STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235541	A. BUILDING _____ B. WING _____	08/26/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
THE LODGE AT TAYLOR	22950 NORTHLINE RD TAYLOR, MI 48180

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 0558 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Reasonably accommodate the needs and preferences of each resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citations pertains to intakes: MI 972,MI 256,MI 012, MI 5 and MI 874 Based on observation, interview and record review the facility failed to answer call lights in a timely manner, Affecting eight residents (R#2, R#3, R#4, R#5, R#6, R#8, R#10, R#13) out of thirteen residents reviewed for call lights, resulting in the potential of unmet needs. Findings include: R#10 On 8/26/20 at 10:15 a.m., during interview with R#10 , when asked how he/she was doing , R#10 said, I am terrible, I had a bowl movement last night and have been asking for someone to change me since 8 pm, it has been more than 12 hours. R#10 was asked if call light was used, R#10 stated, Yes. On 8/26/20, record review revealed R#10 was admitted into the facility on [DATE] with [DIAGNOSES REDACTED]. According to Minimum Data Set ((MDS) dated [DATE], R#10 had intact cognition and was extensive assist with Activities of Daily Living. R#3 On 8/25/20, record review of allegation from complainant revealed that call lights were not answered in a timely manner. On 8/26/20, record review revealed resident was admitted into facility on 2/29/20 with [DIAGNOSES REDACTED]. According to the MDS, R#3 had intact cognition and was extensive assist with ADLs. R#4 On 8/26/20 at 8:30 a.m., during interview with R#4, when asked if ever left wet and soiled for a long periods of time, R#4 typed, I have been wet and put my call light on during the midnight shift and waited until day shift got here to change me. On 8/26/20, record review revealed R#4 was admitted into the facility on [DATE] with [DIAGNOSES REDACTED]. According to MDS dated [DATE], R#4 had intact cognition and was extensive assist with most ADLs. R#6 On 8/26/20 at 8:45 a.m., during interview with R#6, when asked if help with ADLs from staff happen in a timely manner, R#6 said, No, you can put on your call light when you need help and it can take hours for anyone to answer, it is really bad on the midnight shift. On 8/26/20, record review revealed R#6 was admitted into facility on 9/27/19 with [DIAGNOSES REDACTED]. According to MDS dated [DATE], R#6 had intact cognition and was supervised with most ADLs. R#8 On 8/26/20 at 11:15 a.m., during interview with R#8, when asked if staff assist in a timely manner when incontinent, R#8 stated, No, you can wait for hours once you put on your call light. On 8/26/20, record review revealed resident was admitted into facility on 8/3/20 with [DIAGNOSES REDACTED]. According to the MDS dated [DATE], R#8 had intact cognition and was extensive assist with ADLs. Resident #2: During an interview with R#2 at 8/25/20 at 11:00 AM she said that she has to wait almost a hour to get her call light answered, and on the afternoon shift, it's 90 minutes. A medical record review revealed that R#2 has resided in the facility since January of 2019, and has no cognition deficits. Resident #13: During an interview with the complainant and R#13 on 8/26/20 at 1:30 PM, it was reported that the resident had to wait over a hour to have his call light answered and receive incontinence care. A medical record review indicated that R#13 admitted to the facility on [DATE], and had a BIMS (brief interview for mental status) score of 14/15. 8/26/20, review of policy Answering Call lights- The purpose of this procedure is to respond to the resident's requests and needs.
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 051. Based on interviews and record reviews the facility failed to prevent abuse for one of five residents reviewed for abuse (#5) when two staff members forced R#5 to receive incontinence care after the resident had refused care by that staff member several times. This deficient practice resulted in R#5 being physically restrained during incontinence care and experiencing mental anguish. Findings include: According to the facility's reported incident (FRI) dated 6/11/20, R#5 reported to Nurse Manager H that on 6/9/20 at approximately 11:00 PM, CeNA N and CeNA O came into her room to change her brief. R#5 said she refused due to personal issues with CeNA N. CeNA O said she had to get changed by CeNA N and proceeded to hold her down while CeNA N changed her brief. R#5 said she was crying and yelling no and stop. A review of the facility's investigation report dated 6/11/20 revealed the facility substantiated that R#5 's brief was changed after she had refused care. The facility had interviewed R#5, and her roommate (R#2) regarding the incident and both resident's reports were consistent. Both resident had no cognition deficits. At the conclusion of the facility's investigation, both CeNA N and CeNA O were terminated from employment at the facility. R#5 was followed by nursing and social work and no adverse effects were noted. The State Agency and Police were notified of the incident. According to the medical record, R#5 has resided at the facility since 2017 with multiple [DIAGNOSES REDACTED]. The Minimum Data Set ((MDS) dated [DATE] indicated that R#5 had a BIMS (brief interview for mental status) score of 14/15, and only required one person for personal hygiene needs. The resident's care plan for incontinence care/Activities of Daily Living also indicated the resident needed one staff person for incontinence care. During an interview on 8/25/20 at 11:00 AM R#5 said that in June (could not recall the exact date) CeNAs O and N came into her room and said she needed a brief change. R#5 said she told them No, I don't want CeNA N to change my brief because of personal reasons. R#5 said that CeNA O said, It's his job to change your brief and he is going to do it. CeNA N, grabbed her arm, turned her to the side and laid across her body to hold her over and down while CeNA O changed her brief. R#5 said she was crying and yelling No, Stop throughout the brief change. The resident said she cried that night, and felt very violated and traumatized. She said she had something happen to her in the past, and this brought things back that were very upsetting to her. R#5 said that she knew the two CeNAs had been terminated and she felt safe in the facility at this time. During an interview on 8/25/10 at approximately 11:05 AM, R#2 said that she was in the room when CeNA N and CeNA O changed R#5's brief. R#2 said that R#5 told the CeNAs No right off when they said they were going to change her, and she kept telling them Noand Stop it several times and just kept on doing it anyway. She (R#5) was crying loudly throughout the whole thing (brief change). A medical record review for R#2 revealed that she has resided at the facility since January of 2019. The MDS dated [DATE] indicated that R#2 had a BIMS score of 15/15 and no cognition deficits. During an interview on 8/26/10 at approximately 9:30 AM, nurse manager H confirmed R#5's statement regarding the incident on 6/9/20. Nurse H said that CeNA N never even returned the Administrator's call to be interviewed regarding the incident with R#5, and he was terminated immediately. CeNA O was interviewed during the investigation and confirmed that the resident started crying when CeNA N was changing her brief. CeNA N said that it wasn't until after the brief change was completed that the resident said she did not want CeNA N to change her. CeNA O was also terminated for not following the facility's 'abuse' and 'resident rights' policies.
F 0658 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure services provided by the nursing facility meet professional standards of quality.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake MI 680. Based on interviews and record reviews, the facility failed to follow the physician's orders for one of three residents (R#7) reviewed for [MEDICAL TREATMENT] processes, resulting in R#7 not receiving her [MEDICAL CONDITION] infusion as ordered, when a nurse canceled her [MEDICAL CONDITION] appointment without

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 0658 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) consulting with the physician. Findings include: According to the complaint intake R#7 arrived at [MEDICAL TREATMENT] on 7/29/20, but did not get transported to her [MEDICAL CONDITION] appointment. The resident was waiting in the [MEDICAL TREATMENT] lobby for over two hours and transport did not arrive to take her to the [MEDICAL CONDITION] appointment scheduled at 9:30 AM. The complainant called the facility and the nurse thought she had went to the [MEDICAL CONDITION] appointment. The resident ended up being transported back to the facility and never received the [MEDICAL CONDITION] on 7/29/20. During an interview with the complainant on 8/25/20 at 12:35 PM she said the resident never made it to her [MEDICAL CONDITION] appointment because a nurse at the facility had canceled it without reason. The complainant reported that the resident was very upset on 7/29/20 because she had missed her [MEDICAL CONDITION] infusion appointment and the doctor had told it was very important for her to have it. The resident ended up expiring on 7/30/20. A closed medical record review revealed that R#7 admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The hospital admission notes indicated that the resident was to continue [MEDICAL TREATMENT] and receive intravenous Cytotoxin (a [MEDICAL CONDITION]). According to a progress note dated 7/22/20, the nephrologist ordered R#7 to have the Cytotoxin infusion at a local hospital. The order was received and R#7 was scheduled for her infusion on 7/29/20 at 9:30 AM. There is no documentation on 7/29/20 to indicate why the resident did not go to her [MEDICAL CONDITION] appointment. There is no order to cancel or discontinue the [MEDICAL CONDITION] appointment. During an interview with the scheduler on 8/25/20 at 1:15 PM, she could not explain what happened to the resident on 7/29/20. She reviewed her notes and said the resident was scheduled to go to [MEDICAL TREATMENT] on 7/29/20 at 5:30 AM and then the hospital for her 9:30 AM [MEDICAL CONDITION] appointment. She did not know why the resident did not make her [MEDICAL CONDITION] appointment. During an interview with the transportation company manager, staff P on 8/26/20 at 4:10 PM he said nurse A had called them on 7/29/20 at 1:13 AM to cancel the resident's transportation to the [MEDICAL CONDITION] appointment. He said nurse A said the resident's [MEDICAL TREATMENT] was more important than the [MEDICAL CONDITION]. The manager said the resident was scheduled to be transported to both appointment. The [MEDICAL TREATMENT] appointment at 5:30 AM, and then transported to the hospital for her [MEDICAL CONDITION] appointment at 9:30 AM. During a phone interview with nurse A on 8/26/20 at 3:10 PM he said he did not recall what occurred on 7/29/20. After reviewing the medical record nurse A said he had only worked at the facility for two months and still wasn't sure what had occurred on 7/29/20. On 8/27/20 at 10:05 AM the Administrator reviewed the medical record and said that she had determined that Nurse A had not followed 'standards of practice' when he canceled R#7's [MEDICAL CONDITION] appointment for no reason and had not consulted with, or received an order from the physician. The Administrator said that education and inservices will be given to nurse A regarding following physician's orders.
F 0677 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Provide care and assistance to perform activities of daily living for any resident who is unable.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citations pertains to intakes: MI 222, MI 962,MI 012, MI 809 and MI 874 Based on observation, interview, and record review the facility failed to provide consistent services of Activities of Daily Living (ADLs) for dependent residents, Affecting seven residents (R#4, R#5, R#6, R#8, R#9, R#10, R#13) out of thirteen residents reviewed for ADL care, resulting in unmet needs. Findings include: On 8/26/20 at 10:15 a.m., during interview with R#10 , when asked how he/she was doing , R#10 said, I am terrible, I had a bowl movement last night and have been asking for someone to change me since 8 pm, it has been more than 12 hours. I told the Social Worker about it and she said she would get someone. An observation was made, and it was found the resident brief had large amount of feces that had dried and had harden on edges in front and back of brief. Nurse J was asked during observation if residents should be left soiled, Nurse J stated, No. On 8/26/20 at 10:20 a.m., during interview with Social Worker (SW) L, when asked if she had spoken with nursing about R#10 needing to be changed, SW L replied, Yes, I wrote it down. At 8:50 am I told the CNA (Certified Nursing Assistant) I that the resident needed to be changed. On 8/26/20 at 10:40 a.m., During interview with CNA I, when asked if resident had been checked on at the beginning of shift, CNA I stated, I don't know, I wasn't assigned over here until after breakfast. On 8/26/20 at 11:00 a.m., during interview with Director of Nursing (DON) When asked if residents should be left wet and soiled for over 12 hours, DON stated, No. When asked how long should a resident wait to be changed when incontinent, DON stated, They should be taken care of immediately. When asked who was taking care of the residents until CNA I was assigned to that hall, DON said The nurse and another person was over there until the CNA got there. When asked if residents should be checked on every shift, DON stated, Yes. On 8/26/20, record review revealed R#10 was admitted into the facility on [DATE] with [DIAGNOSES REDACTED]. According to Minimum Data Set ((MDS) dated [DATE], R#10 had intact cognition and was extensive assist with Activities of Daily Living. R#4 On 8/26/20 at 8:30 a.m., during interview with R#4, when asked if ever left wet and soiled for a long periods of time, R#4 typed, I have been wet and put my call light on during the midnight shift and waited until day shift got here to change me. On 8/26/20, record review revealed R#4 was admitted into the facility on [DATE] with [DIAGNOSES REDACTED]. According to MDS dated [DATE], R#4 had intact cognition and was extensive assist with most ADLs. R#6 On 8/26/20 at 8:45 a.m., during interview with R#6, when asked if help with ADLs from staff happen in a timely manner, R#6 said, No, you can put on your call light when you need help and it can take hours for anyone to answer, it is really bad on the midnight shift. On 8/26/20, record review revealed R#6 was admitted into facility on 9/27/19 with [DIAGNOSES REDACTED]. According to MDS dated [DATE], R#6 had intact cognition and was supervised with most ADLs. R#8 On 8/26/20 at 11:15 a.m., during interview with R#8, when asked if staff assist in a timely manner when incontinent, R#8 stated, No, you can wait for hours once you put on your call light. On 8/26/20, record review revealed resident was admitted into facility on 8/3/20 with [DIAGNOSES REDACTED]. According to the MDS dated [DATE], R#8 had intact cognition and was extensive assist with ADLs. Resident #9: According to the complaint intake, and the resident did not receive any ADL (activities of daily living) care, including a shower or a bath while she was at the facility. The resident was no longer residing at the facility and therefore a closed medical record review was conducted. According to the closed medical record, R#9 resided at the facility from 7/16/20 through 8/7/20, during this time there is no documentation to support the resident had received any showers or baths while she was at the facility. Resident #13: During an interview with the complainant and R#13 on 8/26/20 at 1:30 PM, it was reported that the resident had to wait over a hour to receive care for incontinence A medical record review indicated that R#13 admitted to the facility on [DATE], and had a BIMS (brief interview for mental status) score of 14/15. On 8/26/20, record review of policy Routine Resident Checks provided from facility documented the following: Routine resident checks shall be made to assure that the resident's safety and well- being are maintained Policy Interpretation and Implementation 1. To ensure the safety and well-being of our residents, a resident check will be made at least every two (2) hours throughout each 24-hour shift by nursing service personnel. 2. Routine resident checks involve entering the resident's room to determine if the resident's needs are being met, if there has been a change in the resident's condition, if the resident has any complaints, if the resident is sleeping, needs toileting assistance, etc. 3. Changes in the resident's condition and medical needs that cannot be performed by the person conducting the routine check must be reported to the Nurse Supervisor/Charge Nurse at once.