STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235650	A. BUILDING _____ B. WING _____	08/20/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MEDILODGE OF MILFORD	**555 HIGHLAND AVE MILFORD, MI 48381**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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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 995 and MI 996. Based on observation, interview and record review, the facility failed to ensure an environment free of verbal abuse between two residents (R907 and R909) of four residents reviewed for abuse, resulting in verbal abuse of R909 to R907, R907 becoming tearful, and the increased potential for decline in R907's psychosocial well-being. Findings include: A review of multiple complaints submitted to the State Agency alleged concern that R907 was being abused, and were concerned about further instances of abuse of R907 as well as other residents that had dementia and may not be able to verbalize instances of abuse. On 8/19/20 at 9:30 AM, a resident was overheard loudly yelling and swearing from a resident room. Upon to the room occupied by R907 and R909, R909 was observed to repeatedly tell R907 to You shut the f*** up. And R907 responded back to R909, No, you shut up. R909 was observed to continue to look at R907 while stating, Shut the f*** up. At that time, Licensed Practical Nurse (LPN J) was observed walking down the hallway towards the medication cart that was placed a few doors down from R907 and R909. The verbal yelling and swearing continued to be heard at this time. When queried about R909 swearing and yelling at R907, LPN J reported, Oh yeah, it's hit or miss with them. (Name of R909) is actually getting ready to leave for [MEDICAL TREATMENT] and I have to do this (treatment for [REDACTED]. LPN J was asked to observe the application of the pain patches to R907's knees. During this time, R909 continued to verbally swear and yell at R907 stating, All she does is complain. Go to hell B****. She thinks she runs the hospital. R907 reported, (R909) makes me sick. Upon completion of the application of the pain patches and opening of the privacy curtain, R909 was observed to say, I don't wanna look at you (R907). R907 was informed that an interview would be completed later on and R909 stated, Don't pay attention to what she says, she's nobody. Throughout this observation, LPN J was not observed to intervene or address the verbal altercation of R909 to R907. LPN J was asked about R909's behavior towards R907 and whether that was considered as abuse and reported, They don't really do that (abuse). They're like sisters. I'll talk to social work and have her come down and talk. Maybe we need to switch rooms. When asked again if that was considered as abuse, LPN J reported, Maybe. Not so much, but they're comfortable. I was in there earlier. I'll have social work talk to them. On 8/19/20 at 9:55 AM, an interview was conducted with the Administrator (also identified as the facility's Abuse Coordinator). When informed about the observation and interview with R907, R909 and LPN J, the Administrator acknowledged the interaction as observed was abuse and would begin an investigation immediately. On 8/19/20 at 11:27 AM, R907 was observed lying in bed and agreed to an interview. When asked about R909's behaviors observed earlier with R907, R907 stated, When she goes to [MEDICAL TREATMENT] she gets like that. A review of R907's progress notes included: An entry by the Social Service Director (SSD) on 8/19/20 at 9:44 AM documented, (LPN J) brought it to my attention that resident and roommate were talking, but staff indicated there was a scuffle between them. Staff indicated there was some name calling, I spoke to resident, who was tearful. She stated that roommate sometimes lashes out before [MEDICAL TREATMENT] appointments due to stress about [MEDICAL TREATMENT] . On 8/20/20 at 8:50 AM, an interview was conducted with Certified Nursing Assistant (CNA E). CNA E reported working with R907 more recently. When asked if there had ever been any witnessed incidents of R909 verbally swearing and yelling at R907, CNA E reported, I think all of us have. (name of R909) I've heard her to call (name of R907) the B-word before. I've had her mostly yell at staff. Review of the clinical record revealed R907 began to share a room with R909 on 5/5/20. R907 initially admitted into the facility on [DATE] with [DIAGNOSES REDACTED]. According to the Minimum Data Set (MDS) assessment dated [DATE], R907 had intact cognition (scored 14/15 on brief interview for mental status exam/BIMS) and exhibited no mood or behavior concerns. Review of the clinical record revealed R909 was admitted into the facility on [DATE] and readmitted on [DATE] with [DIAGNOSES REDACTED]. According to the MDS assessment dated [DATE], R909 had intact cognition (scored 13/15 on BIMS exam), exhibited verbal behaviors directed towards others and rejection of care. A review of the facility's Abuse Prevention Program dated Revised 2/22/18 documented, in part: .Our facility will not condone resident abuse by anyone, including .other residents .All personnel .are encouraged to report incidents of resident abuse or suspected incidents of abuse .Employees .must immediately report any suspected or incidents of abuse to the Administrator .Incidents of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse .Verbal abuse is defined as any use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents .or within their hearing distance .
F 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake #MI 346, MI 995 and MI 996. Based on interview and record review, the facility failed to identify, prevent/protect, and report allegations of abuse immediately to the Administrator for three (R904, R907 and R909) of four residents reviewed for abuse, resulting in abuse situations and allegations not being investigated by the Abuse Coordinator and the potential for unidentified and continued abuse. Findings include: Resident 904: A review of a facility reported incident submitted to the State Agency on 3/23/20 alleged concern that R#904 had been abused/mistreated by a facility staff member. On 8/19/20 the medical record for R#904 was reviewed and revealed the following: R#904 was last admitted to the facility on [DATE] and had [DIAGNOSES REDACTED]. R#904's MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 8/7/20 revealed R#904 needed extensive assistance from facility staff with most of their activities of daily living. R#904 was documented as having severely impaired cognition. On 8/19/20 a facility investigation pertaining to the allegation of abuse/mistreatment involving R#904 was reviewed and revealed the following: On 3/22/2020 at 11:36 p.m., the Administrator was notified of an allegation of verbal abuse by (CNA K). She stated, 'On Wednesday 3/18/2020, I asked (CNA B) to help me change the residents brief and put her in to bed. We entered the room and (CNAB) said, 'Just so you know I think the resident is f****** disgusting.' While we were changing the resident, the resident reached for (CNAB) several times and each time (CNAB) stated, 'Don't F****** touch me, you're f****** disgusting.' (CNAB) was also making vomiting gestures. I then asked her to leave the room and told her I would finish.An interview with CNA K pertaining to their reported allegation revealed the following: .Q (Question): Did you report this to anyone on Wednesday when this happened? A (Answer): No, well I think I told a nurse, but it wasn't my nurse. Q: Who was the nurse? A: I am not sure. Q: Can you describe the nurse that you reported it to? A: No. Q: Who are you supposed to report allegations of abuse to? A: You (Administrator) or (DON) .Further review of the facility investigation revealed the following: (CNAK) received a written discipline for not immediately reporting an allegation of abuse to the abuse coordinator . A performance improvement form

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 0609 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) dated 3/22/0 for (CNAK) revealed the following: Reason for counseling/corrective action: On 3/18/2020, Employee failed to report an allegation of abuse .Expected level of performance: All allegations of abuse are to be reported to the abuse coordinator (Administrator) immediately . On 8/20/20 at approximately 9:53 a.m., during a conversation with the facility Administrator, the Administrator was queried regarding the reporting and investigation of the allegation involving R#904. The Administrator indicated that CNA K did not report the allegation in the time frame that was required of them and they (the Administrator/Abuse coordinator) should have been informed of the allegation immediately. Resident 907 & Resident 909: A review of multiple complaints submitted to the State Agency alleged concern that R907 was being abused, provided care in a rough manner, and had an injury of unknown origin. The allegations further expressed concern that the facility had not investigated these incidents after being reported to facility staff which resulted in an injury and were concerned about further instances of abuse of R907 as well as other residents that had dementia and may not be able to verbalize instances of abuse. On 8/19/20 at 9:30 AM, a resident was overheard loudly yelling and swearing from a resident room. Upon entry to the room occupied by R907 and R909, R909 was observed to repeatedly tell R907 to You shut the f*** up. And R907 responded back to R909, No, you shut up. R909 was observed to continue looking at R907 while stating, Shut the f*** up. At that time, Licensed Practical Nurse (LPN J) was observed walking down the hallway towards the medication cart that was placed a few doors down from R907 and R909. The verbal yelling and swearing continued to be heard at this time. When queried about R909 swearing and yelling at R907, LPN J reported, Oh yeah, it's hit or miss with them. (Name of R909) is actually getting ready to leave for [MEDICAL TREATMENT] and I have to do this (pointed to medicated patch for R907). I had to get pain patches for (name of R907). LPN J was asked to observe the application of the pain patches to R907's knees. During this time, while the privacy curtain was closed, R909 continued to verbally swear and yell at R907 stating, All she does is complain. Go to hell B****. She thinks she runs the hospital. R907 reported, (R909) makes me sick. Upon completion of the application of the pain patches and opening of the privacy curtain, R909 was observed to say, I don't wanna look at you (R907). R907 was informed that an interview would be completed later on and R909 stated, Don't pay attention to what she says, she's nobody. Throughout this interaction, LPN J was not observed to intervene or address the behavior and actions of R909 to R907. LPN J was asked about R909's statements towards R907 and whether that was considered as abuse and reported, They don't really do that (abuse). They're like sisters. I'll talk to social work and have her come down and talk. Maybe we need to switch rooms. When asked again if that was considered as abuse, LPN J reported, Maybe. Not so much, but they're comfortable. I was in there earlier. I'll have social work talk to them. On 8/19/20 at 9:55 AM, an interview was conducted with the Administrator (also identified as the facility's Abuse Coordinator). When informed about the observation and interview with R907, R909 and LPN J, the Administrator acknowledged the interaction as observed was abuse and would begin an investigation immediately. When asked if LPN J should have reported it directly, the Administrator responded yes. On 8/19/20 at 11:27 AM, R907 was observed lying in bed and agreed to participate in an interview. When asked about R909's statements observed earlier with R907, R907 stated, When she goes to [MEDICAL TREATMENT] she gets like that. On 8/19/20 at 11:50 AM, when queried about whether there have been any allegations involving R907 regarding rough handling during care by any staff members, the Administrator denied and stated, Even if accidentally happened, I'm usually told. The Administrator was requested to provide any incident/accident reports for R907. On 8/19/20 at 12:48 PM, the Director of Nursing (DON) provided R907's incident/accident reports which included a report dated 8/4/2020 and documented, in part .Resident noted with black eye to right eye. When asked about the black eye, the DON reported On rounds was noted to have black eye, purplish. I went and grabbed my ADON (Assistant Director of Nursing) and asked if anything had happened. (R907 said she rolled over and hit it on side of the bed. When asked if there were any interviews with staff, the DON denied and reported R907 was able to state what happened. The DON further reported there was no head manager for that unit and when asked if anyone had reported the black eye prior to the DON finding it while doing routine rounds, the DON reported No. When asked if staff should've identified that during daily monitoring such as during skin assessment or bathing, the DON reported, Yes, they should've. Aides do shower sheets and nurses sign off. At that time, the DON was requested to provide any other documentation such as skin assessments, or bathing documentation. On 8/19/20 at 1:43 PM, the DON reported there was no further documentation to provide and further acknowledged the available skin assessments conducted 8/3/20 and 8/6/20 revealed there was no documentation or identification of any bruising for R907. The DON further reported she had spoken to Certified Nursing Assistant (CNA E) who was aware of the bruise prior to when the DON identified it. On 8/19/20 at 2:05 PM, an interview was conducted with Certified Nursing Assistant (CNA C) who reported the usual work schedule was on the midnight shift. When asked about CNA Cs interactions with R907 and whether there have been any observations of injuries such as bruising, CNA C stated, I didn't see anything. Anytime I've dealt with her she grabs and slaps at you. Not sure if (R907) got (bruised eye) slapping at us. When asked to explain what that meant, CNA C stated, Try to finish (providing care) as soon as I can and leave. If I don't change her, I get in trouble for not doing care. When asked to clarify what was done when the resident became agitated and exhibited behaviors of slapping/grabbing, CNA C reported she continued providing care until it was completed. When asked if these behaviors of slapping or grabbing were reported or documented anywhere, CNA C denied being aware of a process to document and reported, I usually make sure there's two of us. (R907's) told other aides I've been mean to her .told (name of CNA D) I was mean to her . On 8/19/20 at 1:53 PM, an interview was conducted with the Social Service Director (SSD). When asked about R907's behaviors, the SSD denied being aware of any allegations of staff being rough with care, or any behaviors. The SSD reported R907 did have teary episodes but that this was the resident's baseline and not a new onset. On 8/19/20 at 2:28 PM, CNA D was attempted to be contacted by phone for an interview, but there was no return call by the end of the survey. On 8/20/20 at 8:15 AM, review of the nursing schedules revealed CNA E worked with LPN F on Monday 8/3/20 during the day shift. The bruise to R907's eye was identified by the DON on Tuesday 8/4/20. On 8/20/20 at 8:50 AM, an interview was conducted with CNA E who reported normal work schedule was on the day shift. When asked to provide information regarding R907's bruised eye, CNA E stated, The night after I think she had got it (bruise), I brought her more blankets and I noticed it (bruise) then. (R907) said I think I hit it. I told my nurse (LPN F). It was gone in a week. When asked about being aware of any allegations of staff providing rough care, CNA E denied. When asked about whether there have been any observations of R909 swearing or yelling at R907, CNA E stated, I think all of us have. (Name of R909) I've heard to call (name of R907) the B-word before. I've had her mostly yell at staff. When asked if these interactions had ever been reported to anyone, CNA E stated, Usually the nurse is right outside the door. When asked if R907 exhibited behaviors of slapping, or grabbing during care, CNA E denied any behavior concerns for R907. On 8/20/20 at 9:07 AM, a phone interview was conducted with LPN F. When asked about R907's bruised eye, LPN F reported, (Name of R907) did have a small spot and I asked her about it and she said it was from rubbing. (This conflicted with earlier discussion with the DON and CNA E.) When asked if the change in skin condition had been documented, or reported, LPN F stated, No, I kinda brushed it off. I forgot about it. When asked what should be done, LPN F stated, We're supposed to report any bruises that we don't know where it came from. We should report bruises. When asked if LPN F had been aware of any allegations of rough care, LPN F stated, I heard that through the grapevine. This was after the fact I heard. When asked to clarify 'after the fact' LPN F stated, After the bruise. When asked if this allegation of rough care had been reported to anyone, LPN F stated, I didn't personally cause I assumed it was already reported. When asked what should be done when any allegations of abuse are reported or discovered, LPN F reported, Should be reported to the Administrator. Resident 907: Review of the clinical record revealed R907 began to share a room with R909 on 5/5/20. R907 initially admitted into the facility on [DATE] with [DIAGNOSES REDACTED]. According to the Minimum Data Set (MDS) assessment dated [DATE], R907 had intact cognition (scored 14/15 on brief interview for mental status exam/BIMS) and exhibited no mood or behavior concerns. A review of R907's progress notes included: An entry by the Social Service Director (SSD) on 8/19/20 at 9:44 AM documented, (LPN J) brought it to my attention that resident and roommate were talking, but staff indicated there was a scuffle between them. Staff indicated there was some name calling, I spoke to resident, who was tearful. She stated that roommate sometimes lashes out before [MEDICAL TREATMENT] appointments due to stress about [MEDICAL TREATMENT] . Resident 909: Review of the clinical record revealed R909 was admitted into the facility on [DATE] and readmitted on [DATE] with [DIAGNOSES REDACTED]. According to the MDS assessment dated [DATE], R909 had intact cognition (scored 13/15 on BIMS exam), exhibited verbal behaviors directed towards others and rejection of care. A review of the facility's Abuse Prevention Program dated Revised 2/22/18 documented, in part: .Our facility will not condone resident abuse by anyone, including .other residents .All personnel .are encouraged to report incidents of resident abuse or suspected incidents of abuse .Employees .must immediately report any suspected or incidents of abuse to the Administrator .Incidents of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse .Verbal abuse is defined as any use of oral, written or gestured language that willfully includes disparaging and

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F 0609 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 2) derogatory terms to residents .or within their hearing distance .Injury of unknown source is defined as an injury that meets both of the following conditions: (1) The source of the injury was not observed by any person or the source of the injury could not be explained by the resident; and (2) The injury is suspicious because of .the location of the injury .
F 0686 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide appropriate pressure ulcer care and prevent new ulcers from developing.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake #MI 163. Based on observation, interview and record review the facility failed to ensure wound dressings were completed as ordered by the Physician for one resident (R#902) of three residents reviewed for pressure ulcers, resulting in the potential for delayed healing. Findings include: R#902 On 8/19/20 a review of a complaint submitted to the state agency indicated R#902 was not receiving wound care as ordered. On 8/20/20 at approximately 8:47 a.m., R#902 was observed in their room, lying in their bed. R#902's coccyx wound dressing was observed to be undated and have a dried brown/red fluid on it. The medical record for R#902 was reviewed and revealed the following: R#902 was last admitted to the facility on [DATE] and had [DIAGNOSES REDACTED].). R#902's Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 7/8/20 revealed R#902 needed extensive assistance from facility staff with most of their activities of daily living. Section M indicated R#902 was at risk for developing pressure ulcers. R#902's BIMS score (brief interview of mental status) was 15 which indicated intact cognition. A physician's orders [REDACTED]. Pat dry. Apply dermaMed ointment as directed to right buttock PI (pressure injury) site, cover with large non bordered Foam every day shift for Right buttock wound. A review of R#902's Treatment Administration Record (TAR) for June 2020 revealed R#902 did not have their right buttock treatment documented as being completed on 6/3 and 6/10. A physician's orders [REDACTED]. Pat dry. Apply topical A&D ointment to buttocks, cover with large 6x6 in non Bordered Foam, secure with [MEDICATION NAME] tape every day shift for Buttocks. A review of R#902's TAR for July 2020 revealed R#902 did not have their buttock treatment documented as being completed on 7/1, 7/11, 7/16. 7/19, and 7/20. A review of R#902's care plan revealed the following: Focus-The resident has Chronic stage 3 pressure ulcers to (RIGHT buttock). Hx (history) of chronic Left buttock pressure ulcer .Goal-The resident's Pressure ulcer will progress through the healing process and remain free from infection through review date .Interventions-Administer medications as ordered. Evaluate/document for side effects and effectiveness .Administer treatments as ordered and evaluate for effectiveness . On 8/20/20 at approximately 9:40 a.m., the Director of Nursing, (DON) was queried how the facility nursing staff documented their completion of treatments. The DON indicated it was their expectation that nursing staff document in the administration record when the treatment has been completed. The DON was queried about how the nursing staff documented when a resident declined having a treatment done and the DON indicated that would also be documented in the administration record. The DON was queried if it was their expectation that residents treatments are completed according to the Physician orders [REDACTED]. The DON was also informed of the observation where R#902's coccyx dressing was undated and soiled and the DON indicated that it was their expectation that wound dressings were to be dated and initialed by the nurse completing the treatment. On 8/20/20 a facility document titled Pressure Ulcers/Pressure Injury Prevention and Treatment-Clinical Protocol (last revised 11/2017) was reviewed and revealed the following: Based on the comprehensive assessment of a resident, a resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and a resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice to promote healing, prevent infection and prevent new ulcers from developing .