STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235296	A. BUILDING _____ B. WING _____	07/15/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MEDILODGE OF SOUTHFIELD	26715 GREENFIELD RD SOUTHFIELD, MI 48076

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 0600 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**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 #s: MI 404 and MI 968. Based on observation, interview and record review, the facility failed to ensure resident to resident physical and verbal abuse did not occur between four (R#s 807, 808, 822 and 823) of 18 residents reviewed for abuse, resulting in these residents being subjected to instances of physical and verbal abuse. Findings include: Resident #807 and Resident #808 The facility reported the following to the State Agency: .Date/Time Incident Discovered: 11/20/19 9:46 PM .Date/Time Incident Occurred: 11/20/19 9:46 PM .Incident: on 11/20/19 (R#807) & (R#808) was observed in the hallway by their adjoining room. (R#808) was observed to be holding (R#807) bilateral wrist with her hands yelling I'm sick of this [***] she keeps coming into my room taking stuff. (R#807) stated She choked me .Skin assessment completed and (R#807) was noted to have bilateral red wrist, neck redness and small scratches . On 7/13/20 - 7/15/20, an unannounced, onsite investigation was conducted. R#808 no longer resided in the facility at the time of the investigation. R#807 was observed on 7/13/20 at 12:12 PM lying in bed while facing the window with a light bedsheet covering most of the resident's body. R#807 was unable to participate in an interview due to significant cognitive limitations. A review of the facility's investigation into this occurrence on 11/20/19 included, .facility has determined a resident to resident altercation has occurred with redness and scratches resulting from the altercation. A review of the clinical record revealed R#807 was admitted into the facility on [DATE] and readmitted on [DATE] with [DIAGNOSES REDACTED]. A review of the Minimum Data Set (MDS) assessments dated 10/26/19 and 4/25/20 both documented R#807 had severely impaired cognition (scored 5/15 on the Brief Interview for Mental Status/BIMS exam), exhibited no behavior concerns, and required supervision with ambulation without an assistive device. A review of the clinical record revealed R#808 was admitted into the facility on [DATE] and had been discharged on [DATE]. [DIAGNOSES REDACTED]. A review of the MDS assessment dated [DATE] documented R#808 had moderately impaired cognition (scored 11/15 on the BIMS exam), exhibited no behavior concerns, and required supervision with ambulation without an assistive device. On 7/14/20 at 11:00 AM, an interview was conducted with the Administrator who also identified as the facility's Abuse Coordinator. When asked about details of this investigation, the Administrator reported she was not in the facility at that time and deferred to the Director of Nursing (DON). On 7/14/20 at 11:04 AM, during an interview with the DON, when asked about the resident to resident incident with R#807 and R#808 on 11/20/19, the DON reported the previous Administrator had completed the investigation and was unable to provide any further details. Resident 822 & Resident 823 The facility reported the following to the State Agency: .Date/Time Incident Occurred: 6/15/20 9:30 AM . Summary: .(R823) was sitting in the common area on the couch watching TV (television). (R822) was walking by and accidentally stepped on (R823's) foot. (R823) got up (race redacted) and said to (R822), (race redacted) (derogatory racial slur), you stepped on on my food (sic), he continued to call (R822) this racial slur and (R822) hit (R823) slapped (R823) (sic) on his face with his hand . Facility Action: (R823) had a small laceration on his chin under his lip on the left side. The physicians was (sic) notified and (R823) was sent to the ER (emergency room) for sutures . (R822) was evaluated and sent to (Name Redacted - local hospital) Gero-Psych (Geropsychology - psychology for older adults) for evaluation . On 7/13/20 at 12:31 PM, R823 was observed seated on a couch in the common area of the unit watching TV. R823 was talking as if to someone, however there were no other residents or staff nearby. On 7/13/20 at 2:17 PM, R822 was observed standing in the doorway to their room asking questions to other residents walking by. A staff member was observed trying to engage R822 in a conversation. R822 appeared confused and annoyed by the attempt and turned around to go back into their room. Review of the clinical record revealed R823 was admitted into the facility on [DATE] with [DIAGNOSES REDACTED]. According to the most recent MDS assessment dated [DATE], R823 had severely impaired cognition (scored 3/15 on the BIMS exam) and exhibited no behavior concerns. Review of the clinical record revealed R822 was admitted into the facility on [DATE] and readmitted [DATE] with [DIAGNOSES REDACTED]. According to the most recent MDS assessment dated [DATE], R822 had severely impaired cognition and exhibited no behavior concerns. On 7/15/20 at approximately 2:00 PM, an interview was conducted with the Administrator. When queried about the incident between R822 and R823, the Administrator reported abuse was not substantiated. However, both resident were sent to hospitals, one for stitches and one for psychiatric evaluation. Review of a facility policy titled, Abuse Prevention Program revised 2/22/18 read in part, Our residents have the right to be free from abuse . Abuse - The willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish . Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm . 'Verbal abuse' is defined as any use of oral, written or gestured language that willfully includes disparaging and derogatory terms to resident or their families, or within their hearing distance, to describe residents, regardless of their age, ability to comprehend, or disability .
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** Based on observation, interview and record review, the facility failed to report an injury of unknown origin (yellow discoloration/bruise) to the Administrator and State Agency for one (R#807) of 18 residents reviewed for abuse, resulting in delayed investigation, and the potential for unidentified and continued abuse. Findings include: On 7/13/20 at 12:12 PM, R#807 was observed lying in bed while facing the window with a light bedsheet covering most of the resident's body. Upon approach, the top of R#807's forearm was observed with a large yellow discoloration (healing bruise) that was approximately three inches by three inches, and a quarter sized yellow discoloration (healing bruise) to the upper arm. R#807 was asked about the yellow discolorations and reported, I don't know. R#807 was unable to participate in an interview due to significant cognitive limitations. A review of the clinical record revealed R#807 was admitted into the facility on [DATE] and readmitted on [DATE] with [DIAGNOSES REDACTED]. A review of the Minimum Data Set (MDS) assessments dated 10/26/19 and 4/25/20 both documented R#807 had severely impaired cognition (scored 5/15 on the Brief Interview for Mental Status/BIMS exam), exhibited no behavior concerns, and required supervision with ambulation without an assistive device. On 7/13/20 at approximately 10:30 AM, the Administrator was requested to provide any incident/accident reports and facility investigations for R#807. On 7/14/20 at 9:40 AM, a review of the incident/accident documentation provided by the facility for R#807 revealed there was no documentation for any injury of unknown origin (such as recent bruise). The most recent

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) fall investigation was noted on 3/24/20. Further review of the clinical record revealed there was no identification of any skin discoloration/bruise to R#807 documented. The most recent skin assessment dated [DATE] identified no new or existing abnormal skin issues. On 7/14/20 at 10:30 AM, Licensed Practical Nurse (LPN BB) was asked about whether there had been any identified changes in skin condition for R#807, such as any bruising and LPN BB reported, No. At that time, LPN BB was asked to observe R#807's left arm. Upon observation of R#807, LPN BB confirmed the multiple yellow skin discolorations and reported, I'm not aware of it. For this bruise the CNAs (Certified Nursing Assistants) have not reported it to me. When asked to explain what the facility's process was for changes in skin condition such as bruising of unknown origin, LPN BB reported, I would make a note and put in book for wound nurse and put in order to take care of it if open area. On 7/14/20 at 10:43 AM, Wound Nurse Y was queried about whether there had been any notification of any changes to R#807's skin condition, and upon review of the wound log reported, No. When informed of the discussion and observation of R#807's skin with LPN BB, Wound Nurse Y reported, Process is to do an incident report, and talk with the Administrator who is the Abuse Coordinator. On 7/14/20 at 11:00 AM, the Administrator was asked if staff had reported any injury of unknown origin for R#807's bruises. The Administrator reported she was unaware of any such notification for R#807. At that time, the Administrator was informed of the observation with LPN BB for R#807. On 7/14/20 at 11:04 AM, the Director of Nursing (DON) was asked about any changes in skin condition such as a bruise and/or injury of unknown origin for R#807. The DON reported, No. Nothing reported and not aware. On 7/15/20 at 1:00 PM, further review of R#807's clinical record revealed, after the notification to the Administrator and DON on 7/14/20, the progress notes revealed a skin assessment was not completed until 7/15/20 at 9:48 AM, and the resident's guardian had not been notified of the yellowish discoloration on left arm until 7/15/20 at 10:40 AM. The facility had not provided any further documentation into R#807's injury of unknown origin by the end of the survey. A review of the facility's Abuse Prevention Program policy dated 2/22/18 documented, in part: .All personnel .must immediately report any suspected abuse or incidents of abuse to the Administrator .When an alleged or suspected case of mistreatment, neglect, injuries of unknown source, or abuse is reported, the facility Administrator, DON .will immediately .NO LATER THAN 2 HOURS IF THE EVENT IS AN ALLEGATION OF ABUSE .notify the following persons or agencies of such incident .The State licensing/certification agency responsible for surveying/licensing the facility .The Resident's Representative (Sponsor) or Record .Injury of unknown source is defined as an injury that .The injury is suspicious because of .the location of the injury .or the number of injuries observed at one particular point in time .A completed copy of the incident Report and written statements from witness, if any, must be provided to the Administrator .the incident must be immediately reported to facility management regardless of time lapse since the incident occurred .
F 0610 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Respond appropriately to all alleged violations.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to Intake #(s): MI 265, MI 432, and MI 580. Based on observation, interview, and record review, the facility failed to thoroughly investigate resident to resident physical, verbal, and sexual abuse, and an injury of unknown origin for five (R#s 801, 812, 813, 814, and 815) of 18 residents reviewed for abuse, resulting in the potential for unidentified and continued abuse. Findings include: R813 and R814 A Facility Reported Incident (FRI) was reported to the State Agency that alleged the following: .resident walked up to female resident (R814), opened his fly and withdrew his penis. He asked her for some vagina. He was immediately redirected. (R814) was surprised but not upset. (R813) had no such behavior in the past. He was sent to the ER (emergency room) where he had no behaviors and did not remember the event. He was returned to the facility and placed om <sic> 1:1 supervision until Psych could evaluate him. (R814) feels safe in the facility. The physician was called with no new orders . On 7/13/20, an investigation conducted by the facility regarding the above allegation was reviewed and revealed the following: A 5 Day Investigation dated 2/19/20 documented, Allegation: Exposing himself to a female resident. On 2/15/2020 at 11:00 AM, a nurse named (name redacted) called the Administrator (name redacted), asking for assistance. She stated the facility had discharged resident (R813) to the ER earlier that morning for exposing his penis to a female resident. A summary of R813's history did not address any sexual behaviors. The Event section of the investigation documented, On 2/15/2020, at 5:00 AM, the CENA (Certified Nursing Assistant) caring for (R813) states he became sexually promiscuous and began grabbing her. She left the room to get assistance and he followed her out into the hall and stated he needed some (explicit term for female genitalia redacted). She received assistance from a fell ow CENA and redirected him. At 5:00 AM, there were few residents up, but other residents were returned to their room and room doors were shut. He was not interested in the residents, but liked the young CENA's. He did not contact nor have any interaction with any residents .Resident to Resident event: Unsubstantiated. After the initial notification of (R813's) behavior by staff to the Administrator on 2/15/2020, the DON called the Administrator later that morning. The 24 hour report had been completed by that time. The DON stated that she had talked to the first hand witness, the midnight nurse, and reported that no incident with a resident occurred. The DON interviewed residents on the unit, including the resident identified as involved, and none reported seeing (R813) expose himself or had interaction with him .This concludes the investigation . The investigation was signed by the Administrator. The 5 Day Investigation did not include any names of witnesses, staff members interviewed, or statements given by staff or residents. On 7/14/20 at 11:20 AM, the Administrator (who was identified as the facility's Abuse Coordinator) was interviewed. When queried about how the investigation was conducted into the alleged sexual abuse by R813 toward R814, the Administrator reported they just started and they did not remember and stated, Whatever is written in the investigation. When queried about whether or not R813 had sexual behaviors in the past, the Administrator reported they did not remember. When queried about who was interviewed as part of the investigation, the Administrator reported they did not remember. When queried about how the conclusion was made that R814 was not sexually abused by R813, the Administrator reported they did not remember. On 7/14/20 at 11:25 AM, the DON was interviewed. The DON reported they were involved in the investigation into the sexual abuse. When queried about who was interviewed as part of the investigation, the DON stated, I talked to staff. The DON reported they did not remember who they talked to because it was a long time ago. The DON reported they had written witness statements. The witness statements were requested at that time. On 7/14/20 at approximately 12:00 PM, the DON reported they could not find the written statements, but when they talked to the midnight staff, they said R813 never entered R814's room. The DON was unable to say why the allegation of R813 exposing themselves to R814 was made or who it was made by and did not interview that person as part of the investigation. The DON reported that R813 was on 1:1 supervision for a very long time. At that time, it was requested when R813 was first placed on 1:1 supervision. That information was not received prior to the end of the survey. R813's clinical record was reviewed and revealed R813 was admitted into the facility on [DATE] and readmitted on [DATE] with [DIAGNOSES REDACTED]. Minimum Data Set (MDS) assessments dated 1/27/20 and 5/26/20 documented R813 had severely impaired cognition. The MDS dated [DATE] documented R813 had physical, verbal, and other behaviors. Progress notes between 12/1/2019 and 7/14/20 for R813 were reviewed and revealed the following: A Nurses' Note dated 12/4/19 documented, .resident was observed grabbing the breast of a female resident . A Nurses' Note dated 12/16/19 documented, .resident ambulating in hallway, and passed the housekeeper and grabbed her buttock . A Social Services Progress Note dated 12/16/19 documented, .verbalized that he will attempt to rape female staff members . A Nurses' Note dated 2/15/20 at 7:44 AM, written by Nurse I documented, At around 6:15 am resident came out from his room observed to be agitated and combative and sexually aggressive he tried to hit another resident both separated from each other then he was chasing the CNAs and showing his private and verbalized 'I want some (explicit word for female genitalia redacted) .' he tried to touch CNAs breast went inside other resident's room and continue to chase everybody and exposing his private . Nurse I was not interviewed as part of the facility's investigation. On 7/14/20 at 11:53 AM, a telephone interview was attempted with Nurse I. A message was left. Nurse I was unable to be interviewed prior to the end of the survey. The above review of R813's clinical record indicated R813 had previous sexual behaviors which was contradicted in the facility's 5 Day investigation. On 7/15/20, R813 was observed ambulating independently up and down the hallway on the unit. A staff member was observed walking with the resident. R813 was not easily redirected and was difficult to understand when they spoke. R814's clinical record was reviewed and revealed R814 was admitted into the facility on [DATE] and readmitted on [DATE] with [DIAGNOSES REDACTED]. A MDS assessment dated [DATE] documented R814 had severely impaired cognition. There were no nursing or social services notes that addressed the alleged sexual abuse by R813 on 2/15/20. On 7/13/20 at 12:20 PM, R814 was observed seated in a wheelchair outside of their room. When spoken to R814 engaged, but did not make sense. When asked questions, answers did not pertain to the question asked. R814 appeared very confused. R812 A FRI submitted to the State Agency reported R812 had a swollen arm and possible fracture of unknown origin. On 7/14/20, an investigation conducted by the facility into R812's injury of unknown origin was reviewed and revealed the following: A 5 Day Investigation Report dated 2/12/20 documented, .(R812) was readmitted to the facility on [DATE] from the hospital after a

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F 0610 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 2) prolonged hospital stay due to an infected [MEDICAL TREATMENT] permacath in her R (right) neck area .It was noted by facility staff in addition to [MEDICAL TREATMENT] staff that her R arm was swollen with 4+ [MEDICAL CONDITION] from her fingers to her shoulder. On 2/7/2020, (R812) was visited by the PA (Physician Assistant). The PA ordered an X-Ray of her R-arm due to her swelling. The X-Ray suggested a fracture of (R812's) R-Humerus (long bone in the arm that runs from the elbow to the shoulder). She was discharged to the hospital for further evaluation. Multiple X-Rays were taken at the hospital of (R812's) R-Humerus and bilateral femurs. X-Ray results showed severe diffuse osteopenia, Fracture of her Humerus with minimal displacement, likely pathological with diffuse [MEDICAL CONDITION] joint disease .Conclusion: (R812), as evidenced by her multiple hospitalization s, [MEDICAL TREATMENT] complications and poor physical condition, has a very low rehab potential. Her obesity makes it difficult to manage her mobility. X-Ray results are conclusive of severe osteopenia, [MEDICAL CONDITION] joint disease and hip necrosis. While the R-Humerus fracture is validated, her transfers between hospitalization s, [MEDICAL TREATMENT] and Skilled Care can all be potential factors in this pathologic fracture. No one entity can be held responsible. There were no reported incidents or accidents that may have attributed to a direct cause. This concludes the investigation. Facility fault not substantiated. The investigation was signed by the facility's Administrator. There was no documentation in the above summary or in the investigation file of any interviews completed with staff between R812's day of admission on 2/4/20 and the documentation of their swollen arm by the PA on 2/7/20. On 7/15/20 at 11:00 AM, the Administrator was interviewed. When queried about how R812's injury of unknown origin was investigated, the Administrator stated, (R812) was in and out of the facility at the hospital and [MEDICAL TREATMENT] (according to the facility's clinical records, R812 received [MEDICAL TREATMENT] within the facility and was not transferred outside of the facility). I looked at hospital notes and spoke with the physician. (R812) wasn't even in the facility long enough to receive any care. When queried about how R812 would not have received any care between their re-admitted on 2/4/20 and the X-ray on 2/7/20, the Administrator did not offer a response. When queried about how the conclusion was made that an incident did not occur in the facility, the Administrator reported they went based on hospital records and the resident's medical history. When queried about who was interviewed as part of the investigation to rule out any abuse or neglect, the Administrator reported they talked to management and they didn't report anything. When asked if any direct care staff were interviewed as part of the investigation, the Administrator reported they were not. When queried about how it could be determined that nothing occurred in the facility that could have caused the fracture to R812's arm, the Administrator stated, I can't answer that. R812's clinical record was reviewed and revealed the following: R812 was admitted into the facility on [DATE] and readmitted on [DATE] and 2/13/20 with [DIAGNOSES REDACTED]. A MDS assessment dated [DATE] documented R812 had no speech and had moderately impaired cognition. The MDS assessment documented R812 was totally dependent on staff assistance for bed mobility, transfers, and all activities of daily living. Progress notes were reviewed since 2/4/20 and documented R812 was readmitted into the facility on [DATE] on intravenous antibiotics. There were no progress notes that documented any pain or swelling to R812's right shoulder/arm until 2/7/20 when Nurse Practitioner (NP) FF documented, .complains of right shoulder pain, unable to recall when pain started, endorses pain during range of motion 10 out of 10 aggravated by movement .noted with swelling . A progress note dated 2/7/20 at 12:24 PM documented R812 was transferred to the hospital due to a fracture to the right shoulder. A note dated 2/9/20 documented R812 was readmitted into the facility with pain and [MEDICAL CONDITION] to the right upper extremity, face, and eyes. R801 and R815 A FRI was reported to the State Agency that alleged the following: .Both residents are on the dementia unit and severely confused. (R815) is in a private room and keeps her door shut. This AM, her door was open and (R801) unintentionally rolled into her room in his wheelchair. (R815) reached out and superficially scratched his cheek. (R801) rolled out of her room and she closed her door . A 5 Day Investigation Report dated 2/25/20 read in part, Event: On 2/20/20 around midnight, the CENA noticed (R801) exiting (R815's) room with minor fresh scratches on the right side of his face. The nurse responded and redirected (R801) to his room. (R815) had her door open and was still awake and up in her room. While neither resident could state what happened, the nurse assessed the situation. It was apparent that (R801) entered (R815's) room as the door was left open. (R815) had apparently scratched (R801's) face in an effort to redirect him out of her room. Neither resident appeared upset and could not verbalize what happened. (R801's) scratches were superficial and cleaned and required no treatment . Conclusion: The facility does not substantiate abuse as there was no intent by either party to harm the other due to their cognition. Accidental scratches were obtained when (R801) was redirected by (R815) . This concludes the report . The report was signed by the the Administrator. The 5 Day Investigation did not include any names of witnesses, staff members interviewed, or statements given by staff or residents. On 7/14/20 at 11:56 AM, an interview was conducted and the Administrator was queried about the investigation of the FRI involving R801 and R815. The Administrator explained she had a limited memory of her first month at the facility, as she was in orientation. When queried about witness statements, the Administrator explained she never included witness statements as those were obtained by the Nursing Department. The Administrator stated, The DON said she always included them, but I don't. When queried about who was interviewed as part of the investigation, the Administrator reiterated the interviews were obtained by the Nursing Department. On 7/14/20 at 12:05 PM, an interview was conducted and the DON was queried about witness statements. The DON explained the interviews were given to the Administrator. The witness statements were requested. The DON explained the statements had been given to the Administrator and she did not remember who she had interviewed as it was a long time ago. Review of the clinical record revealed R801 was admitted into the facility on [DATE] with [DIAGNOSES REDACTED]. The MDS assessment dated [DATE] documented R801 had moderately impaired cognition. Review of R801's progress notes revealed a Pertinent Charting-Behavior note written by Licensed Practical Nurse (LPN) 'Y' dated 2/20/20 that read in part, Resident was observed trying to enter another resident's room, when the other resident became agitated and grabbed the resident by the face. Resolving in scratches to the sides of his face . On 7/14/20 at 1:18 PM, a phone interview was conducted and LPN 'Y' was asked if she witnessed the incident between R801 and R815 on 2/20/20. LPN 'Y' explained she did not see R801 enter R815's room, but was standing near R815's room when she heard something and turned around to see R801 and R815 in the doorway to R815's room. LPN 'Y' went on to explain R801 had minor scratches to his face. LPN 'Y's witness statement was not part of the facility's investigation. Review of the clinical record revealed R815 was admitted into the facility on [DATE] and readmitted [DATE] with [DIAGNOSES REDACTED]. The MDS assessment dated [DATE] documented R815 had severely impaired cognition. There were no progress notes that addressed the incident with R801 on 2/20/20. A facility policy titled, Abuse Prevention Program with a revision date of 2/22/18 was reviewed and documented the following: .A completed copy of the Incident Report and written statements from witnesses, if any, must be provided to the Administrator .Should an incident or suspected incident of resident abuse, mistreatment, neglect or injury of unknown source be reported, the Administrator, or his/her designee, will appoint a member of management to investigate the alleged incident .The individual conducting the investigation will, at a minimum: Review the resident's medical record to determine events leading up to the incident; Interview the person(s) reporting the incident; Interview any witnesses to the incident; Interview the resident (as medically appropriate); .Interview staff members (on all shifts) who have had contact with the resident during the period of the alleged incident; Interview the resident's roommate, family members, and visitors; .Review all events leading up to the alleged incident .Employee witnesses will be required to sign and date any witness report they make .
F 0689 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to Intake Number: MI 085. Based on interview and record review, the facility failed to ensure bed mobility and care was provided according to the residents' plan of care and a resident was transferred with a mechanical lift in a safe manner affecting two (R#s 810 and 812) of five residents reviewed for accidents, resulting in R810 falling from the mechanical lift and R812 rolling out of bed with the potential for injury. Findings include: R810 R810's clinical record was reviewed and revealed the following: R810 was admitted into the facility on [DATE] with [DIAGNOSES REDACTED]. A Minimum Data Set (MDS) assessment dated [DATE] documented R810 had severely impaired cognition, no behaviors, and required extensive two person assistance for bed mobility, transfers, and hygiene. A Nurses' Note dated 1/28/20 at 7:46 AM documented, .Upon beginning of shift, Midnight cna (Certified Nursing Assistant) come <sic> and reported resident was being

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F 0689 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 3) combative while cna was attempting to change resident brief. As a result according to the CNA the resident slipped out of the bed hitting the floor on the left side .resident reported pain score 9/10 on left knee .Unit manger <sic>, DON (Director of Nursing) .notified of fall . A care plan for R810 initiated on 4/19/18 documented, The resident needs activities of daily living assistance related to: immobility, impaired cognition . An intervention initiated on 1/19/20 documented, BED MOBILITY: The resident requires total assistance with the following number of staff to turn and position in bed (2) .TOILET USE: The resident requires (Total assistance) by (2) staff for toileting .TRANSFER: The resident requires Mechanical Lift with 2 staff assist for transfers (date initiated 1/19/18) . On 7/15/20 at 11:00 AM, an investigation conducted by the facility was reviewed and revealed the following: A 5 Day Investigation dated 2/3/20 documented, .(R810) is described as confused .verbally abusive to staff and will strike out at staff during care. She is totally dependent on staff for all of her care and is transferred to a wheelchair during the day using a (brand name redacted) (mechanical) lift .At 6:00 AM in the morning of 1/28/2020, CENA H was (providing AM care to (R810) in her bed. In the process of changing her brief, (R810) became combative, starting calling the CENA's abusive names and swinging her arms. (CNA H) states (R810) was on her side, when she reached behind her to get the brief, (R810) started cursing and rolled off the bed .(R810's) care plan was updated and reflects she is a two person assist for care. Facility CENA's received education on reviewing the care plan when giving care .received education on caring for combative residents, and CENA care plans . On 7/15/20 and 12:48 PM, CNA H was interviewed via the telephone. When queried about what occurred with R810 on 1/28/20, CNA H reported R810 was cussing and fussing and having a fit. CNA H reported they lifted up the bed, set the supplies up at the resident's bedside and got ready to provide incontinence care. CNA H reported they took R810's brief off and R810 was moving all around and swinging. CNA H further reported that when they reached back to grab a clean brief, R810 rolled out of the bed onto the floor. When queried about how many staff members were present at the time, CNA H stated, At the time there was just me. Everyone always did her care with one so I did not get assistance. When queried about what should be done if a resident was combative or resisting care, CNA H reported they should have asked someone to help. On 7/15/20 at 1:25 PM, the Director of Nursing (DON) was interviewed. When queried about how CNAs knew the level of assistance a resident required for care, the DON reported it would be in the care plan and the kardex. When queried about whether or not the care plan and kardex was followed for R810 on 1/28/20, the DON reported CNA H did not follow the resident's plan of care. R812 R812's clinical record was reviewed and revealed the following: R812 was admitted into the facility on [DATE] and readmitted on [DATE] with [DIAGNOSES REDACTED]. A MDS assessment dated [DATE] documented R812 had moderately impaired cognition, no speech, and was totally dependent on at least two staff members for bed mobility and transfers. R812 received [MEDICAL TREATMENT] within the facility. A Pertinent Charting - Falls progress note dated 2/14/20 documented, CNA stated, resident slide out of (brand name of mechanical lift) sling while been <sic> transfer into [MEDICAL TREATMENT] chair .Interventions: use appropriate sling size, and good working devises <sic> . An Incident and Accident (I&A) report for R812 dated 2/14/20 at 9:00 AM, completed by Nurse A, was reviewed. The I&A documented, Writer was notified by CNA that one of the mechanical strap came off. But the resident was lower to the floor. They were 2 people doing the transfer. CNA B was listed as a witness to the incident. The I&A was signed by Nurse A and in the section for the DON's signature, ADON (Assistant Director of Nursing) (no name) was documented and dated 2/14/20. The I&A indicated the incident occurred in the [MEDICAL TREATMENT] room (within the facility). A Fall Investigation Report signed by Nurse A on 2/14/20 documented R812 was lowered to the floor on 2/14/20 at 9:00 AM in the [MEDICAL TREATMENT] room. In the space provided to document staff or witnesses present at the time of or after the fall, it was left blank. The report documented R812 was being assisted by staff according to the plan of care at the time of the fall and required a mechanical lift with assistance from two staff members. In the section labeled Re-creation of Last 3 Hours Before Fall, CNA B wrote a statement that documented, CNA was transferring resident to the [MEDICAL TREATMENT] chair when one of the straps came off so I grab her and lower her to the floor we where <sic> two person transferring the resident. No other staff members names or statements were included in the investigation. The root cause of the fall was documented as, Resident was lower to the floor. The Initial Interventions to prevent future falls documented, Staff re-education. The Falls Team Meeting Notes were left blank. The Quality Assessment & Assurance Investigation Report provided by the facility was incomplete and unsigned and documented R812 had a fall in the [MEDICAL TREATMENT] room and R812 was a two person assist with transfer which was in place at the time of the fall. The staff listed as being present at the time of the incident was CNA B. No other staff members were included in the investigation. On 7/15/20 at 10:11 AM, CNA B was interviewed via the telephone. CNA B reported on 2/14/20, R812 was lowered to the floor by themselves and the [MEDICAL TREATMENT] lady. CNA B reported R812 required the use of a mechanical lift to get from the wheelchair to the [MEDICAL TREATMENT] chair. CNA B explained the [MEDICAL TREATMENT] staff person was holding the lift and R812 started to lean through the side of the sling and started falling through. CNA B reported they were able to lower R812 to the floor. When queried about the slings that were used with the mechanical lift and if there were different sizes or different slings for different lifts, CNA B stated, I use whatever is available. I can't remember what one I used. On 7/15/20 at 11:12 AM, the ADON was interviewed. The ADON reported they did not do the investigation and that it would have been done by the nurse on the unit. When queried about the signature ADON on the I&A, the ADON did not offer an explanation. On 7/15/20 at 11:23 AM, Nurse A (the nurse who completed the I&A and part of the fall investigation report) was interviewed. When queried about what occurred with R812 on 2/14/20, Nurse A reported they completed an I&A because R812 was lowered to the floor when being transferred to the [MEDICAL TREATMENT] chair. When queried about why R812 was lowered to the floor, Nurse A stated, Because the strap came off. Nurse A reported R812 required a two person assist for transfer with the mechanical lift. Nurse A reported the incident was reported to the unit manager, DON, physician, and family. Nurse A reported they looked into the incident and did not remember what sling was used and could not remember if the mechanical lift was evaluated for proper working condition. On 7/15/20 at 12:37 PM, the DON was interviewed. When queried about the I&A process after a fall, the DON reported the nurse would complete the I&A report which would then go to the unit manager. The DON explained all incidents would be discussed with the interdisciplinary team and all parties would sign off on the I&A. The I&A for R812 was reviewed with the DON at that time. The DON reported the I&A was not completed correctly. When queried about how R812 was able to start slipping through the mechanical lift sling or the discrepancy between the report documenting the strap came off, the DON did not offer a response. The DON reported they did not remember who else was present during the fall besides CNA B. The DON reported a verbal education was given to the CNA, but did not have any record of it or what the education pertained to. When queried about how a resident would slide through the sling on a mechanical lift if it was the correct size and connected appropriately, the DON reported from what they remembered, the straps were not crossed properly between the resident's legs. Further review of R812's clinical record revealed a care plan for activities of daily living that included an intervention dated 2/13/20 that indicated R812 required a mechanical lift and two person assistance for transfers. A facility polity titled, Repositioning (revised 3/24/17) was reviewed and documented, .Check the care plan, assignment sheet or the communication system to determine resident's specific positioning needs including special equipment, resident level of participation and the number of staff required to complete the procedure . A facility policy titled, Safe Transfers and Movement of Residents (revised 1/24/11) was reviewed and documented, .Two staff shall be present to assist during all patient lifts utilizing a mechanical lift .A sufficient number of slings, in the sizes required by residents in need, will be available at all time .The transferring needs of residents shall be assessed on an ongoing basis . A facility policy titled, Accidents and Incidents - Investigation and Reporting (revised 12/1/17) was reviewed and documented, .All accident or incidents involving residents .occurring on our premises must be investigated .The Nurse Supervisor/Charge Nurse and/or the department director or supervisor must conduct an immediate investigation of the accident or incident .The following date .must be included .The name(s) of witnesses and their accounts of the accident or incident .completed accident/incident report must be submitted to the Director of Nursing Services . A facility policy titled, Falls - Clinical Protocol (reviewed 1/2020) was reviewed and documented, .Interventions should be developed and implemented per the assessed needs .
F 0690 **Level of harm -** 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** This citation has two deficient practice statements. Deficient Practice #1: This citation pertains to intake #s: MI 766, MI 994, and MI 246. Based on observation, interview and record review, the facility failed to provide timely incontinence care to one (R#802) of four residents reviewed for incontinence care, resulting in the resident sobbing and expressing feelings

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	235296	A. BUILDING _____ B. WING _____	07/15/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MEDILODGE OF SOUTHFIELD	26715 GREENFIELD RD SOUTHFIELD, MI 48076

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 0690 **Level of harm** - Actual harm **Residents Affected** - Few	(continued... from page 4) of degradation and embarrassment, strong, stale urine odors observed on the resident, and the increased potential for infection and skin breakdown. Findings include: A review of multiple complaints reported to the State Agency included allegations that staff were not providing timely incontinence care and residents were subjected to waiting prolonged periods of time while in wet/soiled briefs. On 7/13/20 - 7/15/20, an unannounced, onsite investigation was conducted. On 7/13/20 at 12:02 PM, and 1:20 PM, R#802 was observed seated upright in bed. There was a strong, stale urine odor present at each of these observations. At that time, R#802 agreed to participate in an interview and when asked about the provision of care, specifically incontinence care, R#802 began to cry. R#802 continued to sob uncontrollably, and reported, .Last week I had to wait 13 hours to get changed. 13 hours. Not enough staff to help .Last week it was only one aide on midnights .I care about my personal hygiene but cause I'm paralyzed from the waist down it falls through the cracks .I sit in wet, dirty briefs most of the time .no one is considering the toll it's taking or what I'm going through. I'm only (resident's age redacted) years old . The resident reported this had been discussed with Administration, as well as reported to (name of State Agency and local nursing home advocacy company). On 7/15/20 at 10:45 AM, during an second interview with R#802, there was no urine odor noted. At that time, when asked about the lack of urine odor, R#802 reported It'll be good for a few days since (State Agency name) is here, but then will go back. A review of the clinical record revealed R#802 was admitted into the facility on [DATE] and readmitted on [DATE] with [DIAGNOSES REDACTED]. A review of the Minimum Data Set (MDS) assessment dated [DATE] documented R#802 was cognitively intact (scored 15/15 on Brief Interview for Mental Status Exam/BIMS), exhibited no behavior concerns, required extensive assistance of one person for toilet use, was always incontinent of bowel and bladder and not on a toileting program. A review of R#802's toileting documentation (which included bowel and bladder elimination details) from 6/16/20 to 7/14/20 revealed multiple dates when there was only one entry documented (7/3/20, 7/5/20, 7/10/20, 7/12/20, 7/13/20). On 7/12/20, the only documented entry was at 12:40 AM. The next documented entry was on 7/13/20 at 8:04 pm. A review of R#802's behavior documentation from 6/16/20 to 7/14/20 revealed there was no documentation of any rejection of care. A review of R#802's ADL care plan included interventions which read, TOILET USE: The resident requires assistance by 1 staff for toileting : bedpan. Checked Q2H (every two hours), changed as needed. This intervention had been initiated 1/7/19 and revised on 3/12/19. A review of R#802's OBRA (Omnibus Budget Reconciliation Act) Level II evaluation (an evaluation to determine mental health needs) dated 3/6/20 indicated R#802 had [MEDICAL CONDITION] disorder, currently in remission and met criteria to remain in the nursing home setting. Further review of this extensive evaluation documented, in part, .(name of R#802) is a good historian, cognition intact, with frustration at certain things pertaining to the nursing home, expressed appropriately. There was no evidence of thought pathology or memory deficits. She states .trying to get a staff member here is like trying to flag down a taxi. You'll wait. I sit in my own waste .They don't answer the call light .Per (R#802's guardian) .could do better giving showers and changing her brief more frequently, which he states has mentioned to staff . On 7/14/20 at 12:57 PM, an interview was conducted with the Administrator, Corporate Consultant and Assistant Administrator. When asked about administration being notified of any concerns regarding care issues for R#802, the Administrator reported R#802 had sent an email to (name of local nursing home advocacy agency) and that concern had been forwarded through (name of Corporate Consultant). At that time, the Corporate Consultant acknowledged receipt of the resident's concerns and reported she was unable to provide any specific documentation. The Administrator, Corporate Consultant and Assistant Administrator were informed of the observations of the strong, stale urine odor and concern regarding the lack of incontinence care for R#802. On 7/15/20 at 1:15 PM, during an interview with the Director of Nursing (DON), when asked about the facility's process to ensure resident's were not left in soiled/wet briefs, the DON reported the residents should be checked and changed routinely. On 7/15/20 at 2:30 PM, a review of the documentation provided by the facility regarding urinary incontinence did not address routine care needs to prevent residents being left in wet/soiled briefs. A policy for Activities of Daily Living was requested, and per Administrator, there was no policy. Deficient Practice #2 Based on observation, interview, and record review, the facility failed to ensure urinary catheter care was performed for two residents (R#'s 816 and 825) of three residents reviewed for urinary catheters, resulting in a formal complaint to the State Agency, the potential for poor personal hygiene and the development of infections. Findings include: R#825 On 7/15/20 at 2:10 PM, R825 was observed in bed, asleep. A urinary catheter drainage bag was observed to be hanging on the side of the bed. A review of R825's clinical record revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. R825's most recent Minimum Data Set assessment dated [DATE] indicated R825 had moderately impaired cognition, required extensive assistance for activities of daily living, and had a suprapubic catheter (a device inserted directly into the bladder to drain urine). A review of R825's Certified Nursing Aide (CNA) Tasks in the electronic medical record was conducted and revealed a CNA task for catheter care. A review of a 30-day look-back of the task revealed the following: 6/16/20 Catheter care performed twice 6/17/20 and 6/19/20 Catheter care performed once 6/20/20 Catheter care performed twice 6/28/20 Catheter care performed once 6/29/20 and 7/2/20 Catheter care performed twice 7/3/20 Catheter care performed once 7/4/20, 7/5/20, 7/9/20, 7/11/20, and 7/13/20 Catheter care performed twice. On 7/14/20 at 12:00 PM, an interview with the facility's Director of Nursing (DON) was conducted regarding catheter care. The DON indicated that CNA's were responsible for performing catheter care, the care should be provided at least every shift (three shifts per day), and completion of the task should be documented into their (Name of electronic medical record program). R#816 On 7/14/20 a review of R816's closed clinical record was conducted and revealed an admitted [DATE] and discharge date of [DATE]. R825's [DIAGNOSES REDACTED]. R825's Minimum Data Set assessment dated [DATE] was reviewed and indicated R825 had intact cognition, required extensive assistance for activities of daily living, had bilateral upper and lower extremity range of motion deficits and presence of an indwelling urinary catheter. Continued review of R816's clinical record revealed physician's orders [REDACTED]. A review of R816's CNA tasks that were active during their admission was conducted and did not reveal any tasks for catheter care. A review of the treatment administration records was conducted and did not indicate R816 had any type of catheter care performed. On 7/14/20 at 2:25 PM, a request for documented catheter care for R816 was made to the facility's Administrator. Evidence of catheter care being performed for R816 was not provided by the end of the survey. A review of a facility provided policy titled, Catheter Care, Urinary with a review/revision date of 3/23/2011 was conducted, however; the policy described the process of how to perform catheter care, and did not address how often it was to be performed. The facility was asked if they had any additional information to provide regarding the concern; none was provided by the end of the survey.
F 0691 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate colostomy, urostomy, or ileostomy care/services for a resident who requires such services.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to Intake Numbers MI 069 and MI 378 Based in interview and record review, the facility failed to ensure [MEDICAL CONDITION] (surgical procedure that brings one end of the large intestine out through the abdominal wall) care was consistently provided per physician orders [REDACTED]. Findings include: A complaint was submitted to the State Agency that alleged, .The staff at the facility is not changing (R805's) [MEDICAL CONDITION] bag and (R805) sits in her own feces. Some of the staff are not trained and do not know how to change the [MEDICAL CONDITION] bag . Review of the closed record revealed R805 was admitted into the facility on [DATE] and readmitted on [DATE] with [DIAGNOSES REDACTED]. According to the most recent Minimum Data Set (MDS) assessment dated [DATE], R805 had severely impaired cognition and required the extensive assistance of staff for all Activities of Daily Living (ADL's). Review of R805's Treatment Administration Records (TAR) revealed an order with a start date of 8/14/19 that read, Ostomy -for 2 pc (piece) change pouch/wafer every three days and as needed for ostomy care every 72 hours. The TAR's were left blank, indicating it was not done, on: 8/20/19, 9/1/19, 9/4/19 and 9/13/19. On 7/15/20 at 8:25 AM, an interview was conducted and Certified Nursing Assistant (CNA) 'T' was asked who provided [MEDICAL CONDITION] care at the facility. CNA 'T' explained the CNA's emptied the bag as needed and the nurses changed the bags and wafers. On 7/15/20 at 8:27 AM, an interview was conducted and Licensed Practical Nurse (LPN) 'U' was asked if there had been training on [MEDICAL CONDITION] care at the facility. LPN 'U' explained she couldn't remember if there had been training at the facility, she knew how to change the bag and wafer from being a nurse for a long time. On 7/15/20 at 8:53 AM, inservice training records on [MEDICAL CONDITION] care were requested from Registered Nurse (RN) 'EE', who served as the Staff Development Nurse and Unit Manager. On 7/15/20 at 9:00 AM, an interview was conducted and the Director of Nursing (DON) was asked who at the facility provided [MEDICAL CONDITION]

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F 0691 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 5) care. The DON explained the CNAs emptied the bags and the nurses changed the bags and wafers. On 7/15/20 at approximately 11:00 AM, RN 'EE' provided records of an employee inservice for [MEDICAL CONDITION] Care dated 11/20/19 provided to CNAs and LPNs and read, [MEDICAL CONDITION] care should be rendered to appropriate residents every shift! This include (sic), for nurses to evaluate presence of stoma wafer and bag, and changing as needed. CENA (CNA) staff should only change bag as needed with oversee by charge nurse. Also provided was inservce sign in sheets from February 2020 for [MEDICAL CONDITION]/[MEDICAL CONDITION] Care procedure update provided to all staff. On 7/15/20 at 11:12 AM, an interview was conducted and the Assistant Director of Nursing (ADON) was queried about the inservice on [MEDICAL CONDITION] care provided on 11/20/19. The ADON explained the family for R805 had complained about staff not knowing how to change R805's [MEDICAL CONDITION] bag, so she gave the inservice that day as she was serving as the Staff Development Nurse at that time. Review of a facility policy titled, [MEDICAL CONDITION]/[MEDICAL CONDITION] Care revised 2/17/11 read in part, The purpose of this procedure is to provide guidelines that will aid in preventing exposure of the resident's skin to fecal matter . The following information should be recorded in the resident's medical record: 1. The date and time the [MEDICAL CONDITION]/[MEDICAL CONDITION] care was provided .
F 0725 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**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 intake #s: MI 246. Based on observation, interview and record review, the facility failed to provide adequate staffing to meet resident needs, resulting in complaints of short staffing, staff not being able to provide all aspects of care, prolonged response to call lights and untimely incontinence care. This has the potential to affect all 36 residents that reside within the facility's one north unit. Findings include: A review of multiple complaints reported to the State Agency included allegations that staff were not providing timely incontinence care and resident were subjected to waiting prolonged periods of time while in wet/soiled briefs. On 7/13/20 - 7/15/20, an unannounced, onsite investigation was conducted. On 7/13/20 at 12:02 PM, and 1:20 PM, R#802 was observed seated upright in bed. There was a strong, stale urine odor present at each of these observations. At that time, R#802 agreed to participate in an interview and when asked about the provision of care, specifically incontinence care, R#802 began to cry. R#802 continued to sob uncontrollably, and reported, .Last week I had to wait 13 hours to get changed. 13 hours. Not enough staff to help .Last week it was only one aide on midnights .I care about my personal hygiene but cause I'm paralyzed from the waist down it falls through the cracks .I sit in wet, dirty briefs most of the time .no one is considering the toll it's taking or what I'm going through. I'm only (age redacted) years old . A review of the clinical record revealed R#802 was admitted into the facility on [DATE] and readmitted on [DATE] with [DIAGNOSES REDACTED]. A review of the Minimum Data Set (MDS) assessment dated [DATE] documented R#802 was cognitively intact (scored 15/15 on Brief Interview for Mental Status Exam/BIMS), exhibited no behavior concerns, required extensive assistance of one person for toilet use, was always incontinent of bowel and bladder and not on a toileting program. A review of R#802's behavior documentation from 6/16/20 to 7/14/20 revealed there was no documentation of any rejection of care. A review of R#802's ADL care plan included interventions which read, TOILET USE: The resident requires assistance by 1 staff for toileting : bedpan. Checked Q2H (every two hours), changed as needed. This intervention had been initiated 1/7/19 and revised on 3/12/19. A review of R#802's OBRA (Omnibus Budget Reconciliation Act) Level II evaluation (an evaluation to determine mental health needs) dated 3/6/20 indicated R#802 had [MEDICAL CONDITION] disorder, currently in remission and met criteria to remain in the nursing home setting. Further review of this extensive evaluation documented, in part, .(name of R#802) is a good historian, cognition intact, with frustration at certain things pertaining to the nursing home, expressed appropriately. There was no evidence of thought pathology or memory deficits. She states .trying to get a staff member here is like trying to flag down a taxi. You'll wait. I sit in my own waste .They don't answer the call light .Per (R#802's guardian) .could do better giving showers and changing her brief more frequently, which he states has mentioned to staff . On 7/15/20 at 9:40 AM, review of the facility's staffing assignments by unit revealed the following staff were assigned to the one north unit on the 11:00 PM to 7:30 AM shift: On 7/4/20, census was 37. There was one Nurse and one Certified Nursing Assistant (CNA) assigned. On 7/11/20, census was 36. There was one Nurse and one CNA assigned. On 7/12/20, census was 36. There was one Nurse and one CNA assigned. On 7/15/20 at 9:45 AM, the Administrator was asked about staffing and deferred to speak with the staffing scheduler (Staff P). On 7/15/20 at 9:55 AM, an interview was conducted with Staff P. When asked to verify the staff that worked on the one north unit for 7/4/20, 7/11/20 and 7/12/20, Staff P confirmed there was one Nurse and one CNA. Staff P reported she was on vacation from 7/1/20 to 7/14/20 and in her absence, nursing management was responsible to manage the staff scheduling. On 7/15/20 at 10:15 AM, an interview was conducted with the Administrator. When asked about the facility's staffing, high number of call-ins and what was being done to address this, the Administrator reported, We mandate staff .Staff pick up shifts and work doubles. The Administrator reported working on 7/4/20 and 7/5/20 and when asked what shift, reported Day. When asked whether there was any nursing management that covered shifts other than the day, the Administrator reported, (Nurse GG) works as our midnight supervisor. At that time, when asked for a facility policy for staffing, the Administrator reported there was no such policy. On 7/15/20 at 10:25 AM, an interview was conducted with Nurse Manager EE who reported, The average census for (one north) unit is 36. All residents on that unit are two person assist. When asked if there was a midnight supervisor, Nurse Manager EE reported, We have (Nurse GG) who handles issues at night. On 7/15/20 at 11:50 AM, Nurse GG was attempted to be interviewed by phone. There was no return call by the end of the survey. On 7/15/20 at 11:54 AM, a phone interview was conducted with Staff M who confirmed there was only one CNA assigned to work on the one north unit on 7/11. Staff M further reported that on 7/12, there was only one CNA assigned until 3:00 AM. When asked what the usual staffing assignment was for the unit, Staff M reported there were usually at least two CNAs. On 7/15/20 at 11:58 AM, a phone interview was conducted with Staff N who confirmed there was only one CNA that worked on the one north unit on 7/4/20. Staff N was asked about whether there were any other nursing management staff that were available to assist with resident needs, such as Nurse Manager GG and reported Nurse Manager GG did not work on 7/4/20. Staff N further reported that due to low staffing, residents remained in bed and not gotten up for the day on 7/4/20, 7/5/20 and 7/6/20. A facility policy regarding staffing was requested from the Administrator. The Administrator reported they did not have a policy.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake #'s MI 6 and MI 6 This citation has two deficient practices. Deficient Practice #1 Based on observation, interview, and record review, the facility failed to engage in appropriate infection prevention and control procedures related to use of personal protective equipment (PPE) and hand hygiene, resulting in the potential for spread of infection. This has the potential to affect all 122 residents who resided in the facility, including R813. Findings include: On 7/13/20, 7/14/20, and 7/15/20 at multiple times, the Director of Nursing (DON) was observed with a surgical mask that did not cover their nose. On 7/14/20 at approximately 8:00 AM, Activities Aide K was observed to enter the facility and proceed toward the 1 North Unit without wearing a face mask. Activities Aide K then proceeded to go back to the front desk where they received a health screening for COVID-19 (Coronavirus Disease 2019 - a highly contagious virus) prior to entering and obtained a mask. On 7/14/20 at 2:00 PM, an observation of the 2 South Hallway was conducted. During the observation, CNA (Certified Nusing Assistant) 'AA' was observed in the hallway to have their surgical mask looped around their ears, however the mask was pulled down under their chin and did not cover either their mouth or nose. CNA 'AA' was then observed to pull their mask up over their mouth, but not over their nose. After touching their mask and placing it on their face, CNA 'AA' was not observed to perform hand hygiene and entered a room on the hallway. CNA 'AA' exited the room with a finished lunch tray and placed it in the meal cart. On 7/15/20 at 10:54 AM, Floor Technician (Tech) HH was observed in a resident's room on the 2nd floor unit. Floor Tech HH was observed to exit the resident's room and was carrying a ladder. A surgical mask was observed on Floor Tech' HH's face positioned over the mouth, but not covering the nose. When queried, Floor Tech HH reported the mask should cover both the mouth and the nose. On 7/15/20 at 10:57 AM, CNA II was observed walking with R813 on the 2nd floor unit. R813 was observed with a surgical mask that was covering their mouth and not their nose. CNA II was observed wearing a surgical mask that was covering part of their mouth and not covering their nose. CNA II was observed talking with R813 within inches of their face. CNA II stated, Put your mask on to R813 repeatedly. CNA II proceeded to pull R813's mask over their nose without performing hand hygiene before or after

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	235296	A. BUILDING _____ B. WING _____	07/15/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MEDILODGE OF SOUTHFIELD	26715 GREENFIELD RD SOUTHFIELD, MI 48076

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 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 6) touching R813's mask. CNA II then pulled their own mask over their nose without performing hand hygiene before or after contact with the mask. R813 repeatedly pulled their mask down past their nose and CNA II repeatedly pulled R813's mask up but did not reposition their own mask. No hand hygiene was performed. On 7/15/20 at 1:30 PM, the facility's Infection Control Preventionist (ICP) was interviewed. When queried about the facility's protocol for mask use, the ICP reported surgical masks were required for all staff at all times while in the building. The ICP reported that the mask must be worn covering the nose and mouth completely. When queried about what staff should do if they were assisting a resident with positioning the mask or if they had to adjust or remove or apply their own mask, the ICP did not offer a response. The ICP reported they did rounds on the units to ensure staff were properly utilizing PPE but had not had any concerns. On 7/15/20 at 2:03 PM, CNA II was observed on the 1 North unit assisting a resident with brushing their hair in the common area. CNA II was within close contact of the resident and was observed with a surgical mask pulled underneath their chin, not covering the mouth or nose. A facility policy titled, Personal Protective Equipment (Reviewed/Revised 7/12/20) was reviewed but did not address how to properly wear surgical masks. A facility policy titled, Handwashing/Hand Hygiene (Reviewed/Revised 3/2020) was reviewed and documented, This facility considers hand hygiene the primary means to prevent the spread of infections .Employees must wash their hands for twenty (20) seconds using antimicrobial or non-antimicrobial soap and water under the following conditions: .Before and after direct contact with residents .After contact with blood, body fluids, secretions, mucous membranes .If hands are not visibly soiled, use of an alcohol-based hand rub containing 60-95% [MEDICATION NAME] or [MEDICATION NAME] for all the following situations: Before and after direct contact with residents .After contact with a resident's intact skin .After handling used dressings, contaminated equipment .Hand hygiene is always the final step after removing and disposing of personal protective equipment . Deficient Practice #2 Based on observation, interview, and record review, the facility failed to ensure accurate isolation precaution orders and updated care plans for isolation for two residents, (R#'s 824 and 825) of four residents reviewed for isolation precautions, resulting in the potential for miscommunication and confusion regarding whether residents should be on isolation precautions, and the potential for the spread of infections. Findings include: On 7/14/20 at 9:10 AM, R824 was observed from the hallway in their room in bed. A sign on R824's door indicated they were in isolation precautions and anyone entering the room must don gloves, an isolation gown, and a face shield or goggles. A caddy was observed hanging on the door that contained the personal protective equipment. A review of R824's clinical record was conducted and reviewed an admission date of [DATE] and a re-admission date of [DATE]. R824's [DIAGNOSES REDACTED]. A review of R824's physician's orders [REDACTED]. On 7/14/20 at 2:10 PM, R825 was observed in their bed asleep. It was noted R825 shared a room with two other residents. There was no signage on the room door or any other indication the room was on any type of isolation precautions. A review of R825's clinical record was conducted and revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. A review of R825's active physician's orders [REDACTED]. R825's care plans were reviewed and read, .Focus: Resident is at risk for contracting [MEDICAL CONDITION] related to pandemic events (COVID-19) .Interventions: .Isolation (DROPLET) GOWN, GLOVES MASK) .Dated Initiated: 3/24/20 . On 7/14/20 at 2:30 PM, an interview with the facility's Assistant Director of Nursing/Infection Control Preventionist was conducted regarding the process for implementing isolation precautions. It was explained that if a resident was placed on any type of isolation there should be signage on the room door, a caddy of personal protective equipment supplies, a physician's orders [REDACTED]. On 7/14/20 at 2:50 PM, an interview with the facility's Director of Nursing (DON) was conducted regarding isolation precautions. The DON was asked if there should be a physician's orders [REDACTED]. At that time the DON was made aware that R824 did not have a physician's orders [REDACTED]. The DON indicated that this could be very confusing for staff, especially given the current situation with COVID-19. A review of a facility provided policy titled, Isolation-Categories of Transmission-Based Precautions with a review/revised date of 2/22/2011 was conducted and read, Appropriate precautions shall be used either at all times (Standard Precautions) or for individuals who are documented or suspected to have infections or communicable diseased that can be transmitted to others (Transmission Based Precautions) . The policy did not address the requirement for a physician's orders [REDACTED].
F 0919 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Make sure that a working call system is available in each resident's bathroom and bathing area.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to Intake #(s): MI 246 Based on observation, interview, and record review, the facility failed to utilize a fully functioning resident call system that ensured residents had direct communication to staff members when assistance was needed, failed to ensure staff were equipped with pagers which were the component of the call system that provided direct communication between resident and staff, failed to ensure there was a functional, centralized area to monitor resident call requests for assistance in the absence of pagers or an audible or visual alert, and failed to address resident call lights that were not functioning in resident rooms and bathrooms occupied by (R830, R831, R832, and R833), resulting in complaints regarding toileting needs not being met timely when call lights were activated, and the increased likelihood of unmet care needs, neglect, and unidentified and unaddressed emergency situations. This deficient practice affects all residents in the facility, including R802 who was observed sobbing uncontrollably due to the lack of call light response and who was observed to have a stale, strong urine odor present on the resident, and R811's call light being activated while on the toilet but not responded to for over 25 minutes. Findings include: Resident #802 On 7/13/20 at 12:02 PM, and 1:20 PM, R#802 was observed seated upright in bed. There was a strong, stale urine odor present at each of these observations. At that time, R#802 agreed to participate in an interview and when asked about the provision of care, specifically incontinence care, R#802 began to cry. R#802 continued to sob uncontrollably, and reported, .Last week I had to wait 13 hours to get changed. 13 hours. Not enough staff to help .Last week it was only one aide on midnights .I care about my personal hygiene but cause I'm paralyzed from the waist down it falls through the cracks .I sit in wet, dirty briefs most of the time .no one is considering the toll it's taking or what I'm going through. I'm only (age redacted) years old . R811 On 7/13/20 at 12:43 PM, R811 was observed seated in a wheelchair next to the bed in their room. During a conversation, R811 moved their wheelchair to the door of the bathroom, stood, and walked into the bathroom, and sat on the toilet. On 7/13/20 at 12:50 PM, R811 was observed to pull the cord for the call light that was located in the bathroom next to the toilet. On 7/13/20 at 1:17 PM, R811 remained seated on the toilet in the bathroom. R811 was noted to be restless and asked for help. An observation of the hallway was made and Licensed Practical Nurse (LPN) 'L' was visible at the other end of the hallway, by the nurse's station. No other staff were visible in the hallway. LPN 'L' was informed R811 had pulled the call light 25 minutes previously. LPN 'L' stated, And no one came? I'll go right now. Review of the clinical record revealed R811 was admitted into the facility on [DATE] and readmitted on [DATE] with [DIAGNOSES REDACTED]. According to the most recent Minimum Data Set (MDS) assessment dated [DATE], R811 had severely impaired cognition, and required the assistance of staff for all Activities of Daily Living (ADL's). On 7/13/20 at 2:20 PM, an interview was conducted and Certified Nursing Assistant (CNA) 'W' was asked how staff knew when a call light was activated. CNA 'W' explained when a call light was pushed, it would show up on a monitor located in the hallway. CNA 'W' stated, We used to have pagers. We need them again. CNA 'W' was asked if there was an audible alarm. CNA 'W' explained there was no audible alarm, only the monitor in the hallway. Usually someone would walk by and look at the monitor, or when passing the room that was occupied by a resident look in to see if they needed anything. On 7/13/20 at 2:23 PM, an interview was conducted and LPN 'L' was asked about the call light system. LPN 'L' explained the only notification was on the monitor in the hallway, so staff do hourly rounds, and that was why she was always walking around to check to see if any resident needed assistance. On 7/13/20 at 2:43 PM, an interview was conducted with the Administrator and Assistant Administrator to discuss the facility's call light system. The Administrator reported they did not have a Maintenance Director for the building at that time and that the Regional Director of Maintenance (RDM) came to the building two to three times per week. When asked if there was a way to provide call light audits to verify the facility had monitored their system and if any concerns had been identified, the Administrator reported Yes. The Administrator was requested to provide documentation of call light audits, however, there was no such documentation provided by the end of the survey. When asked if the facility had been aware of any concerns regarding the facility's call light system, the Administrator confirmed and reported maintenance had come to check about a month ago. The Administrator reported they were unaware of any current issues with the resident call system. Any documentation of concerns regarding call lights reported to maintenance through the facility's electronic reporting system

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F 0919 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	(continued... from page 7) was requested from the Administrator at that time, however there was no such documentation provided by the end of the survey. When asked if there was a back-up system in place for residents to call for help, such as a bell, the Administrator reported, We haven't passed out hand bells because no one reported a concern currently. At that time, the current call light monitor on the one north unit was observed with the Administrator. On 7/13/20 at approximately 2:45 PM, an observation of the call system monitor located on the one North unit was conducted. There were no staff members observed at the monitor. Upon review of the monitor housed in an alcove on the one north unit with the Assistant Administrator, there were seven call light alerts noted in blue highlight that indicated low battery (5/8/20 at 6:20 AM; 5/28/20 at 5:29 PM; 6/18/20 at 7:55 PM; 6/22/20 at 6:34 AM; 6/27/20 at 7:14 PM, 7/8/20 at 5:18 PM, and 7/12/20 at 9:57 PM) for resident rooms and a shower room throughout the facility. When asked about the blue highlighted area on the screen, a nursing staff member reported, If it's still in blue, that means it's not been addressed. When asked how it could not have been addressed from over two months ago, staff were unable to offer any explanation. On 7/13/20 at approximately 2:50 PM, in the room occupied by R#630 and R#631 which was identified on the monitor to have a had a low battery since 5/28/20 at 5:29 PM, Nurse C attempted to activate the call lights for both residents, but the call light did not activate on the monitor (which was verified by the Assistant Administrator at that time). When asked about the facility's call light system and how it normally functioned (such as an audible alert in room, at monitor, or by pager), Nurse C indicated there used to be pagers but they could not locate most of them and that it had been that way for a few weeks now. When queried about how the resident call system worked, Nurse C stated, When it was working, the room number would show up on our pagers and we would answer the call light. Nurse C further stated, We make rounds and look into the room to see if the red light is on. When queried about what light staff were looking at inside of the room, Nurse C explained it was the small red light that lit up on the box by the residents' beds where the call light plugged into. The light would not be visible if the residents' privacy curtains were pulled or if the call light was activated from the bathroom. When queried about how staff would know if a resident needed assistance while in the bathroom, Nurse C stated, We don't leave the residents in the bathrooms now because that is unsafe. When queried about what would happen if a resident took themself to the bathroom without staff knowledge or if there was an emergency, Nurse C reported that would be difficult to know. On 7/13/20 at approximately 2:54 PM, in the room occupied by R#632 and R#633, Nurse C attempted to activate the call lights for both residents, but the call light did not activate on the monitor. On 7/13/20 at approximately 2:56 PM, the Assistant Administrator was asked about the lack of a functional call light system and who was responsible to oversee and/or monitor and reported, Generally if it's not working, they (staff) will tell us. No one mentioned to me today. On 7/13/20 at approximately 3:00 PM, the Administrator brought Central Supply Staff E to speak about the call light system. Central Supply Staff E stated, We have bells. When queried about the bells and who was currently utilizing them and why, Central Supply Staff E reported they were in storage and they could pass them out to residents who wanted them. Central Supply Staff E further stated, There is a monitor at the front desk so when a resident puts their call light on, the receptionist will see and notify the unit. On 7/13/20 at 3:05 PM, upon review of the receptionist desk, a monitor was observed with the same alerts as identified on the one north unit monitor. At that time, Staff D was asked about the monitor with call light alerts and reported, They didn't tell me what this was. I've been here maybe a week, week and a half. On 7/13/20 at 3:10 PM, an observation of the 2nd floor unit was made. Nurse L was interviewed at that time about the resident call system. Nurse L acknowledged staff did not have pagers and when queried about how staff knew when residents activated their call lights for assistance, Nurse L reported the nurses did hourly rounds and check the residents, walk by their rooms and look to see if the light is on. When queried about the light, Nurse L reported it was a small red light located on the box the call light was plugged into, which was only visible if the privacy curtain was not blocking it and was not visible for the bathroom. When queried about how staff would know if a resident required assistance in the bathroom, Nurse L stated, Nobody would be in the bathroom without us knowing. I don't have falls. We don't leave people in the bathroom. When queried about the earlier observation of R811's call light not being answered, Nurse L reported the resident took themself to the bathroom and therefore staff did not know they were on the toilet. When asked how staff would have known if the resident needed assistance, Nurse L did not offer a response. On 7/13/20 at 3:35 PM, the Administrator and Director of Nursing (DON) were asked how long staff had been without pagers (as this was a component of the facility's call light system) and did not offer any further explanation. The Administrator reported that there were some pagers available now and nursing did a sweep and found them in drawers. When asked about whether the Administrator or DON had been notified or made aware of any concerns regarding the facility's call light system, the Administrator reported, System was functioning last week. Maintenance got it (previous work order), so we cancelled work order at that time. (Which conflicted from earlier interview statements). The Administrator was asked to provide any documentation of work orders that had been placed, cleared, or currently in progress in regards to the facility's call light system and reported, I don't have access to (name of facility's electronic work order system). So (name of RDM) will be in first thing tomorrow. When queried about how the facility monitored the resident call light system, the DON reported they did an audit last week. The DON reported they were unaware there was a problem with the call light system currently. When queried about whether or not staff not having pagers was identified during the audit, the DON did not offer a response. The Administrator further reported that some of the pagers were being replaced and that right now, residents who asked, were provided with bells. When asked why all residents were not included in the provision of an alternate means to summons help if needed, the Administrator offered no further response. On 7/14/20 at 9:50 AM, the RDM was interviewed. The RDM reported they were assigned to multiple buildings in the region and came to the facility on ce or twice a month. The RDM reported there was currently no Maintenance Director but thought there was a Maintenance Assistant who worked in the facility. The RDM reported they were not made aware of any concerns with the resident call system. The RDM reported any work orders entered in the electronic maintenance work order system would come to them if they were labeled as critical. The RDM reported all concerns related to call lights should be classified as critical. When queried about how the facility's resident call system worked, the RDM reported it was a wireless system that utilized pagers that all direct care staff should wear. The RDM further reported that the pagers would alert the CNA on the floor and if not answered would alert the charge nurse and would go up the chain of command if not answered. The RDM reported there were monitors on each unit that would show the room number of the activated call light, the time it was activated and the time it was answered. It would be deleted from the monitor when the monitor was reset. When queried about why the facility staff did not have pagers, the RDM reported there were not enough pagers and some did not have working batteries which was not acceptable. At that time, the electronic work order system for the maintenance department was reviewed with the RDM from 6/1/20 through 7/14/20. There were no open or closed out work orders related to call lights besides one on 7/13/20 for the room and bathroom occupied by R811 that was generated after the observations above. The work order on 7/13/20 documented, Call light not working in room or bathroom. The work order was classified as medium. On 7/14/20 at 10:15 AM, the Assistant Administrator was further interviewed. The Assistant Administrator was asked who the Maintenance Assistant was. The Assistant Administrator reported it was Staff J and they resigned from working at the facility the day prior on 7/13/20. The Assistant Administrator reported the last day the facility had a Maintenance Director was 6/5/20. On 7/14/20 at 12:15 PM, an attempt was made to interview Staff J via the telephone. Staff J was unavailable for an interview prior to the end of the survey. A facility policy titled, Answering the Call Light (Reviewed 1/2020) was reviewed and documented, .Report all defective call lights to the Nurse Supervisor promptly .Answer the resident's call as soon as possible .If assistance is needed when you enter the room, summon help by using the call signal .