STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235416	A. BUILDING _____ B. WING _____	03/11/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MEDILODGE OF STERLING	500 SCHOOL RD STERLING, MI 48659

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 0578 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to follow up timely and follow Do Not Resuscitate (DNR) wishes for one resident (Resident #18) of three residents reviewed for Advanced Directives, resulting in the likelihood of unwanted CPR. Findings include: On [DATE], at 2:01 PM, a record review of Resident #18's electronic medical record revealed a [AGE] year old female with an admission on [DATE] with [DIAGNOSES REDACTED]. Resident had moderately impaired cognition. A review of physician orders [REDACTED]. A review of progress notes revealed [DATE] 11:47 . Met with resident to review advanced directives. Resident reports she is a DNR, informed her she is a full code pending physician signature . There were no other Social Service progress notes following up on their code status wishes. On [DATE], at 2:34 PM, Social Worker F was asked if Resident #18 was their own person and Social Worker F stated, Yes, she is her own person. A record review along with Social Worker F of Resident #18 electronic medical record revealed Advanced Directives Discussion Document . Date [DATE] . Cardiopulmonary Resuscitation . the box for Withhold was check marked and was signed by the resident. Social Worker F was asked to review the progress notes and provide documentation the follow up on Resident #18's no CPR wishes and Social Worker F stated, Oh, I must have missed that. On [DATE], at 4:13 PM, Social Worker Fstated, I put a note in and I got witnesses so she is a DNR. I don't know how it got missed. A further record review of Resident #18's progress notes and physician orders [REDACTED]. Met with resident to review POC (plan of care) with (nurse) present as well. Discussed with resident her wishes regarding code status. Resident stated, I'm a DNR just like before. DNR signed with witnessed present . Full Resuscitate Stop Date [DATE] . Code Status: Do Not Resuscitate (DNR) . On [DATE], at 8:49 AM, Resident #18 was asked if they wanted resuscitation if needed and Resident #18 stated, I don't want it. Resident #18 further offered that she had a neighbor who was on life support for 23 days and that it was more heartbreaking than passing away. On [DATE], at 9:19 AM, Director of Nursing (DON) was asked how they could ensure that all residents advanced directives and code status wishes were assessed and are being following and the DON stated, we did go through and check everyone in the building. On [DATE], at 9:30 AM, a record review of the facility provided Advanced Directives . Policy Revised [DATE] . revealed Advance directives will be respected in accordance with state law and facility policy . In accordance with current OBRA definitions and guidelines governing advance directives, our facility has defined advanced directives as preferences regarding treatment options and include, but are not limited to: . b. Do Not Resuscitate .
F 0657 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to care plan a cardiac monitor/ transmitter machine for one resident (Resident #14) of twelve residents reviewed for care planning, resulting in unmet care needs. Findings include. On, 3/09/20, at 8:25 AM, Resident #14 was lying in bed. There was a machine on their nightstand with a green light on. The front of the machine was not aimed towards the resident. Resident #14 was asked what the machine was used for and Resident #14 stated, I have a defibrillator. My son brought it in when I came here. On 3/10/20, at 10:00 AM, a record review of Resident #14's electronic medical record revealed an admission on 6/6/19 with [DIAGNOSES REDACTED]. Resident #14 had moderately impaired cognition. A review of the resident has altered cardiovascular status r/t (related to) Arrhythmia, [MEDICAL CONDITION], Hypertension, MI ([MEDICAL CONDITION]) Date Initiated: 06/06/2019 Revision on 06/06/2019 . care plan revealed no intervention regarding the cardiac monitoring machine. On 3/10/20, at 3:07 PM, Social Worker/Unit Manager F was in Resident #14's room and was asked what the machine was used for and Social Worker/Unit Manager F stated, I will have to find out. Social Worker/Unit Manager F was asked to provide documentation why Resident #14 had a heart monitoring machine in their room. On 3/10/20, at 4:00 PM, Social Worker/Unit Manger F offered that they updated Resident #14's cardiac care plan and that the machine reads her pacemaker from 2 am to 4 am. It just needs to be facing her. On 3/11/20, at 9:30 AM, a further record review of Resident #14's cardiac care plan revealed . Interventions 3/10/2020 - Resident chooses to have her Merlin cardiac monitor at the facility from her home. Machine must be less than 6 feet from her, and facing her. Ensure green light is on. Reads information from 2-4 am. Date Initiated: 03/10/2020 . On 3/11/20, at 10:00 AM, a record review of the facility provided Care Planning Policy Reviewed/Revised 01/28/2011 revealed A comprehensive care plan for each resident is developed within seven (7) days of completion of the resident assessment . The resident, the resident's family and/or the legal representative/guardian or surrogate are encouraged to participate in the development of and revisions to the resident's care plan .
F 0732 **Level of harm** - Potential for minimal harm **Residents Affected** - Some	**Post nurse staffing information every day.** Based on observation, interview, and record review the facility failed to ensure nurse staffing information was posted or posted timely for seven shifts resulting in the potential for residents or visitors to be unaware/unable to know how many nurses and certified nursing aides were available to assist with cares. Findings include: During an observation on 03/09/20 at 08:57 AM, the Direct Care Staffing Hours/nurse staffing information was posted on the wall in the front entrance of the lobby area. The staffing sheet was dated 3/6/20; the nurse staffing information hadn't been updated since third shift on 3/6/20 at the posted area. There was no nurse staffing information posted for 3/7/2020, 3/8/2020, or for the first shift on [DATE]20 (seven shifts with no posted nurse staffing information). During an observation and interview on 03/09/20 at 08:58 AM, Social Service Designee/Registered Nurse F removed the staff posting papers from the wall holder, and they were all from old dates; 3/6/20 or prior. Staff F reported Station 2 (staff member) was supposed to update the posted nurse staffing information over the weekend. Staff Fconfirmed 3/6/20 was Friday and the nurse staffing information hadn't been updated over the weekend or the first shift of today ([DATE]20). Staff F reported she changes the staff posting sheet and would update it at that time. During an interview on 03/11/20 at 08:12 AM, Payroll Director A reported she oversaw the nurse staffing postings and that the Station Two Nurse was responsible for updating/posting the nurse staffing information on weekends. Payroll Director A confirmed there were seven total shifts with no posted nurse staffing information. (6 shifts over 3/7/2020 and 3/8/2020 had no nurse staffing information posted and [DATE]20 first shift's nursing staff information wasn't posted until approximately 3 hours after the start of the shift). When asked what time the posting should be put up for residents/visitors to see Payroll Director A stated, before the shift and confirmed first shift started at 6 AM. Review

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

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F 0732 **Level of harm -** Potential for minimal harm **Residents Affected -** Some	(continued... from page 1) of the facility's posted nurse staffing sheet, on [DATE] at 08:57 AM, at the front entrance lobby area, dated 3/6/20, stated, To be posted by 2 hours prior to shift start.