STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235331	A. BUILDING _____ B. WING _____	07/09/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MEDILODGE OF HOWELL	1333 W GRAND RIVER HOWELL, MI 48843

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 0585 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation is related to intake MI 851, MI 672 and MI 378 Based on observation, interview and record review the facility failed to address grievance concerns related to 1 sampled resident (Resident #7) and potentially the remaining 189 facility residents, resulting in missing and omitted documentation to confirm residents concerns were addressed, and the potential for health care and/or request for assistance not being provided. Findings Include: The Resident Council Minutes were requested for the month of October, November and December 2019 by the Activity Director (AD BB) on 7/7/20 at 12:59 PM. The October and November 2019 Resident Council Minutes were provided (no meeting was held December 2020 per residents' request) on 7/8/20 at 10:55 AM. Resident Council Minutes dated 11/22/19 reflected one area of concern as, Residents state long wait time for call lights. The facility's response sheet reflected: Concern reported: Residents state they are having long wait times for call lights to be answered. Affected Departments: Nursing. Department response: Will run a call light report and educate staff accordingly. Council Response: Residents spoke to previous Director Of Nursing (DON R). The document was signed by a resident council member, and the concern was circled yes for solved. The form reflected date sent as 11/2019, no date of return was written/indicated, and no date of response was signed and/or dated by facility staff indicating completion. On 7/8/20 at 11:13 AM, Administrator (ADM A) was asked to provide the completed call light response audit, reflected in the 11/22/19 concern report. Later the same day at 1:11 PM, DON A provided a copy of the 11/2019 concern form. When asked where was the call light audit reports and documentation of education provided to staff, DON B revealed he did not have that. The facility was unable to provide documentation to reflect the residents concern of 11/22/19 was addressed. On 7/10/20 the ADM A was asked to provide a copy of the facility's grievance policy. At 10:06 AM ADM A provided a July 2018 copy of what she revealed was the facility's grievance policy entitled, Quality Assistance Procedure which reflected: Policy Statement -Residents, their representatives (sponsors), other interested family members, or resident advocates may file a Quality Assistance Form. The facility will provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. The facility will consider the views of a resident or family group and act upon the assistance request and recommendations of such groups concerning issues of resident care and life in the facility. Policy Interpretation and Implementation 4. Quality Assistance request may be submitted orally or in writing. The administrator may delegate the responsibility of Quality Assistance investigation to appropriate department manager. 5. Upon receipt of a written Quality Assistance Form/request, the department manager will investigate the allegations and submit a written report of such findings to the administrator. 6. The administrator will review the findings with the person investigating the complaint to determine what corrective actions, if any, need to be taken. 7. The resident, or person filing the Quality Assistance Form on behalf of the resident, will be informed of the findings of the investigation and the actions that will be taken to correct any identified problems. According to the clinical record, including the Minimum Data Set ((MDS) dated [DATE], R7 was a [AGE] year old male admitted to the facility on [DATE] and discharged home on[DATE] with a primary [DIAGNOSES REDACTED]. On 07/07/2020 at 8:45 am, during a phone interview with family member AA it was reported she had multiple complaints regarding R7's stay at the facility, related to unmet care needs, laundry services, food, and a violation of Health Insurance Portability Accountability Act (HIPPA), that she never received resolution to. Family Member AA, reported she had verbalized her concerns several times to Unit Manager Q , Director of Nursing (DON) B, Administrator A and eventually to Regional Director of Operations (RDO) Z. Family member AA was restricted visitation in the building due to Covid 19 and did not have access to grievance forms, voicing her concerns via phone calls and emails. Review of the facility grievance logs for April and May 2020, reflected 1 grievance related to food dated 5/05/2020 from family member AA. On 07/08/2020 at 8:25 am, during an interview with DON B he acknowledged R7's family member had multiple complaints related to care (medications, call light response time and various other nursing concerns) and that he had met with R7 and spoke with family member AA. When queried why only one of the many concerns brought to the facility's attention was addressed on the grievance log. DON B offered no explanation, but did state the facility investigated the alleged HIPPA violation. The investigation related to the HIPPA violation was requested at that time. Review of a unnamed file provided by DON B on 07/08/2020 reflected miscellaneous information related R7 , which included an e-mail correspondence dated 5/05/2020 from RDO Z to Administrator A. The e-mail reflected Family member AA reported to RDO Z concerns including but not limited; lack of follow up and communication from facility staff, an alleged HIPPA violation, laundry services and food. There was no investigation to the alleged HIPPA violation. On 07/09/2020 at 8:10 AM, during an interview with Administrator A she reported the file provided on 07/08/2020 were her notes of things to follow up from the complaints related to R7. When queried where the investigation on the HIPPA violation was, Administrator A reported there was no formal investigation done for that allegation. When queried where the grievance forms related to R7 and the numerous voiced complaints, were located (with the exclusion of the food preferences dated 5/05/2020) Administrator A reported the only grievance form the facility completed on behalf of R7 was the issue pertaining to food. Administrator A reported she spoke to R7 and family member AA so frequently and assumed her concerns were resolved.
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 refers to Intake #MI 467. Based on interview and record review, the facility failed to prevent the verbal abuse of one resident (#8) out of 5 residents reviewed for abuse resulting in the potential that other residents in the facility would be subjected to abuse and threats from facility staff. Findings include: Resident #8 (R8) was admitted to the facility on [DATE] and re-admitted on [DATE] with the following Diagnoses: [REDACTED]. According to her brief interview for mental status (BIMS), her score was 99 indicating severely impaired cognition. R8 used a walker for mobility and needed reminders to use her walker because she was unable to identify and make safe choices. According to the documentation provided by the facility, on 5/10/20 at approximately 11:20 am, Resident #8 (R8) stood up and began walking down the hall without the support of her walker. R8 then lost her balance and fell . Registered Nurse (RN) K had seen R8 walking down the hall and grabbed R8's walker to take to her. RN K was unable to get to the resident before R8 fell in the hallway. According to the documentation, RN K stated I told you not to walk without your walker. I'm done with this. You need to

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 0600 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) stop this. As RN K assisted R8 off the floor and to her bed, RN K said in a loud voice You are staying in your room the rest of the day. I don't care if I have to strap you to the bed. I'm done with you. The documentation of the interview with Certified Nursing Assistant (CENA) L indicated CENA L told the Director of Nursing B I heard yelling. I walked around the corner and saw (location) nurse (RN K) stand with (resident name) yelling at her that she (RN K) didn't have time for her . Additionally CENA L stated when help came from (location) they asked if they could help. RN K said I don't care what you do with her. Strap her to the bed for all I care. I don't have time for this. According to the interview with witness CENA M, I had walked out of a resident's room and saw (resident name) on the floor with a blood pressure machine next to her. The nurse (RN K) came around the corner saying not today. I'm on a 16 (one 12 hour shift plus 4 hours) and don't have time to stop for 2 hours and fill out the forms. Also said I can't believe she would do this to me. Saying She needs to go to her room and lay in bed. And something about how she doesn't care if we have to strap her down. On 7/7/20, record review of the Human Resource (HR) file for RN K revealed she was hired on 4/8/2020 and was terminated on 5/10/2020 due to an allegation of abuse. RN K was deemed not eligible for rehire. On 7/7/20 at 1:23 PM, an attempt to contact RN K was made. A voicemail requesting a return call was left. On 7/8/20, Administrator A provided documentation which indicated RN "K's" license was reported to the State Licensing Board. On 7/8/20 at 12:15 PM, an interview was done with CENA M. CENA M was asked to describe what happened when R8 fell on [DATE]. CENA M stated On that day, R8 was standing up a lot all day and staff kept reminding R8 to sit down. R8 was sitting next to the med cart and was playing in the trash can on the cart. This upset RN K. I came to the unit after R8 fell and noticed RN K was furious with the resident and with the CENAs because R8 fell . RN K said in a mean way I don't care if you have to strap her to the bed and blamed the CENA staff that she fell (You guys should have been watching her (R8). There's no reason she (R8) fell .) CENA M indicated that R8 normally walked with a walker. CENA M tried to console the resident after the incident and the resident wanted to leave the unit after this happened. RN K was sent home after Director of Nursing B interviewed her. On 7/8/20, a record review of the Abuse Prevention Program policy, revised on 2/22/18, revealed the following information: 1. Our facility will not condone resident abuse by anyone, including staff members, physicians, consultants, volunteers, and staff of other agencies serving the resident, family members, legal guardians, resident representatives, sponsors, other residents, friends, or other individuals. 2. All personnel, residents, family members, resident representatives, visitors, etc., are encouraged to report incidents of resident abuse or suspected incidents of abuse. Such reports may be made without fear of retaliation from the facility or its staff. 3. Employees, facility consultants and/or attending Physicians must immediately report any suspected abuse or incidents of abuse to the Administrator. In the absence of the administrator, such reports may be made to his/her designee. 4. The Administrator must be immediately notified of alleged abuse/neglect or incidents of abuse/neglect. If such incidents occur or are discovered after hours, the Administrator and Director of Nursing Services must be called at home or must be paged and informed of such incident.