STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235293	A. BUILDING _____ B. WING _____	07/09/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MEDILODGE OF FARMINGTON	**34225 GRAND RIVER AVE FARMINGTON, MI 48335**

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 0550 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to MI 9: Based on observation, interview, and record review the facility failed to ensure residents were treated in a dignified manner for two (R#809, R#811) of two residents reviewed for dignity, resulting in the potential for diminished feelings of self worth. Findings include: On 7/7/20 during a conversation with the complainant, the complainant expressed concern with facility staff shouting obscenities in the facility and staff on phones talking through bluetooth most of the day. Resident #809: On 7/9/20 at 10:05 am, R#809 was observed laying on their back in bed. The resident was queried if they had any concerns/issues with their care and stated in part . I begged for the social worker to come and talk to me, so that I can tell her what's going on . She came and I started telling her the stuff that goes on around here and she walked right out of the door while I was talking. I am ready to leave this place . How do you walk out when I'm talking to you and trying to tell you all of the things that I'm having to go through here . I have to get out of here . I had staff come in a few weeks ago trying to get us up at 6 in the morning and I was tired from not sleeping all night. She came in complaining about how her coworkers don't do this or that and I told her I'm sorry but I don't care about your coworkers I'm tired . Review of the medical record revealed R#809 was admitted into the facility on [DATE] with a readmission date of [DATE] and [DIAGNOSES REDACTED]. A Minimum Data Set ((MDS) dated [DATE] documented A Brief Interview for Mental Status (BIMS) score of 15 out of 15 indicating intact cognition and with no documentation of mood or behaviors exhibited. R#809 required staff assistance for all ADL's (Activities of Daily Living). On 7/9/20 at 10:30 AM, Licensed Practical Nurse (LPN) Q was observed to have a pink blue tooth device in their right ear while preparing the residents' medications. Resident #811: On 7/9/20 at approximately 10:15 AM R#811 was observed in their room in bed. When queried as to whether the resident had noticed staff talking on phones in the resident's room, R#811 nodded. When queried as to how it made him feel, R#811 explained it made the resident feel bad. The clinical record for R#811 was reviewed and revealed the resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Per review of the resident's MDS assessment dated [DATE] the resident scored 15 out of 15 on a BIMs assessment, which indicated the resident was cognitively intact. On 7/9/20 at 10:30 AM the facility's Administrator was queried in regard to staff use of cellphones. The Administrator explained that now and again staff were reminded of cellphone usage and the Administrator explained staff should try to limit it to a break. When queried in regard to ear devices (bluetooth), the Administrator acknowledged staff shouldn't be walking around with the devices. Review of a facility policy titled, Resident Rights dated 8/2016 revealed, in part, Employees shall treat all residents with kindness, respect, and dignity .3. Our facility will make every effort to assist each resident in exercising his/her rights to assure that the resident is always treated with respect, kindness, and dignity .
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 to MI 9 and MI 9: Based on observation, interview and record review the facility failed to ensure an adequate amount of staff to meet resident need for three (R#809, R810, and one anonymous resident) of four reviewed for staffing, resulting in resident complaints of short staffing and facility staff reporting the following: staff not able to promptly assist residents with dining and resident food was cold, residents found wet (incontinent), and lack of consistent bathing for residents. This deficient practice had the potential to affect all 82 residents at the facility. Findings include: On 7/7/20 a complaint was received by the State Agency which alleged, in part, that residents were left in feces and urine for hours, and alleged concerns with call light response. On 7/9/20 a complaint was received by the State Agency which alleged concerns with staffing at the facility. Anonymous Resident: On 7/13/20 an anonymous resident was queried in regard to their stay at the facility. The resident explained that staffing on 7/12/20 was horrible. Per the resident, they had taken a diuretic medication and had been wet from their shoulders to their heels for hours. The resident reported a concern with no aides on 7/12/20. It was noted per review of the anonymous resident's clinical record that the resident was cognitively intact. Resident #809: On 7/9/20 at 10:05 am, R#809 was observed laying on their back in bed. The resident was queried if they had any concerns/issues with their care and stated in part . The care is not very good. They don't have enough people to run this place. They call in and quit. I don't get changed There were no CNA's (Certified Nursing Assistants) all night long. I sat in poop all night . This place should be closed the hell down as far as I am concerned . There's no staff here and you can't work with no staff. I am sick and tired of the neglect . I've had to sit in poop and pee for two shifts . R#809 was admitted into the facility on [DATE] with a readmission date of [DATE] and [DIAGNOSES REDACTED]. A Minimum Data Set ((MDS) dated [DATE] documented A Brief Interview for Mental Status (BIMS) score of 15 out of 15 indicating intact cognition and with no documentation of mood or behaviors exhibited. R#809 required staff assistance for all ADL's (Activities of Daily Living). Resident #810: On 7/13/20 at approximately 9:40 AM R#810 was observed in their bed. The resident was queried if there was enough staff at the facility, and shook their head in a no motion. Review of the clinical record for R#810 revealed the resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of a MDS assessment for R#810 dated 6/27/20 documented the resident scored 11 out of 15 on a BIMS assessment, which indicated the resident was moderately cognitively impaired. On 7/13/20 at 10:53AM Staff Member 'I' was queried in regard to staffing at the facility. Staff Member 'I' explained that they had worked recently and had stayed over due to staffing issues. Per Staff Member 'I', residents were not being taken care of, including their hands and skin, and a lot of residents had not been showered. Staff Member 'I' explained that they had cried. Per Staff Member 'I' they had provided a resident with a bed bath, the resident's bed was soaking wet (with urine), and if they had squeezed the resident's brief it would have been a tsunami. On 7/13/20 at 12:00 PM, Staff Member M was queried in regard to any concerns/issues with their employment at the facility and stated in part . We need more staff. We used to have to care for 6-8 residents and now it's 12 residents up here on the vent/trach unit, with less staff. The residents are always wet or have BM (bowel movement in their briefs) . Everyday that I come in it's overwhelming . On 7/13/20 at 12:13 PM, Staff Member N was queried in regard to any concerns/issues with their employment at the facility and stated in part . Staffing is a big issue . It's exhausting . On 7/13/20 at 12:27 PM, Staff Member O was queried in regard to any concerns/issues with their employment at the facility and stated in part . Everything is not good. Staffing is not good. There are no nursing assistants . It's overwhelming. Its

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

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F 0725 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	(continued... from page 1) going downhill . Midnight nurses are working by themselves, no CNA's . We are trying to pass trays, feed them, and trying to give out medications and we can't do all of that. Its bad. The nurses are crying . We can't do the actual nursing that we want to do because we have so much to do . On 7/13/20 at 12:57 PM, Staff Member P was queried in regard to any concerns/issues with their employment at the facility and stated in part . There's no help . I can't give the time and care that the residents need and should have, because of lack of help . showers are not being done because we don't have enough staff. We have multiple residents that need assistance with eating. By the time I get finished feeding one, I may have two more to go. By the time I get to them they don't want it because their food is cold, so they go without their meal. I have moments when I have to think about what I learned in school because I am having to work a whole unit by myself . The residents were complaining that they weren't being changed all night, so I started putting my initials on their briefs. I would come in and see the same briefs on the residents. The same brief on the residents for 16 hours. Why do they have to sit in urine for 16 hours? . We don't have the staff to turn and reposition the residents every few hours like we're supposed to . We don't even have time to chart . A lot of stuff could be prevented here . On 7/13/20 at 2:32PM Staff Member 'J' was queried in regard to staffing at the facility, and explained the facility had a shortage of staffing. When queried if they were able to meet their job duties, Staff Member 'J' responded no, explained there were not enough aides, and staff were doing patient care and nursing duties. On 7/13/20 at 2:58PM Scheduler 'H' was queried in regard to staffing at the facility. Scheduler 'H' explained that before she had gotten to the facility staff members had been terminated or quit, which had left open voids (in scheduling). Scheduler 'H' explained that staff would volunteer to pick up extra shifts, and acknowledged there were times that the open holes in scheduling could not be filled. Scheduler 'H' explained this was more with CNAs, and if she was aware in enough time then she could mandate (non-voluntary overtime) staff. Scheduler 'H' also explained a scenario where if staff called in after the start of their shift, then at that point nurses would do total care. Scheduler 'H' explained that staff were to call in two hours before their shift began. When queried as to how many staff were needed at the facility, Scheduler 'H' explained that at a minimum nine nurses were required per shift and a minimum of seven CNAs were required per shift. The number of open positions for nurses and CNAs was requested from Scheduler 'H'. Scheduler 'H' returned and explained there were three positions for nurses open and thirteen CNA positions open. On 7/13/20 at 3:34PM the facility's Director of Nursing (DON) was queried about staffing at the facility, and acknowledged there were lots of call-ins. When queried about managerial staff who could fill in, the DON explained that they and one of the managers were the only persons in the clinical rotation (who could perform nursing duties). The DON acknowledged the facility had been very short staffed the past weekend. Review of a facility policy titled, Staffing dated 1/16/15 and reviewed on 10/5/17 documented, in part, 1. Our facility maintains adequate staffing on each shift to ensure that out resident's needs and services are met. Licensed registered nursing and licensed nursing staff are available to provide and monitor the delivery of resident care services. 2. Certified Nursing Assistants are available on each shift to provide the needed care and services of each resident as outlined on the resident's comprehensive care plan .5. Adequate staffing is reviewed daily in the morning stand up meeting for the 24 to 48 hours and adjusted based on anticipated changes in acuity and workload .
F 0770 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide timely, quality laboratory services/tests to meet the needs of residents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to MI 9: Based on interview and record failed to ensure laboratory tests were obtained per physician order [REDACTED].#801, R#803) of two residents reviewed for laboratory services, resulting in STAT (immediate) labs being completed outside of the required timeframe, and a lack of results of physician ordered laboratory tests. Findings include: R#801 A review of R# 801's clinical record revealed the following: A Nursing noted dated 7/1/20 at 10:54 am, documented in part . Patient was seen by myself at 0945. (Doctor name redacted) notified of changes and temp . STAT (immediate) labs were ordered: CBC with diff (Complete Blood Count with Differential), CMP (Comprehensive Metabolic Panel), Mg (Magnesium) . Chest Xr (Chest X-ray), UA, and urine culture (Urinalysis and Culture) . On 7/1/20 STAT (immediate) orders were placed for the following: At 10:47 am- CBC with Diff 10:48 am- CMP 10:49 am- Magnesium 10:50 am- Chest xr 10:51 am- UA and Urine Culture Laboratory Results revealed the following: CBC with Differential and Magnesium laboratory results documented in part . COLL (collection) DATE&TIME: 07/01/20 15:15, RCVD (received) : 07/02/20, RPTD (reported) : 07/02/20 . Although the R# 801's CBC with Diff, CMP and Magnesium levels were collected on 7/1/20 the laboratory did not receive the STAT specimen until 7/2/20. A Radiology Report revealed a date of service of 07/02/2020 for the STAT chest x-ray. Further review revealed no results for the UA and Urine Culture ordered. R# 801 was admitted into the facility on [DATE] with [DIAGNOSES REDACTED]. A Nursing note dated 7/2/20 at 18:29 (6:29 pm) documented in part, . RT (Respiratory Therapist) observed resident in respiratory distress notified writer. Writer observed skin clammy, cyanotic, low 02 (oxygen saturation) 84%, moderate pale secretion . resident sent to the hospital . On 7/13/20 at 9:18 am, the Director of Nursing (DON) was queried on the facilities protocol/process for STAT labs and stated in part . Typically STAT labs are done in 4 hours. The nurses call the laboratory and tell them it's a STAT order . R#803: Per a physician order [REDACTED].#803 had been ordered multiple laboratory tests, which included a Hemoglobin A1C. Review of physician order [REDACTED].#803 revealed the following: The resident was ordered a CBC (Complete Blood Count), BMP (Basic Metabolic Panel) and a Hgb A1C (Hemoglobin A1C blood test). The clinical record for R#803 was reviewed and revealed the resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Per review of the resident's quarterly minimum data set (MDS) assessment dated [DATE] the resident scored 6 out of 15 on a brief interview for mental status exam, which indicated the resident was severely cognitively impaired. Review of a progress note for R#803 dated 5/18/20 documented the resident had refused their blood draw for lab. On 7/9/20 at 8:30AM A1C tests for R#803 for the time period of April to present were requested from the facility's Director of Nursing (DON). Also, all labs for the resident for the time period of April to present were requested for the resident. The DON was queried in regard to the process for labs at the facility, and explained the physician would order the lab, the physician would input the lab order unless it was a verbal order, it would be pending until the nurse confirms it, and the nurse was to confirm by the end of their shift unless it was urgent. The DON explained there were lab services Monday through Friday, and certain groups had certain lab days. The DON also explained lab could come in as needed and STAT labs were to be done in four hours. The DON was queried if they had identified concerns with labs, and acknowledged they had not identified concerns recently. Labs were provided for R#803 with a received date of 7/6/20. On 7/13/20 at 9:21AM the DON explained the lab was to send the draw list. On 7/13/20 at 11:22AM the DON explained information from the lab was to be obtained shortly. No additional documentation was received prior to the exit of the survey. A Hemoglobin A1C result for the resident was not provided by the exit of the survey. Review of a facility policy titled, Laboratory and Diagnostic Tracking Guidelines dated 9/2014 revealed, in part, the following: .5.STAT labs will be obtained per physician order [REDACTED]. The physician should be notified of all refused lab/diagnostic test orders and reason why. 11. The physician should be notified if the lab/diagnostic test is unable to be completed, reason why, and request for new orders .15. STAT orders a. Upon receipt of a STAT lab/diagnostic test, the nurse should contact the appropriate vendor to obtain the ordered test, or b. If phlebotomy is drawn in-house, obtain the specimen per protocol and arrange transport or pick-up of specimen. c. If unable to obtain the STAT test within facility established time frames, the physician should be notified for further orders or resident sent to a provider who can perform such test. D. Documentation of the above should be completed in the resident's medical record as explained in the documentation section of this procedure. Review of the facility's laboratory agreement with the lab provider dated 2/8/19 documented, in part, (Company) provides STAT (life threatening situation) service 24 hours per day, 365 days per year. Laboratory STAT testing will be provided within 5 hours .