#801 intended to harm R#802. Review of a facility policy titled, Abuse Prevention Program revised 2/22/18 read in part, .Abuse - the willful infliction of injury . Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm . Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm .

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.