STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235653	A. BUILDING _____ B. WING _____	07/31/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MEDILODGE OF CAPITAL AREA	2100 E PROVINCIAL HOUSE DR LANSING, MI 48910

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 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** Linked Intakes MI 771, MI 656, MI 490 Based on observation, interview, and record review the facility failed to prevent moisture associated skin damage for one Resident (#53) of two residents reviewed for bladder incontinence. This deficient practice resulted in the potential for further skin breakdown and development of pressure injuries. Findings include: On 7/28/20 at 1:03 p.m., an interview with Family Member (FM) H revealed the following: The last several (care conferences) we were addressing my concerns, my mother (Resident #53) being changed at night, and the dressing of her back side. I would say at least six weeks ago the wound on her back side started. They (facility) had to report it to me because she was telling me her back side was hurting and she was getting medication on it. When I told them about her needing to be changed more often, they told me she was being changed every two hours, and I know for a fact they weren't doing that, because they have been so short staffed. I've heard they have had one CNA (Certified Nurse Aide) for three halls. Most of this happens at night. (The Facility) always says we are addressing it, but nothing ever changes. They tell me she should be changed more often . I want her to be clean and dry. That's not too much to ask. I had a conversation with (the wound nurse) about her not improving to where they really wanted it, so they are changing the treatment plan. On 7/29/20 at 8:20 a.m., an interview with Licensed Practical Nurse (LPN) C on the 200 hall revealed only one CNA (L) for 16 residents today. Resident #53 was among those residents. On 7/29 20 at 8:45 a.m., an interview with Resident #53 revealed the following: At night they (staff) don't do me right, they don't change me but once a night. They've gotten a little better, I think because my son spoke to them. Last night was bad though. On 7/29/20 at 10:20 a.m., incontinence care and wound care were observed. CNA L and CNA N (Admissions Director) who was taking over for CNA L performed incontinence care. The brief bands were observed not in the creases of Resident #53's legs. When asked if the brief was properly placed, CNA L stated No, that's probably why she has that on her leg (Left thigh noted to have a open bleeding area below the leg crease in line with the brief being improperly placed). No bowel movement was noted in the brief when Resident #53 was initially rolled onto her side. CNA L continued to clean Resident #53, and noted bowel movement on the wash cloth coming from the urethral area of the vagina. CNA L stated, That shouldn't be there. They didn't clean her very well. That could cause an infection. CNA L stated (CNA T), who was on last night told CNA L, (CNA T) had three halls last night and felt overwhelmed. CNA L stated CNA T reported being responsible for the 200, 300 and 400 hall last night and stated CNA T expressed feelings of being overwhelmed. The dressing change was observed performed by LPN C. The two areas addressed had macerated wound edges and exposed epithelium (second layer of skin). Resident #53 A review of the Electronic Medical Record (EMR) for Resident #53 revealed admission to the facility on [DATE] with [DIAGNOSES REDACTED]. A review of the Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview of Mental Status (BIMS) assessment of 15 (Scale 0-15), indicating intact cognition. Resident #53 had no physical behaviors or rejection of care, and required extensive assist of two staff for bed mobility, transfers, dressing, toileting and hygiene. Resident #53 also required total dependence for bathing. Resident #53 was rated as always incontinent of bladder and bowel. Resident #53 was also at risk of development of pressure ulcers, but had no active skin issues. A review of a Weekly Skin assessment dated [DATE] revealed no areas of impairment. A review of a Weekly Skin assessment dated [DATE] revealed coccyx excoriation. A review of a Weekly Skin assessment dated [DATE] revealed worsening to bilateral buttocks excoriation. A review of a Weekly Skin assessment dated [DATE] revealed worsening to bilateral buttocks excoriation and upper inner thighs with a treatment in progress. A review of a Pertinent Charting Initial-Skin dated 7/28/20 revealed an area of MASD (Moisture Associated Skin Damage) containing red/pink granulation tissue and poorly defined borders had developed on the left posterior thigh. On 7/29/20 at 10:36 a.m., the Director of Nursing (DON) provided a list of Aides who worked the midnight shift from 10:30 p.m. on 7/28/20 through 6:30 a.m. on 7/29/20. The list included CNA's T, and V, and WCA's R (Dietitian) and U. On 7/30/20 at 11:23 a.m., an interview with WCA U revealed the following: When asked if staffing had dropped to three aides at 2:30 a.m., stated Yes. When asked if it was challenging to get tasks done, WCA U stated Challenging to get stuff done is an understatement. We literally only have time to check and change (residents). Last night we had four (Aides) which was a breath of fresh air. One night there were 3 nurses and 3 aides, and one had just completed the class . (Call Lights) are going off longer than they should be, and I feel like I can't give (residents) more than the bare minimum. On 7/30/20 at 2:13 p.m., time sheet detail reports were provided by the DON for 7/28/20. A review revealed 2 staff WCA X and CNA Y who were not on the original list provided by the DON as staff working the night of 7/28/20 from 10:30 p.m. through 7/29/20 at 6:30 a.m. with time cards presented. WCA X had a time in punch of 10:42 p.m., and a hand written statement on the time card indicating CNA X had forgotten to punch out at 6:30 a.m. the morning of 7/29/20. CNA Y had a time in punch of 11:12 p.m. on 7/28/20 and a time out punch of 2:42 p.m. on 7/29/20 with an Out Exc code LE (Left Early). On 7/30/20 at 3:32 p.m., an interview with the DON revealed the following: When asked why the time cards for WCA X and CNA Y were provided for the staff working on the midnight shift from 7/28/20 at 10:30 p.m. through 6:30 a.m. 7/29/20 when they were not on the original list provided, the DON stated I pulled the list from the staffing sheets before pulling the time cards. When asked about WCA R (Dietitian) who was listed as a WCA from 4:00 a.m. to 8:00 a.m., the DON stated, All of my administrative staff have been added to non-certified waiver care aides. The DON stated WCA R was working the morning of 7/29/20 as a WCA from 4:00 a.m. to 8:00 a.m. On 7/30/20 at 4:09 p.m., an interview with CNA V revealed the following: When asked if CNA V could confirm if WCA R was working as a WCA from 4:00 a.m. to 8:00 a.m. on 7/29/20, CNA V stated, No, that did not happen. It was just us three (Aides) . I don't even really know who (WCA R) is. As far as I know she comes in to do kitchen stuff She didn't help us at all. (WCA X) worked 2nd (shift) and was gone at 10:30 p.m. (WCA X) definitely was not out there until 6:30 a.m. (CNA Y) definitely was not out there either. (CNA Y) works afternoons . I've worked with two WCA's and three nurses before, and we technically met state minimum. That was within the last week . That left me with the bulk of the work. I think we were only able to get two rounds done and charting, and that's it. On 7/30/20 at 4:34 p.m., a follow up interview with CNA T revealed the following: When asked if WCA R was out helping care for the residents, CNA T stated, I didn't work with WCA R. When asked if WCA X or CNA Y were working during the time frame of 10:30 p.m. 7/28/20 through 6:30 a.m. 7/29/20 stated, That's not true at all. (CNA Y went home after 11 p.m. that night (7/28/20). (CNA Y) had to finish up her charting. (CNA Y) did not stay that night and I don't even know who (WCA X) is, but I know he wasn't there that night. On 7/30/20 at 5:17 p.m., an interview with WCA X revealed the following: When asked what hours were worked on 7/28/20, WCA X stated, I worked second shift (2:30 p.m. - 10:30 p.m.). When asked about the hand written information on the time card and whether he worked on the midnight shift, WCA X stated, No, I forgot to clock in that day at 2:30 p.m. They did try to mandate me though. On 7/31/20 at 9:19 a.m., an interview with WCA R revealed the following: When asked what role was being filled from 4:00 a.m. to 8:00 a.m. on 7/29/20, WCA R stated she was there and comes in every Wednesday at 4:00 a.m. to assist on the floor with things like answering

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235653	A. BUILDING _____ B. WING _____	07/31/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MEDILODGE OF CAPITAL AREA	2100 E PROVINCIAL HOUSE DR LANSING, MI 48910

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 0690 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) lights and passing waters. When asked if she helped with actual care of the residents, WCA R stated, I did not do any direct care. CNA Y was contacted twice and a messages was left requesting an interview. No return call was received from CNA Y by the end of the survey. After review of all of the pertinent interviews and documentation provided by the facility. It was determined there were only three CNA's and/or WCA's providing direct care during the time frame from 7/28/20 at 10:30 p.m. to 7/29/20 at 6:30 a.m.
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.** Linked Intakes: MI 168, MI 822, MI 656, MI 775 Based on observation, interview and record review the facility failed to provide sufficient staffing to provide adequate care to the entire facility population. This deficient practice resulted in actual (R53) and potential skin impairment issues, and the potential for multiple other unmet care needs in a current facility census of 77 residents. Findings include: On 7/28/20 at 1:03 p.m., an interview with Family Member (FM) H revealed the following: The last several (care conferences) we were addressing my concerns, my mother (Resident #53) being changed at night, and the dressing of her back side. I would say at least six weeks ago the wound on her back side started. They (facility) had to report it to me because she was telling me her back side was hurting and she was getting medication on it. When I told them about her needing to be changed more often, they told me she was being changed every two hours, and I know for a fact they weren't doing that, because they have been so short staffed. I've heard they have had one CNA (Certified Nurse Aide) for three halls. Most of this happens at night. (The Facility) always says we are addressing it, but nothing ever changes. They tell me she should be changed more often . I want her to be clean and dry. That's not too much to ask. I had a conversation with (the wound nurse) about her not improving to where they really wanted it, so they are changing the treatment plan. On 7/29/20 at 08:15 a.m., an interview with Waiver Care Aide (WCA) K revealed she was the only Aide down the 300 hallway with 17 residents and stated at least four are total (two person) care. When asked if it was hard to keep up with all the care to be provided with the case load she had, stated, Yes, I don't think it's enough to have just one down here. Especially when I am not usually down here. On 7/29/20 at 8:20 a.m., an interview with Licensed Practical Nurse (LPN) C on the 200 hall revealed only one CNA (L) for 16 residents. Resident #53 was among those residents. On 7/29 20 at 8:45 a.m., an interview with Resident #53 revealed the following: At night they (staff) don't do me right, they don't change me but once a night. They've gotten a little better, I think because my son spoke to them. Last night was bad though. On 7/29/20 at 10:20 a.m., incontinence care and wound care were observed. CNA L and CNA N (Admissions Director) who was taking over for CNA L performed incontinence care. The brief bands were observed not in the creases of Resident #53's legs. When asked if the brief was properly placed, CNA L stated No, that's probably why she has that on her leg (Left thigh noted to have a open bleeding area below the leg crease in line with the brief being improperly placed). No bowel movement was noted in the brief when Resident #53 was initially rolled onto her side. CNA L continued to clean Resident #53, and noted bowel movement on the wash cloth coming from the urethral area of the vagina. CNA L stated, That shouldn't be there. They didn't clean her very well. That could cause an infection. CNA L stated (CNA T), who was on last night told CNA L, (CNA T) had three halls last night and felt overwhelmed. CNA L stated CNA T reported being responsible for the 200, 300 and 400 hall last night and stated CNA T expressed feelings of being overwhelmed. The dressing change was observed performed by LPN C. The two areas addressed had macerated wound edges and exposed epithelium (second layer of skin). On 7/29/20 at 10:36 a.m., the Director of Nursing (DON) provided a list of Aides who worked the midnight shift from 10:30 p.m. on 7/28/20 through 6:30 a.m. on 7/29/20. The list included CNA's T, and V, and WCA's R (Dietitian) and U. On 7/30/20 at 10:20 a.m., an interview with CNA T revealed the following: This is really the worst job I've had in my life. I've been in a number of other facilities. I've never been in a facility where it is so short staffed . we have one CNA for 20 - 25 (residents) . The other night (7/28/20) we had a no-call/no-show, another CNA (AA)left at 2:30 a.m., which left me with 200, 300, and 400 halls (approximately 45 residents). until I went home. (WCA U, and CNA V) came out to help for 2 (bed check) rounds. When asked if WCA R was there helping, CNA T stated (WCA R) did not work. I don't even know who that is. On 7/30/20 at 11:23 a.m., an interview with WCA U revealed the following: When asked if staffing had dropped to three aides at 2:30 a.m., stated Yes. When asked if it was challenging to get tasks done, WCA U stated Challenging to get stuff done is an understatement. We literally only have time to check and change (residents). Last night we had four (Aides) which was a breath of fresh air. One night there were three nurses and three aides, and one had just completed the class . (Call Lights) are going off longer than they should be, and I feel like I can't give (residents) more than the bare minimum. On 7/30/20 at 2:13 p.m., time sheet detail reports were provided by the DON for 7/28/20. A review revealed two staff WCA X and CNA Y who were not on the original list provided by the DON as staff working the night of 7/28/20 from 10:30 p.m. through 7/29/20 at 6:30 a.m. with time cards presented. WCA X had a time in punch of 10:42 p.m., and a hand written statement on the time card indicating WCA X had forgotten to punch out at 6:30 a.m. the morning of 7/29/20. CNA Y had a time in punch of 11:12 p.m. on 7/28/20 and a time out punch of 2:42 p.m. on 7/29/20 with an Out Exc code LE (Left Early). On 7/30/20 at 3:32 p.m., an interview with the DON revealed the following: When asked why the time cards for WCA X and CNA Y were provided for the staff working on the midnight shift from 7/28/20 at 10:30 p.m. through 6:30 a.m. on 7/29/20 when they were not on the original list provided, the DON stated I pulled the list from the staffing sheets before pulling the time cards. When asked about WCA R (Dietitian) who was listed as a WCA from 4:00 a.m. to 8:00 a.m., the DON stated, All of my administrative staff have been added to non-certified waiver care aides. The DON stated WCA R was working the morning of 7/29/20 as a WCA from 4:00 a.m. to 8:00 a.m. On 7/30/20 at 4:09 p.m., an interview with CNA V revealed the following: When asked if CNA V could confirm if WCA R was working as a WCA from 4:00 a.m. to 8:00 a.m. on 7/29/20, CNA V stated, No, that did not happen. It was just us 3 (Aides) . I don't even really know who (WCA R) is. As far as I know she comes in to do kitchen stuff She didn't help us at all. (WCA X) worked 2nd (shift) and was gone at 10:30 p.m. (WCA X) definitely was not out there until 6:30 a.m. (CNA Y) definitely was not out there either. (CNA Y) works afternoons . I've worked with two WCA's and three nurses before, and we technically met state minimum. That was within the last week . That left me with the bulk of the work. I think we were only able to get two rounds done and charting, and that's it. On 7/30/20 at 4:34 p.m., a follow up interview with CNA T revealed the following: When asked if WCA R was out helping care for the residents, CNA T stated, I didn't work with WCA R. When asked if WCA X or CNA Y were working during the time frame of 10:30 p.m. 7/28/20 through 6:30 a.m. 7/29/20 stated, That's not true at all. (CNA Y went home after 11 p.m. that night (7/28/20). (CNA Y) had to finish up her charting. (CNA Y) did not stay that night and I don't even know who (WCA X) is, but I know he wasn't there that night. On 7/30/20 at 5:17 p.m., an interview with WCA X revealed the following: When asked what hours were worked on 7/28/20, WCA X stated, I worked second shift (2:30 p.m. - 10:30 p.m.). When asked about the hand written information on the time card and whether he worked on the midnight shift, WCA X stated, No, I forgot to clock in that day at 2:30 p.m. They did try to mandate me though. On 7/31/20 at 9:19 a.m., an interview with WCA R revealed the following: When asked what role was being filled from 4:00 a.m. to 8:00 a.m. on 7/29/20, WCA R stated she was there and comes in every Wednesday at 4:00 a.m. to assist on the floor with things like answering lights and passing waters. When asked if she helped with actual care of the residents, WCA R stated, I did not do any direct care. CNA Y was contacted twice and a messages was left requesting an interview. No return call was received from CNA Y by the end of the survey. A review of staffing requested over a two week period from 7/14/20 - 7/28/20 revealed the following: The resident census ranged from 76 to 81 with an average census of 78.1 for the above time period. CNA hours ranged from as high as 201.6 hours to as low as 118 hours with an average of 152.34 hours daily. RN/LPN combined hours ranged from as high as 128 hours to as low as 75.4 hours with an average of 107.1 hours daily. The lowest number of overall hours was on 7/19/20 with 221.9 hours worked and a census of 80. The highest number of overall hours worked was 7/14/20 with 394.6 total hours worked and a census of 78. 7/14/20 had 394.6 total hours worked with a census of 78 and 7/28/20 had 295.7 total hours worked with a census of 76. This was difference of 98.9 total hours. After review of all of the pertinent interviews and documentation provided by the facility. It was determined there were only 3 CNA's and/or WCA's providing direct care during the time frame from 7/28/20 at 10:30 p.m. to 7/29/20 at 6:30 a.m.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide and implement an infection prevention and control program.** Linked intakes: MI 168, MI 656 Based on observation, interview, and record review, the facility failed to maintain infection control measures and surveillance during a focused COVID-19 Infection Control survey. This deficient practice resulted in the potential for spread of COVID-19 (Novel Coronavirus Infection) in one unit (500) out of a total of five

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235653	A. BUILDING _____ B. WING _____	**07/31/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MEDILODGE OF CAPITAL AREA	**2100 E PROVINCIAL HOUSE DR LANSING, MI 48910**

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 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 2) residential units in the facility. Findings include: An initial tour of the facility was conducted by this Surveyor on 7/29/20 at 8:10 a.m. An observation was conducted of the 500 unit in which it was noted that the 500 unit had been split into an 14-day isolation and a rehabilitation unit. An interview with Registered Nurse (RN) 'O' on 7/29/20 at approximately 8:20 a.m. confirmed that the 500 unit hallway had been split up to accommodate the 14-day isolation. On 7/29/20 at 10:50 a.m. an observation of the 14-day isolation side of the 500 unit was conducted by this Surveyor. It was noted that in three rooms (507, 509, and 510) there were two blue gowns located on the inside of resident rooms hanging by a white metal hook. An interview was conducted with Licensed Practical Nurse (LPN) 'D' on 7/29/20 at 11:55 a.m. LPN 'D' confirmed that she was the nurse for both sides of the 500 unit including the 14-day isolation unit. When asked about the blue gowns located in the 14-day isolation resident rooms, LPN 'D' confirmed that the gowns are shared amongst the staff and they are not individually assigned. On 7/29/20 During the lunch observation on the 500 unit starting at approximately 12:00 p.m., it was observed that LPN 'D' and RN 'O' were passing out lunch meals to Residents located on the 14-day isolation unit. LPN 'D' was observed having to reach into the Resident rooms to grab a blue gown before donning the gown to enter into the room. On 7/29/20 at approximately 2:10 p.m. an interview was conducted with Speech Language Pathologist (SLP) 'G'. SLP 'G' asked this Surveyor if it was allowed to share the same isolation gowns amongst staff when entering into the 14-day isolation Resident rooms. When asked if staff have assigned personal protective equipment (PPE) including isolation gowns, SLP 'G' stated, No, and we have had staff test positive for COVID-19. Review of the facility's COVID Timeline (undated sent on 7/30/20) read, July 13th - July 17th: Weekly universal testing for staff completed. One staff (Certified Nurse Aide (CNA) 'Z') tested positive on July 15th. He did not work the unit or with the same resident that tested positive. He worked on 500 hall. A review of the Centers for Disease Control (CDC) website (accessed 7/31/20 at 3:25 p.m.) https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html revealed the following: .Extended use of isolation gowns. Consideration can be made to extend the use of isolation gowns (disposable or cloth) such that the same gown is worn by the same HCP . .Gowns Put on a clean isolation gown upon entry into the patient room or area . .Page last reviewed : July 15th, 2020