STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235284	A. BUILDING _____ B. WING _____	03/12/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MEDILODGE OF MIDLAND	4900 HEDGEWOOD DR MIDLAND, MI 48640

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0550 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to treat 2 Residents (R 29 and R 45) and 8 of 8 Residents in the confidential group with dignity and respect, resulting in feeling loss of self-worth and frustration. Findings include: During the confidential group meeting on 3/10/20 at 10:30 AM, Residents were asked if they were treated with dignity and 8 of 8 Residents responded, no. They reported staff frequently refuse to provide care or assistance. They make comments like do it yourself. They expressed fear of retaliation and when they report things the care gets worse. When asked what care had been refused, they said using a bed pan, getting towels so they could do their morning care, and getting clean briefs. When asked how it makes them feel one resident said, retarded. Others said upset. They all appeared very frustrated and upset. Resident #45 admitted to the facility 1/1/19, the MDS dated [DATE] reflected Resident #45 was diagnosed with [REDACTED]. The Minimum Data Set (MDS) reflected Resident #45 scored 15 out of 15 on the Brief Interview for Mental Status (BIMS) which indicated the Resident was cognitively intact. The MDS reflected Resident #45 used a walker and a wheelchair for mobility. During an interview conducted [DATE] at 11:08 AM, Family Member (FM) OO, the spouse of Resident #45, reported the facility is short staffed on weekends. FM OO reported two weeks prior Resident #45 had soiled herself in her bed because of an extended call light wait. FM OO reported a CNA responded to the call light but Resident #45 had to wait additional time before she was cleaned. FM OO reported two other occasions when Resident #45 laid in a wet bed awaiting a call light response. Resident #45 was questioned about these incidents and she reported these incidents always occur on weekends and holidays. FO OO reported he complained to the Nursing Home Administrator (NHA) and that the NHA told him that maybe (Resident #45) should go to another nursing home.
F 0553 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Allow resident to participate in the development and implementation of his or her person-centered plan of care.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure regular opportunities for care planning and comprehensive inclusion of disciplines in the care planning process to afford the responsible party for one resident (Resident #10) to be provided pertinent and meaningful information regarding status, care, and goals and to be able to request revisions to a person-centered care plan, of two residents reviewed for Care Plans, resulting in a frustrated, uninformed responsible party and the potential for all facility residents and responsible parties to not participate in establishing care goals and outcomes. Findings include: Resident #10 was admitted to the facility 3/7/18 with [DIAGNOSES REDACTED]. Review of the Minimum Data Set ((MDS) dated [DATE] reflected Resident #10 had a Brief Interview for Mental Status (BIMS) score of 7 out of 15 which reflected the Resident was severely cognitively impaired. In a telephone interview conducted 3/10/20 at 3:12 PM, Responsible Party (RP) KK for Resident #10 reported she has not been informed of any Care Conference meetings in quite some time. RP KK reported for the last Care Conference she had to search all over the facility before finding SW B and when she did RP KK reported SW B told her she forgot about the Care Conference. RP KK reported she does not recall any other discipline being represented at a Care Conference. On 3/11/20 at 10:34 AM, Social Worker (SW) B reported an initial Care Conference is conducted shortly after admission to the facility and then quarterly after that. SW B reported the full Interdisciplinary Team (IDT) is invited to each Care Conference. SW B reported that she documents the Care Conferences and speaks to all disciplines in this documentation. SW B was asked to provide the documentation of the Care Conferences for Resident #10. During an interview conducted 3/12/20 at 8:48 AM, Unit Manager (UM) K reported Nursing, along with Activities and Dietary, is always represented at Care Conferences. UM K reported she usually finds out during the morning meeting that a Care Conference is scheduled for that day. UM K did not report any problems of attending these Care Conferences despite the short notice. On 3/11/20 at 2:40 PM, SW B provided Resident #10 documentation of an initial Care Conference on 3/9/18, 6/28/18. and lastly, 3/28/19. No other documentation was provided of quarterly Care Conferences since 3/28/19. Review of the documentation for the Care Conference conducted 3/28/19 reflected that Social Services was the only disciple represented and no other discipline was present for the conference.
F 0558 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Reasonably accommodate the needs and preferences of each resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to assess for, and provide, proper medical equipment for one facility resident (Resident #59) of 3 residents reviewed for accommodation of needs, resulting in pain, discomfort, and the potential for decreased activity of an elderly and vulnerable Resident and the potential for all facility residents to not have their needs assessed and accommodated. Resident #59 According to Resident #59's face sheet she was a [AGE] year-old female admitted to the facility on [DATE] and had [DIAGNOSES REDACTED]. Resident #59's face sheet also indicated was her own responsible party. On 3/10/20 at 9:49 AM, Resident #59 was in the therapy department. Physical Therapist Assistant (PTA) EE had just finished Resident #59's therapy treatment and assisted Resident #59 back to her room. Resident #59 complained of back pain. Resident #59 had a deformed back. Resident #59's upper back had a large curve (severe kyphosis). This Surveyor asked PTA EE how the facility assessed residents for their wheelchair seating needs. PTA EE said, Occupational Therapy (OT) screens them. The Surveyor asked why Resident #59 had not been provided a special back support as the wheelchair did not appear to fit well and Resident #59 was complaining of back pain. PTA EE said Resident #59 had not been complaining of back pain, but a back support could be added. On 3/12/20 at 12:45 PM, Resident #59 was observed in her wheelchair in the main dining room. Resident #59 said she was done eating and needed to get back to her room as her back hurt. Resident #59's back at the large curved area was in contact with the back of the wheelchair. Resident #59's low back did not have any support. On 3/12/20 at 12:50 PM, this Surveyor was informed by PTA EE that an order for [REDACTED].#59 was admitted to the facility on [DATE] and there was no indication the facility had attempted to adjust Resident #59's wheelchair to accommodate her abnormal posture.
F 0561 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice.** **Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice.**

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235284	A. BUILDING _____ B. WING _____	03/12/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MEDILODGE OF MIDLAND	4900 HEDGEWOOD DR MIDLAND, MI 48640

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 0561 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to support resident choices for 1 of 22 residents (Resident #15) and 8 of 8 residents in the confidential group meeting, resulting in residents being restricted from social interactions and activities with other residents and visitors outside of scheduled facility group activities. Findings include: Resident #15 A review of Resident #15's Admission Record, dated 3/11/20, revealed Resident #15 was a [AGE] year-old resident admitted to the facility on [DATE]. In addition, Resident #15's Admission Record revealed Resident #15 had multiple [DIAGNOSES REDACTED]. A review of Resident #15's Minimum Data Set (MDS) (a tool used for assessing a resident's care needs), dated [DATE], revealed Resident #15 had a Brief Interview for Mental Status (BIMS) (a scale used to determine a resident's cognitive status) score of 13 which revealed Resident #15 was cognitively intact. During an observation on 3/10/20 at 12:15 PM, a sign was observed on the main dining room door that indicated the dining room was closed. During an interview on 03/10/20 at 02:54 PM, Resident # 15 stated the residents wants to use the main dining room to play board games or do puzzles during the day and at night. But they (facility staff) won't let us go in there. They say no one can be in there unsupervised and they don't have people to be in there to watch us. Resident # 15 stated he knew some residents can't be in there unsupervised because of behaviors. Resident # 15 also stated there are residents who are independent and know what they are doing who should be able to use the main dining room to hang out in. In addition, Resident #15 stated they (residents) can ask staff and get drinks whenever and food whenever. But they (residents) just want to use the main dining room as a place to just sit and relax. During the confidential group meeting on 3/10/20 at 10:30 AM, 8 of 8 Residents said they were not able to use the dining room from 9:00 PM to 7:30 AM and said they had informed the DON and NHA and they (facility staff) insist on keeping them out of the dining room. They said they do not have anywhere to go outside their rooms during those hours other than the halls. During an interview with the NHA and DON on 3/10/20 at 12:05 pm at the nurses station, this Surveyor informed them that during the meeting with the confidential group they all reported they were not allowed into the dining room from 9:00 PM to 7:30 AM. They all said they were afraid of retaliation, so they were not wanting to discuss these concerns with the NHA or DON. The DON initially denied the dining room was not available from 9:00 PM to 7:30 AM, as she had been there at 5:30 AM that day and had made sure it was open. When questioned further she did admit she made changes to the use of the dining room due to some resident behaviors. The DON was asked where the residents can get drinks and meet when the dining room was closed. The DON did not have a response. As the Surveyor was discussing the dining room access concern with the DON, the NHA started talking to Resident #15. The NHA interrupted the Surveyor's conversation saying to Resident #15, tell her what you just told me about the dining room. Resident #15 said he was able to get into the dining room at 6:30 AM that morning. When this Surveyor asked if he had any problems normally getting in after 9:00 PM to 7:30 AM, he said staff normally would not let him in. The NHA made several comments to Resident #15 attempting to get him to change his answer to he was able to get into the dining room, but Resident #15 maintained he was not able to access the dining room on several occasions. This conversation was witness by another Surveyor.
F 0565 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Honor the resident's right to organize and participate in resident/family groups in the facility.** Based on interview and record review, the facility failed to resolve grievances in a timely manor resulting in feelings of fear, frustration and social isolation. Findings include: Review of the Resident Council minutes for 6 months (September 2019 to (NAME)2020) revealed there was only one concern that came out of the meetings and one concern form for that concern. During the confidential group meeting on 3/10/20 at 10:30 the residents were asked if the facility resolved their grievances and 8 of 8 residents said, no. Examples given were they were not satisfied with the taste and quality of the food served. They all indicated the facility used to have meetings to discuss the food, but they no longer have the food meetings. They were all very upset about a resident that would wander into their rooms and take their belonging. All 8 residents were afraid of that resident. They were all afraid of one resident that yells and swears at the men. They were all upset that they were not able to use the dining room or have any area to met from 9:00 PM to 7:30 AM. They all said they did not want to discuss these issues with management as when they bring concerns to them, they are retaliated against them. None of the concerns discussed during the confidential group meeting were reflected in the 6 months of Resident Council minutes provide to the Surveyor. On 3/10/20 at approximately 12:30 PM, the Nursing Home Administrator (NHA) was asked why the Resident Council Minutes only reflected one concern in 6 months. The NHA responded that the Activity Director (AD) GG must be doing it wrong. I will educate her.
F 0578 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to determine residents were unable to make medical decisions prior to having resident family members or Durable Power of Attorneys (DPOA's) signing advanced directive/code status paperwork for 7 of 22 residents (Resident #22, Resident #57, Resident #58, Resident #59, Resident #63, Resident #365, and Resident #370) and failed to have the attending physician and another physician, or psychologist, re-evaluate a resident's medical decision-making capability in a timely manner for 1 of 22 residents (Resident #40), resulting in family members or DPOA's signing advanced directive/code status paperwork for residents that had not been deemed unable to make medical decisions, Resident #40's medical decision-making capability not being re-evaluated after a considerable amount of time, the potential for residents with changes in medical decision-making capabilities not being timely screened, the potential for resident wishes/desires related to medical care not being honored, and the potential for residents and/or their responsible parties not being able to make appropriate medical decisions (such as advanced directives) because of any delays in screening. Findings include: Resident #40 A review of Resident #40's Admission Record, dated 3/11/20, revealed Resident #40 was an [AGE] year-old resident admitted to the facility on [DATE]. In addition, Resident #40's Admission Record revealed Resident #40 had multiple [DIAGNOSES REDACTED]. A review of Resident #40's Minimum Data Set (MDS) (a tool used for assessing a resident's care needs), dated 2/3/20, revealed Resident #40 had a Brief Interview for Mental Status (BIMS) (a scale used to determine a resident's cognitive status) score of 0 which revealed Resident #40 was severely cognitively impaired. A review of Resident #40's Durable Power of Attorney (DPOA) paperwork, dated 10/15/12, failed to specifically address specific medical powers (e.g. what to do in the event of respiratory and/or heart failure, make medical treatment decisions), except the DPOA may sign documents related to release of medical records and share those records with whomever they deem appropriate. A review of Resident #40's Determination of Inability to Participate In Medical Treatment Decisions, dated 7/19/16, revealed Resident #40 was deemed unable to make medical decisions on 7/25/16 by a second physician or licensed psychologist (approximately 3 years and 8 months prior to this survey). During an interview on 03/11/20 at 11:46 AM, Social Worker (SW) B stated, It's the responsible party that signs the code status. SW B stated if the resident is their own responsible party, they should sign their code status. In addition, SW B stated Resident #40 was not his own responsible party and the DPOA had been activated. SW B stated, As long as nothing changes, we don't have to do anything with it (re-evaluating medical decision-making ability). SW B was shown Resident #40's DPOA paperwork and verbally agreed medical decision-making abilities (except release of medical records) were not specifically addressed in this paperwork. SW B was requested to provide any documentation specifying Resident #40's DPOA could make medical treatment decisions for Resident #40. As of the time of the completion of the survey and exit from the facility, the facility failed to provide this requested documentation. Resident #57 A review of Resident #57's MDS, dated [DATE], revealed Resident #57 was a [AGE] year-old resident admitted to the facility on [DATE] with multiple [DIAGNOSES REDACTED].g. [MEDICAL CONDITIONS], hardening of the arteries). In addition, Resident #57's MDS revealed Resident #57 had a BIMS score of 15 which indicated Resident #57 was cognitively intact. A review of Resident #57's Advance Directives/ Medical Treatment Decisions form, dated 2/3/20, revealed Resident #57's DPOA had signed Resident #57 as a Do Not Resuscitate (DNR) (in the event

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235284	A. BUILDING _____ B. WING _____	03/12/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MEDILODGE OF MIDLAND	4900 HEDGEWOOD DR MIDLAND, MI 48640

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0578 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 2) Resident #57's heart or lungs stop working). A review of Resident #57's medical records, dated 2/1/20 (admission) to 3/11/20, failed to reveal that Resident #57 had been deemed unable to make medical decisions and Resident #57's DPOA had been activated. During an interview on 03/11/20 at 11:46 AM, SW B stated, It's the responsible party that signs the code status. SW B stated if the resident is their own responsible party, they should sign their code status. In addition, SW B stated, Resident #57 scores well on his BIMS. He's his own responsible party. SW B further stated, When I looked at it (Resident #57's Advance Directives/ Medical Treatment Decisions form), I believe his mother signed his code status paperwork (it was actually Resident #57's sister/DPOA). Resident #58 A review of Resident #58's Admission Record, dated 3/11/20, revealed Resident #58 was a [AGE] year-old resident admitted to the facility on [DATE] with multiple [DIAGNOSES REDACTED]. A review of Resident #58's MDS, dated [DATE], revealed Resident #58 had severely impaired cognitive decision-making skills. A review of Resident #58's medical record, dated 7/22/19 to 3/11/19, failed to reveal if Resident #58 had DPOA documentation or a designated person who could make medical decisions if Resident #58 was deemed unable to make medical decisions. A review of Resident #58's medical record, dated 7/22/19 to 3/11/19, failed to reveal if Resident #58 had been deemed unable to make medical decisions even though Resident #58 had severely impaired cognitive decision-making skills. A review of Resident #58's Advance Directives/ Medical Treatment Decisions form, dated 10/10/19, revealed an illegible signature, without a printed name, authorizing efforts to be made to prolong Resident #58's life and to provide life-sustaining treatment (Full Code). The signature did not appear to be consistent with Resident #58's name. Resident #63 A review of Resident #63's Admission Record, dated 3/11/20, revealed Resident #63 was an [AGE] year-old resident admitted to the facility on [DATE]. In addition, Resident #63's Admission Record revealed Resident #63 had multiple [DIAGNOSES REDACTED]. A review of Resident #63's MDS, dated [DATE], revealed Resident #63 had a BIMS score of 5 which indicated Resident #63 was severely cognitively impaired. A review of Resident #63's Advance Directives/ Medical Treatment Decisions form, dated 2/18/20, revealed Resident #63's daughter had signed Resident #63 as a Do Not Resuscitate (DNR) (in the event Resident #63's heart or lungs stop working). A review of Resident #63's medical record, dated 3/7/19 to 3/11/20, failed to reveal if Resident #63 had designated a medical DPOA (no medical DPOA documentation was located in Resident #63's medical record) in the event Resident #63 was deemed unable to make medical decisions. A review of Resident #63's medical record, dated 3/7/19 to 3/11/20, did revealed Resident #63's daughter was designated as his financial DPOA (able to make financial decisions) in the event Resident #63 was deemed unable to make financial decisions. A review of Resident #63's medical record, dated 3/7/19 to 3/11/20, failed to reveal that Resident #63 had been deemed unable to make medical, or financial, decisions. During an interview on 03/11/20 at 11:46 AM, SW B stated, It's the responsible party that signs the code status. SW B stated if the resident is their own responsible party, they should sign their code status. In addition, SW B stated she believed Resident #63 was his own responsible party. SW B stated she had requested Resident #63's daughter provide a copy of the medical DPOA to the facility. However, SW B stated she did not have any evidence of when, or if, this had actually occurred. A review of the facility's advanced directive policy and procedure, dated 12/7/12, revealed, 4. Should the resident indicate that he or she has issued advance directives about his or her care and treatment, documentation must be recorded in the medical record of such directive and a copy of such directive must be included in the resident's medical record. A review of the facility's Decision Making Determination Form, undated, revealed, Note: Pursuant to MCL, 700.5508, the authority under a patient advocate designation is exercisable by a patient advocate only when the patient is unable to participate in medical treatment or, as applicable, mental health treatment decisions. The patient's attending physician and another physician or licensed psychologist shall determine upon examination of the patient whether the patient is unable to participate in medical treatment decisions, shall put the determination in writing, shall make the determination part of the patient's medical record, and shall review the determination not less than annually. Resident #59 According to Resident #59's face sheet she was a [AGE] year-old female admitted to the facility on [DATE] and had [DIAGNOSES REDACTED]. And disorders of bone density and structure. Resident #59 was her own responsible party. During an interview with facility Social Worker (SW) B on 3/11/20 at 10:39 AM, Resident #59's advanced directive was reviewed. SW B confirmed Resident #59's last Brief Interview of Mental Status (BIMS) score was 12/15 (normal cognition) and Resident #59's face sheet was correct as she was still her own responsible party. The Surveyor asked why Resident #59 did not sign her own advanced directive and SW B said the facility policy is that the next of kin can sign the advanced directive. The Surveyor requested a copy of the facility policy and when SW B returned she said she was not correct and Resident #59 should have signed her own advanced directive. According to Resident #59's Advanced Directive/Medical Treatment Decisions she was made a Do Not Resuscitate on 2/14/20. However, the signature line for resident was blank and there was a signature (not Resident #59) on the line for Legal Representative was signed, but not by Resident #59. Resident #365 According to Resident #365's Minimum Data Set (MDS) (a nursing assessment tool), dated 3/5/19, she was a [AGE] year-old female admitted on [DATE] and her [DIAGNOSES REDACTED]. Her Brief Interview of Mental Status (BIMS) score was 3/15 (severely mentally impaired). During an interview with facility Social Worker (SW) B on 3/11/20 at 10:39 AM, Resident #365's advanced directive was reviewed. SW B confirmed Resident #365 was still listed as her own responsible party. The facility had assessed Resident #365 as being severely mentally impaired, but had not assessed her capacity to understand medical decisions or complex information. During an interview with Resident #365's husband on 03/10/20 at 08:52 AM, her husband said his wife has suffered from a [MEDICAL CONDITION] for the last [AGE] years and he was her medical decision maker (facility records did not have this information). Resident #367 According to Resident #367's MDS, dated [DATE], she was an [AGE] year-old female admitted on [DATE]. She was coded as being severely cognitively impaired and unable to verbally communicate. During an interview with facility Social Worker (SW) B on 3/11/20 at 10:39 AM, SW B said Resident #367 was still her own responsible party. SW B said Resident #367's daughter has applied to be her guardian, but she did not know when she did that and did not have any documentation to confirm the daughter had filed the correct paperwork. Resident #370 According to Resident #370's face sheet, dated 3/10/20, she was a [AGE] year-old female admitted to the facility on [DATE]. She was her own responsible party. During an interview with SW B on 3/11/20 at 12:03 PM, SW B said Resident #370's Brief Interview of Mental Status (BIMS) score was 3/15. SW B said we are working with adult and child protective services for Resident #370. SW B was aware the hospital paperwork indicated Resident #370 had a family member as her guardian, but said that was not confirmed. SW B said the facility is working on guardianship, but did not have any documentation to show that they had petitioned the court for guardianship. The facility did not have any documentation to show they had assessed Resident #370 for her capacity to understand information. Resident #22 Resident #22 was originally admitted to the facility 2/3/11 with a [DIAGNOSES REDACTED]. Review of the Minimum Data Set ((MDS) dated [DATE] (the pertinent MDS for this citation) reflected Resident #22 was severely cognitively impaired. Review of the Advance Directive for Resident #22 reflected it was dated 4/10/2018 and witnessed by an Licensed Practical Nurse (LPN). The Advance Directive reflected the box was checked for I do not choose to formulate or issue any Advanced Directive at this time. On the signature line for the Resident were lines that went above the signature box with most of the writing below the signature line and off the page. These lines were indiscernible as a signature. However, the date of 4/10/2018 written on the Resident signature line was clear and matched the date written on the Facility Representative signature line that was signed by the witness. During an interview conducted 3/11/20 at 11:46 AM, Social Worker (SW) B reported Advance Directives are reviewed quarterly. SW B reported this issue did not need to be revisited for Resident #22. SW B reported the Advance Directive documented in the medical record stands because Resident #22 was not declared incompetent until shortly after 4/10/18. While a default Full Code status is in place, SW B did not indicate that obtaining an illegible signature from a resident documented as severely impaired six days prior on an MDS assessment was of concern.
F 0580 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to notify the responsible party and physician of changes in condition for one Resident (Resident #13), resulting in the responsible party not being informed of a change of the Resident's condition and the physician not informed of a test result outside of a Doctor ordered parameter and the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235284	A. BUILDING _____ B. WING _____	03/12/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MEDILODGE OF MIDLAND	4900 HEDGEWOOD DR MIDLAND, MI 48640

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 0580 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 3) potential for pertinent health information to not be conveyed to responsible parties and health Providers for all facility residents. Resident #13 was initially admitted to the facility 1/11/19 with [DIAGNOSES REDACTED]. Review of the Medication Administration Record [REDACTED]. The MAR indicated [REDACTED]. Review of the Electronic Medical Record (EMR) did not reflect that the physician was notified of the blood sugar test result of 494 mg/dl on 11/30/20. Review of the medical record reflected an SBAR (An acronym to facilitate communication between nurses and physician) Communication Form dated 12/1/19. The form reflected the Situation of a potential infection. The form reflected Resident #13 was started on an oral antibiotic. On 12/5/20 at 6:00 AM the medical record reflected the condition of Resident #13 had not improved and changed from oral antibiotics to intramuscular injections of an antibiotic. The medical record did not reflect the responsible party was informed of this change.
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** Based on observation, interview and record review, the facility failed to prevent abuse for 5 residents (R15, R16, R28, R37, R45) of 22 residents, and 8 of 8 Residents in the confidential group, resulting in feelings of fear and anxiety when abuse was ongoing. Findings include: Resident #15 According to Resident #15's face sheet, dated 3/11/20, he was a [AGE] year-old male admitted to the facility on [DATE] and had [DIAGNOSES REDACTED]. He was his own responsible party. Review of Resident #15's Minimum Data Set (MDS), nursing assessment tool, dated 12/27/19 revealed he had a [MEDICAL CONDITION]. His Brief Interview of Mental Status (BIMS) score was 13/15 (normal cognition) Resident #16 According to Resident #16's face sheet, dated 3/11/20, he was a [AGE] year old male admitted to the facility on [DATE] and had [DIAGNOSES REDACTED]. He was not his own responsible party. Resident #28 According to Resident #28's face sheet, dated 3/12/20, he was a [AGE] year-old male admitted to the facility on [DATE] and had [DIAGNOSES REDACTED]. He was his own responsible party. Resident #37 According to Resident #37's face sheet, dated 3/11/20, he was an [AGE] year-old male admitted to the facility on [DATE] and had [DIAGNOSES REDACTED]. He was not his own responsible party. During the confidential group meeting on 3/10/20 at 10:30 AM, 8 of 8 Residents said they were afraid of Resident #16 and #37. They said Resident #16 did not like men and he would yell and swear at them. They said he was a big man and they were afraid he would hurt them. They said the Nursing Home Administrator (NHA) and the Director of Nursing (DON) and several other staff were aware of the concern, but they were not doing anything. They said when they report things, they were in fear of retaliation. They are told they can find some place else for them to live if they do not like it here when they bring concerns to management's attention. They have also been denied care and yelled at by some of the care staff. When asked for staff names all 8 residents said Certified Nurse Aide (CNA) D has yelled at them and told them things like you can take care of that yourself. They said CNA D was not the only one that has refused to provide care or be rude. They said they had reported CNA D and she still works here, so they did not want to name other staff or report abuse to anyone as their care gets worse when they bring up any concerns. Eight (8) of 8 Residents said they are not able to use the dining room from 9:00 PM to 7:30 AM and said they had informed the DON and NHA and they (facility staff) insist on keeping them out of the dining room. They said they do not have anywhere to go outside their rooms during those hours other than the halls. During an interview with the NHA and DON on 3/10/20 at 12:05 pm at the nurses station, this Surveyor informed them that during the meeting with the confidential group they all reported being afraid of Resident #16 and #37 and were upset that they were not allowed into the dining room from 9:00 PM to 7:30 AM. They all said they were afraid of retaliation, so they were not wanting to discuss these concerns with the NHA or DON. The DON and NHA said they only had one report to the State Survey Agency about abuse related to Resident #37. They denied knowledge of abuse allegations for Resident #16. The DON initially denied the dining room was not available from 9:00 PM to 7:30 AM, as she had been there at 5:30 AM that day and had made sure it was open. When questioned further she did admit she made changes to the use of the dining room due to some resident behaviors. The DON was asked where the residents can get drinks and meet when the dining room was closed. The DON did not have a response. While we were discussing these issues Resident #15 was headed to the dining room for lunch and the DON and NHA yelled at him twice to come to the nurse's station. As the Surveyor was discussing the dining room access concern with the DON, the NHA started talking to Resident #15. The NHA interrupted the Surveyor's conversation saying to Resident #15, tell her what you just told me about the dining room. Resident #15 said he was able to get into the dining room at 6:30 that morning. When the Surveyor asked if he had any problems normally getting in after 9:00 PM to 7:30 AM, he said staff normally would not let him in. The NHA made several comments to Resident #15 attempting to get him to change his answer to he was able to get into the dining room. But Resident #15 maintained he was not able to access the dining room on several occasions. This conversation was witness by another Surveyor. On 3/10/20 at approximately 12:30 PM, the Surveyor informed the NHA that all 8 residents in the confidential group reported CNA D had yelled at them and had refused to provide care. The NHA denied any concern forms or reports to the State Survey Agency related to CNA D (no report to the state for discipline for CNA D's abusive comments and behaviors were located). All 8 residents in the confidential group meeting had all said they had reported the abuse. On 3/10/20 at approximately 2:35 PM, the DON informed the Surveyor that Resident #16 was not capable of swearing and yelling at residents as he cannot speak clearly. She said he does not behave like that and said at lunch today Resident #28 (male resident) blew a kiss at Resident #16 (male resident) and Resident #16 just moved to another table and did not say anything. The Surveyor asked what the DON did when she found out about this situation. The DON said she told Resident #28 he can not do that and checked to see that Resident #16 was ok. The Surveyor went to Resident #16's room with the DON. Resident #16 was able to say yes to questions and nod his head no to questions. Resident #16 was able to say he wanted to call his sister and my girls. Other words were difficult to make out, but he did attempt to speak when asked questions. Resident #16 responded yes to did someone blow you a kiss today? and did it make you mad? When asked if Resident #28 had blown kisses at him before, he answered yes. When asked if he does it once a day or once a week, he nodded no. When asked if he does it once a month he said yes. Based on verbal response and facial expression it was clear Resident #28 upsets Resident #16. After leaving the room, the Surveyor asked the DON if that event was an allegation of abuse she said yes, I will report it now. During an interview with confidential staff (CS) CC on 3/10/20 at 3:20 PM, CS CC confirmed Resident #16 swears at the men and is sexually inappropriate with the female staff. CS CC said all staff and the residents are afraid of him. He is 240 pounds and gets very mad. CS CC said she reports it to the charge nurse and is told to have someone else take care of him when she is afraid. CS CC said she cannot chart the information. She can only chart on the two behaviors they have listed for him. On 3/10/20 at approximately 3:15 PM, the Surveyors reported the conversation and observation they had with the DON and NHA at 12:05 PM as intimidation to the Regional Director of Operations (RDO) X when he inquired about survey concerns. RDO X informed the Surveyors he was suspending the NHA pending investigation. During an interview on 3/12/20 at 9:30 AM, confidential employee (CE) DD said she was aware Resident #28 blew a kiss at Resident #16 the other day. CE DD said Resident #28 is a bully and does things like this to residents and staff frequently. Review of Resident #16's progress notes revealed a note dated, 3/10/20 at 19:09 (7:09 PM), (Name of resident) appears at psychosocial baseline, no impaired function noted, maintained his baseline routine. There was no indication why Resident #16 was being assessed and no indication of the event earlier in the day where Resident #28 had blown him a kiss and Resident #16 indicated it was not the first time and it made him upset. The note indicated Resident #16 was able to say, hope there's soup and You be here tomorrow. During the interview with the DON on 3/10/20 the DON said Resident #16 was not able to speak. Review of Resident #16's progress note, dated 3/11/20 at 6:00 AM, revealed, Behavior Displayed: -History of using inappropriate and racial slurs when speaking with staff. -History of being possessive over female staff as evidenced by following them and staring at them from a distance or sitting in wheelchair in front of staff offices. -Wandering in/out of others personal space/room without permission. Precipitation factors/events: - Resident has intellectual disability with impaired safety awareness and potential impulsiveness. Ect . Review of Resident #16's progress note, dated 3/11/20 at 13:58, revealed, (Name of resident) accepted at (name of another facility) Dementia unit, ect . Review of Resident #37's progress notes from 3/5/20 to 3/9/20 failed to indicate resident wanders or has any issues with other residents or goes into other resident rooms. Review of Resident #37's progress note, dated 3/10/20, revealed, IDT (interdisciplinary team) met today in regard to complaints from other residents of resident entering their room. Activity supplies provide to the table area near the nurse's station to offer distraction when the resident is up wandering. Resident enjoys ice cream, which is present in the refrigerator in the break room. Staff instructed to provide activities and snack to resident when wandering. Resident is easily redirectable. Social Services director contacting the resident's wife in regard to a possible

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235284	A. BUILDING _____ B. WING _____	03/12/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MEDILODGE OF MIDLAND	4900 HEDGEWOOD DR MIDLAND, MI 48640

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	(continued... from page 4) transfer to a secured unit. Staff will monitor resident location when up in w/c and provide activities and snacks as needed. Review of Resident #37's progress note, dated 3/11/20 at 11:26 AM, IDT (interdisciplinary team) met to review resident will be increased supervision while awake resident will be 1:1 while awake at this time care plan reviewed and updated. Review of a facility reported incident (FRI), dated 3/3/20 at 1:15 PM, revealed Resident #37 hit a [AGE] year-old female resident. The [AGE] year-old female resident reported Resident #37 was in her room while she was in the bathroom. When she came out Resident #37 was taking her pens and pencils. When she told him to get out Resident #37 told her that he did not have to. When he left her room, he hit her in the left shoulder. Review of the facility video confirmed Resident #37 had been in the female resident's room. Facility staff helped remove Resident #37 from the female resident's room. Staff heard the female resident tell Resident #37 to get out of her room. Resident #37 had a history of [REDACTED]. The facility was not able to substantiate that the female resident was hit. There was no indication in this report, or in Resident #37's medical record, of interventions placed to prevent him from entering other residents' rooms and taking things that did not belong to him. No interventions were place until the Surveyor informed the facility that 8 of 8 residents in the confidential group meeting were afraid of Resident #37 and frustrated that he was allowed to continue to steal their belongings. Resident #15 A review of Resident #15's Admission Record, dated 3/11/20, revealed Resident #15 was a [AGE] year-old resident admitted to the facility on [DATE]. In addition, Resident #15's Admission Record revealed Resident #15 had multiple [DIAGNOSES REDACTED]. A review of Resident #15's Minimum Data Set (MDS) (a tool used for assessing a resident's care needs), dated 12/27/19, revealed Resident #15 had a Brief Interview for Mental Status (BIMS) (a scale used to determine a resident's cognitive status) score of 13 which revealed Resident #15 was cognitively intact. During an observation on 3/10/20 at approximately 12:15 PM, this Surveyor overheard another Surveyor discussing the dining room access concern that was mentioned in the confidential group meeting with the DON at the nurse's station. During the conversation between the other Surveyor and the DON, the NHA was observed talking to Resident #15. The NHA then turned to the other Surveyor and said, tell her what you just told me about the dining room to Resident #15. Resident #15 stated he was able to get into the dining room at 6:30 that morning. The NHA then stated, See he changed his story to the other Surveyor. The other Surveyor asked Resident #15 if he normally had any problems getting into the dining room and he stated the staff normally do not allow him in the dining room that early in the morning. The NHA then tried to get Resident #15 to say he normally can get in the dining before breakfast every morning, but he insisted that he could not. During an interview on 3/10/20 at 2:54 PM, Resident #15 stated the NHA had called him over to talk with him at the nurse's station while she was talking to a Surveyor (see above observation). He stated he wasn't upset that she had done it or that she had tried to get him to say he could access the dining room early in the morning when he really couldn't. Resident #15 stated he was just trying to advocate for himself and the other residents at the facility. Resident # 15 stated the residents want to use the main dining room to play board games or do puzzles during the day and at night. But they won't let us go in there. They say no one can be in there unsupervised and they don't have people to be in there to watch us. Resident # 15 stated he knew some residents can't be in there unsupervised because of behaviors. Resident # 15 stated there are residents who are independent and know what they are doing who should be able to use the main dining room to hang out in. He stated they can get drinks whenever and food whenever. But they just want to use the main dining room as a place to just sit and relax. During a review of the facility's video camera footage on 3/11/20 at 10:15 AM of the conversation between the other Surveyor, NHA, and DON on 3/10/20, the DON was observed waving, or signaling, to someone off camera as she was talking to the other Surveyor. Within a minute or two, Resident #15 was observed wheeling in his wheelchair up to the NHA and engaging in a conversation with her. During the conversation, the NHA was observed turning back and forth between the other Surveyor and Resident #15. There was no audio to the tape, so the actual words could not be heard, or verified. However, the video camera footage was consistent with the observation this Surveyor made on 3/10/20 at approximately 12:15 PM. During the recertification survey a telephone interview was conducted with Confidential Witness (CW) NN whose mother is a resident at the facility. CW N reported she preferred a telephone interview because she feared her mother would suffer retribution if she were observed talking to the survey team. CW NN reported she feels her mother is intimidated by staff to say what staff want to hear. CW NN reported an incident when CW NN felt intimidated by staff when she had concern for her mother and raised it with two nurses. CW NN reported both nurses started yelling at her. CW NN reported the Director of Nursing (DON) came to her and yelled at her for the treatment of [REDACTED]. CW NN reported while in the hall during a visit a resident had asked a staff member to take her to the bathroom and that the staff member responded out loud, you're fifth in line. CW NN reported the facility does not have enough staff to meet the needs of the residents and highlighted her mother's needs. CW NN reported her mother used to be able to walk and was walked regularly. CW NN reported because of the demands on staff they do not have the time to regularly walk residents, this lack of exercise and range of motion has caused her mother to be, forced into a wheelchair. CW NN reported she has found her mother soiled and neglected and that she doesn't get regular showers. CW NN reported her mother's shower day frequently changes. CW NN reported, once, she was scolded by staff for complaining of the room being dirty. CW NN reported since then, her mother's roommate will clean the bathroom and the floor. CW NN reiterated that she was afraid for her mother if she were to take her concerns to the facility or if it was known she complained to the survey team. Prior to survey exit CW NN was contacted and informed that the facility should have the opportunity to address her specific concerns. CW NN reported she did not have confidence in the facility Administration, and she is sure her mother would suffer if she were to try to address her concerns directly. On 3/9/20 at 4:06 PM, Confidential Resident (CR) QQ reported, I try to stay isolated because of disrespectful treatment by staff. CR QQ reported she has witnessed other residents get chewed at when a concern was voiced. CR QQ reported two different Certified Nurse Aides (CNA) blew me off when I asked for water about 8:00 AM this day. CR QQ reported she had told a CNA this morning that her stomach was bothering her, but no one ever came to assess her. CR QQ: reported she knows not to say anything against staff because she will get spoken to. CR QQ reported she was afraid of staff retribution. I'm nervous now that I said something(to the surveyor). During a follow up interview on 3/10/20 at 12:24 PM, CR QQ was informed the Confidential Group interview raised similar concerns. Confidential Resident QQ was asked if her specific concerns could be addressed with the facility. CR QQ declined to be identified to have her concerns addressed stating, they (facility staff) will come at me Resident #45 admitted to the facility 1/1/19, the MDS dated [DATE] reflected Resident #45 was diagnosed with [REDACTED]. The Minimum Data Set (MDS) reflected Resident #45 scored 15 out of 15 on the Brief Interview for Mental Status (BIMS) which indicated the Resident was cognitively intact. The MDS reflected Resident #45 used a walker and a wheelchair for mobility. During an interview conducted 3/9/20 at 11:08 AM, Family Member (FM) OO, the spouse of Resident #45, reported the facility is short staffed on weekends. FM OO reported two weeks prior Resident #45 had soiled herself in her bed because of an extended call light wait. FM OO reported a CNA responded to the call light but Resident #45 had to wait additional time before she was cleaned. FM OO reported two other occasions when Resident #45 laid in a wet bed awaiting a call light response. Resident #45 was questioned about these incidents and she reported these incidents always occur on weekends and holidays. FO OO reported he complained to the Nursing Home Administrator (NHA) and that the NHA told him that maybe (Resident #45) should go to another nursing home.
F 0607 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Develop and implement policies and procedures to prevent abuse, neglect, and theft.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to implement their abuse policy for 4 of 22 residents (R15, R16, R28, R37) and 8 of 8 Residents in the confidential group, resulting in feelings of fear and anxiety when abuse was ongoing. Findings include: According to the facility Abuse Prevention Program, dated 2/22/18, 2. Comprehensive polices and procedures have been developed to aid our facility in preventing abuse, neglect, or mistreatment of [REDACTED].*Identification of occurrences and patterns of potential mistreatment/abuse. *The protection of residents during abuse investigations. *The reporting and filing of accurate documents relative to incidents of abuse. ect 8. Any individual observing an incident of resident abuse or suspecting resident abuse must immediately report such incident to the Administrator or Director of Nursing or designee (Note 2 hour reporting requirement at section 9). ect. Resident #15 According to Resident #15's face sheet, dated 3/11/20, he was a [AGE] year-old male admitted to the facility on [DATE] and had [DIAGNOSES REDACTED]. He was his own responsible party. Review of Resident #15's Minimum Data Set (MDS), nursing assessment tool, dated 12/27/19 revealed he had a [MEDICAL CONDITION]. His Brief Interview of Mental Status (BIMS) score was 13/15 (normal cognition) Resident #16 According to Resident #16's face sheet, dated 3/11/20, he was a [AGE] year-old

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235284	A. BUILDING _____ B. WING _____	03/12/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MEDILODGE OF MIDLAND	4900 HEDGEWOOD DR MIDLAND, MI 48640

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 0607 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 5) male admitted to the facility on [DATE] and had [DIAGNOSES REDACTED]. He was not his own responsible party. Resident #28 According to Resident #28's face sheet, dated 3/12/20, he was a [AGE] year-old male admitted to the facility on [DATE] and had [DIAGNOSES REDACTED]. He was his own responsible party. Resident #37 According to Resident #37's face sheet, dated 3/11/20, he was an [AGE] year-old male admitted to the facility on [DATE] and had [DIAGNOSES REDACTED]. He was not his own responsible party. During the confidential group meeting on 3/10/20 at 10:30 AM, 8 of 8 Residents said they were afraid of Resident #16 and #37. They said Resident #16 did not like men and he would yell and swear at them. They said he was a big man and they were afraid he would hurt them. They said the Nursing Home Administrator (NHA) and the Director of Nursing (DON) and several other staff were aware of the concern, but they were not doing anything. They said when they report things, they were in fear of retaliation. They are told they can find some place else for them to live if they do not like it here when they bring concerns to management's attention. They have also been denied care and yelled at by some of the care staff. When asked for staff names all 8 residents said Certified Nurse Aide (CNA) D has yelled at them and told them things like you can take care of that yourself. They said CNA D was not the only one that has refused to provide care or be rude. They said they had reported CNA D and she still works here, so they did not want to name other staff or report abuse to anyone as their care gets worse when they bring up any concerns. Eight (8) of 8 Residents said they are not able to use the dining room from 9:00 PM to 7:30 AM and said they had informed the DON and NHA and they (facility staff) insist on keeping them out of the dining room. They said they do not have anywhere to go outside their rooms during those hours other than the halls. During an interview with the NHA and DON on 3/10/20 at 12:05 pm at the nurses station, this Surveyor informed them that during the meeting with the confidential group they all reported being afraid of Resident #16 and #37 and were upset that they were not allowed into the dining room from 9:00 PM to 7:30 AM. They all said they were afraid of retaliation, so they were not wanting to discuss these concerns with the NHA or DON. The DON and NHA said they only had one report to the State Survey Agency about abuse related to Resident #37. They denied knowledge of abuse allegations for Resident #16. The DON initially denied the dining room was not available from 9:00 PM to 7:30 AM, as she had been there at 5:30 AM that day and had made sure it was open. When questioned further she did admit she made changes to the use of the dining room due to some resident behaviors. The DON was asked where the residents can get drinks and meet when the dining room was closed. The DON did not have a response. While we were discussing these issues Resident #15 was headed to the dining room for lunch and the DON and NHA yelled at him twice to come to the nurse's station. As the Surveyor was discussing the dining room access concern with the DON, the NHA started talking to Resident #15. The NHA interrupted the Surveyor's conversation saying to Resident #15, tell her what you just told me about the dining room. Resident #15 said he was able to get into the dining room at 6:30 that morning. When the Surveyor asked if he had any problems normally getting in after 9:00 PM to 7:30 AM, he said staff normally would not let him in. The NHA made several comments to Resident #15 attempting to get him to change his answer to he was able to get into the dining room. But Resident #15 maintained he was not able to access the dining room on several occasions. This conversation was witness by another Surveyor. On 3/10/20 at approximately 12:30 PM, the Surveyor informed the NHA that all 8 residents in the confidential group reported CNA D had yelled at them and had refused to provide care. The NHA denied any concern forms or reports to the State Survey Agency related to CNA D (no report to the state for discipline for CNA D's abusive comments and behaviors were located). All 8 residents in the confidential group meeting had all said they had reported the abuse. On 3/10/20 at approximately 2:35 PM, the DON informed the Surveyor that Resident #16 was not capable of swearing and yelling at residents as he cannot speak clearly. She said he does not behave like that and said at lunch today Resident #28 (male resident) blew a kiss at Resident #16 (male resident) and Resident #16 just moved to another table and did not say anything. The Surveyor asked what the DON did when she found out about this situation. The DON said she told Resident #28 he can not do that and checked to see that Resident #16 was ok. The Surveyor went to Resident #16's room with the DON. Resident #16 was able to say yes to questions and nod his head no to questions. Resident #16 was able to say he wanted to call his sister and my girls. Other words were difficult to make out, but he did attempt to speak when asked questions. Resident #16 responded yes to did someone blow you a kiss today? and did it make you mad? When asked if Resident #28 had blown kisses at him before, he answered yes. When asked if he does it once a day or once a week, he nodded no. When asked if he does it once a month he said yes. Based on verbal response and facial expression it was clear Resident #28 upsets Resident #16. After leaving the room, the Surveyor asked the DON if that event was an allegation of abuse she said yes, I will report it now. During an interview with confidential staff (CS) CC on 3/10/20 at 3:20 PM, CS CC confirmed Resident #16 swears at the men and is sexually inappropriate with the female staff. CS CC said all staff and the residents are afraid of him. He is 240 pounds and gets very mad. CS CC said she reports it to the charge nurse and is told to have someone else take care of him when she is afraid. CS CC said she cannot chart the information. She can only chart on the two behaviors they have listed for him. On 3/10/20 at approximately 3:15 PM, the Surveyors reported the conversation and observation they had with the DON and NHA at 12:05 PM as intimidation to the Regional Director of Operations (RDO) X when he inquired about survey concerns. RDO X informed the Surveyors he was suspending the NHA pending investigation. During an interview on 3/12/20 at 9:30 AM, confidential employee (CE) DD said she was aware Resident #28 blew a kiss at Resident #16 the other day. CE DD said Resident #28 is a bully and does things like this to residents and staff frequently. Review of Resident #16's progress notes revealed a note dated, 3/10/20 at 19:09 (7:09 PM), (Name of resident) appears at psychosocial baseline, no impaired function noted, maintained his baseline routine. There was no indication why Resident #16 was being assessed and no indication of the event earlier in the day where Resident #28 had blown him a kiss and Resident #16 indicated it was not the first time and it made him upset. The note indicated Resident #16 was able to say, hope there's soup and You be here tomorrow. During the interview with the DON on 3/10/20 the DON said Resident #16 was not able to speak. Review of Resident #16's progress note, dated 3/11/20 at 6:00 AM, revealed, Behavior Displayed: -History of using inappropriate and racial slurs when speaking with staff. -History of being possessive over female staff as evidenced by following them and staring at them from a distance or sitting in wheelchair in front of staff offices. -Wandering in/out of others personal space/room without permission. Precipitation factors/events: - Resident has intellectual disability with impaired safety awareness and potential impulsiveness. Ect . Review of Resident #16's progress note, dated 3/11/20 at 13:58, revealed, (Name of resident) accepted at (name of another facility) Dementia unit, ect . Review of Resident #37's progress notes from 3/5/20 to 3/9/20 failed to indicate resident wanders or has any issues with other residents or goes into other resident rooms. Review of Resident #37's progress note, dated 3/10/20, revealed, IDT (interdisciplinary team) met today in regard to complaints from other residents of resident entering their room. Activity supplies provide to the table area near the nurse's station to offer distraction when the resident is up wandering. Resident enjoys ice cream, which is present in the refrigerator in the break room. Staff instructed to provide activities and snack to resident when wandering. Resident is easily redirectable. Social Services director contacting the resident's wife in regard to a possible transfer to a secured unit. Staff will monitor resident location when up in w/c and provide activities and snacks as needed. Review of Resident #37's progress note, dated 3/11/20 at 11:26 AM, IDT (interdisciplinary team) met to review resident will be increased supervision while awake resident will be 1:1 while awake at this time care plan reviewed and updated. Review of a facility reported incident (FRI), dated 3/3/20 at 1:15 PM, revealed Resident #37 hit a [AGE] year-old female resident. The [AGE] year-old female resident reported Resident #37 was in her room while she was in the bathroom. When she came out Resident #37 was taking her pens and pencils. When she told him to get out Resident #37 told her that he did not have to. When he left her room, he hit her in the left shoulder. Review of the facility video confirmed Resident #37 had been in the female resident's room. Facility staff helped remove Resident #37 from the female resident's room. Staff heard the female resident tell Resident #37 to get out of her room. Resident #37 had a history of [REDACTED]. The facility was not able to substantiate that the female resident was hit. There was no indication in this report, or in Resident #37's medical record, of interventions placed to prevent him from entering other residents' rooms and taking things that did not belong to him. No interventions were place until the Surveyor informed the facility that 8 of 8 residents in the confidential group meeting were afraid of Resident #37 and frustrated that he was allowed to continue to steal their belongings. Resident #15 A review of Resident #15's Admission Record, dated 3/11/20, revealed Resident #15 was a [AGE] year-old resident admitted to the facility on [DATE]. In addition, Resident #15's Admission Record revealed Resident #15 had multiple [DIAGNOSES REDACTED]. A review of Resident #15's Minimum Data Set (MDS) (a tool used for assessing a resident's care needs), dated 12/27/19, revealed Resident #15 had a Brief Interview for Mental Status (BIMS) (a scale used to determine a resident's cognitive status) score of 13 which revealed Resident #15 was cognitively intact. During an observation on 3/10/20 at approximately 12:15 PM, this Surveyor overheard another Surveyor discussing the dining room

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235284	A. BUILDING _____ B. WING _____	03/12/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MEDILODGE OF MIDLAND	4900 HEDGEWOOD DR MIDLAND, MI 48640

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 0607 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 6) access concern that was mentioned in the confidential group meeting with the DON at the nurse's station. During the conversation between the other Surveyor and the DON, the NHA was observed talking to Resident #15. The NHA then turned to the other Surveyor and said, tell her what you just told me about the dining room to Resident #15. Resident #15 stated he was able to get into the dining room at 6:30 that morning. The NHA then stated, See he changed his story to the other Surveyor. The other Surveyor asked Resident #15 if he normally had any problems getting into the dining room and he stated the staff normally do not allow him in the dining room that early in the morning. The NHA then tried to get Resident #15 to say he normally can get in the dining before breakfast every morning, but he insisted that he could not. During an interview on 3/10/20 at 2:54 PM, Resident #15 stated the NHA had called him over to talk with him at the nurse's station while she was talking to a Surveyor (see above observation). He stated he wasn't upset that she had done it or that she had tried to get him to say he could access the dining room early in the morning when he really couldn't. Resident #15 stated he was just trying to advocate for himself and the other residents at the facility. Resident # 15 stated the residents want to use the main dining room to play board games or do puzzles during the day and at night. But they won't let us go in there. They say no one can be in there unsupervised and they don't have people to be in there to watch us. Resident # 15 stated he knew some residents can't be in there unsupervised because of behaviors. Resident # 15 stated there are residents who are independent and know what they are doing who should be able to use the main dining room to hang out in. He stated they can get drinks whenever and food whenever. But they just want to use the main dining room as a place to just sit and relax. During a review of the facility's video camera footage on 3/11/20 at 10:15 AM of the conversation between the other Surveyor, NHA, and DON on 3/10/20, the DON was observed waving, or signaling, to someone off camera as she was talking to the other Surveyor. Within a minute or two, Resident #15 was observed wheeling in his wheelchair up to the NHA and engaging in a conversation with her. During the conversation, the NHA was observed turning back and forth between the other Surveyor and Resident #15. There was no audio to the tape, so the actual words could not be heard, or verified. However, the video camera footage was consistent with the observation this Surveyor made on 3/10/20 at approximately 12:15 PM.
F 0609 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**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 all allegations of abuse for 4 of 22 residents (R15, R16, R28, R37) and 8 of 8 Residents in the confidential group, resulting in continued abuse or residents due to no action by administration. Findings include: Resident #15 According to Resident #15's face sheet, dated 3/11/20, he was a [AGE] year-old male admitted to the facility on [DATE] and had [DIAGNOSES REDACTED]. He was his own responsible party. Review of Resident #15's Minimum Data Set (MDS), nursing assessment tool, dated 12/27/19 revealed he had a [MEDICAL CONDITION]. His Brief Interview of Mental Status (BIMS) score was 13/15 (normal cognition) Resident #16 According to Resident #16's face sheet, dated 3/11/20, he was a [AGE] year old male admitted to the facility on [DATE] and had [DIAGNOSES REDACTED]. He was not his own responsible party. Resident #28 According to Resident #28's face sheet, dated 3/12/20, he was a [AGE] year-old male admitted to the facility on [DATE] and had [DIAGNOSES REDACTED]. He was his own responsible party. Resident #37 According to Resident #37's face sheet, dated 3/11/20, he was an [AGE] year-old male admitted to the facility on [DATE] and had [DIAGNOSES REDACTED]. He was not his own responsible party. During the confidential group meeting on 3/10/20 at 10:30 AM, 8 of 8 Residents said they were afraid of Resident #16 and #37. They said Resident #16 did not like men and he would yell and swear at them. They said he was a big man and they were afraid he would hurt them. They said the Nursing Home Administrator (NHA) and the Director of Nursing (DON) and several other staff were aware of the concern, but they were not doing anything. They said when they report things, they were in fear of retaliation. They are told they can find some place else for them to live if they do not like it here when they bring concerns to management's attention. They have also been denied care and yelled at by some of the care staff. When asked for staff names all 8 residents said Certified Nurse Aide (CNA) D has yelled at them and told them things like you can take care of that yourself. They said CNA D was not the only one that has refused to provide care or be rude. They said they had reported CNA D and she still works here, so they did not want to name other staff or report abuse to anyone as their care gets worse when they bring up any concerns. Eight (8) of 8 Residents said they are not able to use the dining room from 9:00 PM to 7:30 AM and said they had informed the DON and NHA and they (facility staff) insist on keeping them out of the dining room. They said they do not have anywhere to go outside their rooms during those hours other than the halls. During an interview with the NHA and DON on 3/10/20 at 12:05 pm at the nurses station, this Surveyor informed them that during the meeting with the confidential group they all reported being afraid of Resident #16 and #37 and were upset that they were not allowed into the dining room from 9:00 PM to 7:30 AM. They all said they were afraid of retaliation, so they were not wanting to discuss these concerns with the NHA or DON. The DON and NHA said they only had one report to the State Survey Agency about abuse related to Resident #37. They denied knowledge of abuse allegations for Resident #16. The DON initially denied the dining room was not available from 9:00 PM to 7:30 AM, as she had been there at 5:30 AM that day and had made sure it was open. When questioned further she did admit she made changes to the use of the dining room due to some resident behaviors. The DON was asked where the residents can get drinks and meet when the dining room was closed. The DON did not have a response. While we were discussing these issues Resident #15 was headed to the dining room for lunch and the DON and NHA yelled at him twice to come to the nurse's station. As the Surveyor was discussing the dining room access concern with the DON, the NHA started talking to Resident #15. The NHA interrupted the Surveyor's conversation saying to Resident #15, tell her what you just told me about the dining room. Resident #15 said he was able to get into the dining room at 6:30 that morning. When the Surveyor asked if he had any problems normally getting in after 9:00 PM to 7:30 AM, he said staff normally would not let him in. The NHA made several comments to Resident #15 attempting to get him to change his answer to he was able to get into the dining room. But Resident #15 maintained he was not able to access the dining room on several occasions. This conversation was witness by another Surveyor. On 3/10/20 at approximately 12:30 PM, the Surveyor informed the NHA that all 8 residents in the confidential group reported CNA D had yelled at them and had refused to provide care. The NHA denied any concern forms or reports to the State Survey Agency related to CNA D (no report to the state for displine for CNA D's abusive comments and behaviors were located). All 8 residents in the confidential group meeting had all said they had reported the abuse. On 3/10/20 at approximately 2:35 PM, the DON informed the Surveyor that Resident #16 was not capable of swearing and yelling at residents as he cannot speak clearly. She said he does not behave like that and said at lunch today Resident #28 (male resident) blew a kiss at Resident #16 (male resident) and Resident #16 just moved to another table and did not say anything. The Surveyor asked what the DON did when she found out about this situation. The DON said she told Resident #28 he can not do that and checked to see that Resident #16 was ok. The Surveyor went to Resident #16's room with the DON. Resident #16 was able to say yes to questions and nod his head no to questions. Resident #16 was able to say he wanted to call his sister and my girls. Other words were difficult to make out, but he did attempt to speak when asked questions. Resident #16 responded yes to did someone blow you a kiss today? and did it make you mad? When asked if Resident #28 had blown kisses at him before, he answered yes. When asked if he does it once a day or once a week, he nodded no. When asked if he does it once a month he said yes. Based on verbal response and facial expression it was clear Resident #28 upsets Resident #16. After leaving the room, the Surveyor asked the DON if that event was an allegation of abuse she said yes, I will report it now. During an interview with confidential staff (CS) CC on 3/10/20 at 3:20 PM, CS CC confirmed Resident #16 swears at the men and is sexually inappropriate with the female staff. CS CC said all staff and the residents are afraid of him. He is 240 pounds and gets very mad. CS CC said she reports it to the charge nurse and is told to have someone else take care of him when she is afraid. CS CC said she cannot chart the information. She can only chart on the two behaviors they have listed for him. On 3/10/20 at approximately 3:15 PM, the Surveyors reported the conversation and observation they had with the DON and NHA at 12:05 PM as intimidation to the Regional Director of Operations (RDO) X when he inquired about survey concerns. RDO X informed the Surveyors he was suspending the NHA pending investigation. During an interview on 3/12/20 at 9:30 AM, confidential employee (CE) DD said she was aware Resident #28 blew a kiss at Resident #16 the other day. CE DD said Resident #28 is a bully and does things like this to residents and staff frequently. Review of Resident #16's progress notes revealed a note dated, 3/10/20 at 19:09 (7:09 PM), (Name of resident) appears at psychosocial baseline, no impaired function noted, maintained his baseline routine. There was no indication why Resident #16 was being assessed and no indication of the event earlier in the day where Resident #28 had blown him a kiss and Resident #16 indicated it was not the first time and it made him upset. The note indicated Resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235284	A. BUILDING _____ B. WING _____	03/12/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MEDILODGE OF MIDLAND	4900 HEDGEWOOD DR MIDLAND, MI 48640

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 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 7) #16 was able to say, hope there's soup and You be here tomorrow. During the interview with the DON on 3/10/20 the DON said Resident #16 was not able to speak. Review of Resident #16's progress note, dated 3/11/20 at 6:00 AM, revealed, Behavior Displayed: -History of using inappropriate and racial slurs when speaking with staff. -History of being possessive over female staff as evidenced by following them and staring at them from a distance or sitting in wheelchair in front of staff offices. -Wandering in/out of others personal space/room without permission. Precipitation factors/events: - Resident has intellectual disability with impaired safety awareness and potential impulsiveness. Ect . Review of Resident #16's progress note, dated 3/11/20 at 13:58, revealed, (Name of resident) accepted at (name of another facility) Dementia unit, ect . Review of Resident #37's progress notes from 3/5/20 to 3/9/20 failed to indicate resident wanders or has any issues with other residents or goes into other resident rooms. Review of Resident #37's progress note, dated 3/10/20, revealed, IDT (interdisciplinary team) met today in regard to complaints from other residents of resident entering their room. Activity supplies provide to the table area near the nurse's station to offer distraction when the resident is up wandering. Resident enjoys ice cream, which is present in the refrigerator in the break room. Staff instructed to provide activities and snack to resident when wandering. Resident is easily redirectable. Social Services director contacting the resident's wife in regard to a possible transfer to a secured unit. Staff will monitor resident location when up in w/c and provide activities and snacks as needed. Review of Resident #37's progress note, dated 3/11/20 at 11:26 AM, IDT (interdisciplinary team) met to review resident will be increased supervision while awake resident will be 1:1 while awake at this time care plan reviewed and updated. Review of a facility reported incident (FRI), dated 3/3/20 at 1:15 PM, revealed Resident #37 hit a [AGE] year-old female resident. The [AGE] year-old female resident reported Resident #37 was in her room while she was in the bathroom. When she came out Resident #37 was taking her pens and pencils. When she told him to get out Resident #37 told her that he did not have to. When he left her room, he hit her in the left shoulder. Review of the facility video confirmed Resident #37 had been in the female resident's room. Facility staff helped remove Resident #37 from the female resident's room. Staff heard the female resident tell Resident #37 to get out of her room. Resident #37 had a history of [REDACTED]. The facility was not able to substantiate that the female resident was hit. There was no indication in this report, or in Resident #37's medical record, of interventions placed to prevent him from entering other residents' rooms and taking things that did not belong to him. No interventions were place until the Surveyor informed the facility that 8 of 8 residents in the confidential group meeting were afraid of Resident #37 and frustrated that he was allowed to continue to steal their belongings. Resident #15 A review of Resident #15's Admission Record, dated 3/11/20, revealed Resident #15 was a [AGE] year-old resident admitted to the facility on [DATE]. In addition, Resident #15's Admission Record revealed Resident #15 had multiple [DIAGNOSES REDACTED]. A review of Resident #15's Minimum Data Set (MDS) (a tool used for assessing a resident's care needs), dated 12/27/19, revealed Resident #15 had a Brief Interview for Mental Status (BIMS) (a scale used to determine a resident's cognitive status) score of 13 which revealed Resident #15 was cognitively intact. During an observation on 3/10/20 at approximately 12:15 PM, this Surveyor overheard another Surveyor discussing the dining room access concern that was mentioned in the confidential group meeting with the DON at the nurse's station. During the conversation between the other Surveyor and the DON, the NHA was observed talking to Resident #15. The NHA then turned to the other Surveyor and said, tell her what you just told me about the dining room to Resident #15. Resident #15 stated he was able to get into the dining room at 6:30 that morning. The NHA then stated, See he changed his story to the other Surveyor. The other Surveyor asked Resident #15 if he normally had any problems getting into the dining room and he stated the staff normally do not allow him in the dining room that early in the morning. The NHA then tried to get Resident #15 to say he normally can get in the dining before breakfast every morning, but he insisted that he could not. During an interview on 3/10/20 at 2:54 PM, Resident #15 stated the NHA had called him over to talk with him at the nurse's station while she was talking to a Surveyor (see above observation). He stated he wasn't upset that she had done it or that she had tried to get him to say he could access the dining room early in the morning when he really couldn't. Resident #15 stated he was just trying to advocate for himself and the other residents at the facility. Resident # 15 stated the residents want to use the main dining room to play board games or do puzzles during the day and at night. But they won't let us go in there. They say no one can be in there unsupervised and they don't have people to be in there to watch us. Resident # 15 stated he knew some residents can't be in there unsupervised because of behaviors. Resident # 15 stated there are residents who are independent and know what they are doing who should be able to use the main dining room to hang out in. He stated they can get drinks whenever and food whenever. But they just want to use the main dining room as a place to just sit and relax. During a review of the facility's video camera footage on 3/11/20 at 10:15 AM of the conversation between the other Surveyor, NHA, and DON on 3/10/20, the DON was observed waving, or signaling, to someone off camera as she was talking to the other Surveyor. Within a minute or two, Resident #15 was observed wheeling in his wheelchair up to the NHA and engaging in a conversation with her. During the conversation, the NHA was observed turning back and forth between the other Surveyor and Resident #15. There was no audio to the tape, so the actual words could not be heard, or verified. However, the video camera footage was consistent with the observation this Surveyor made on 3/10/20 at approximately 12:15 PM.
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** Based on observation, interview and record review the facility failed to thoroughly investigate all allegations of abuse for 4 of 22 residents (R15, R16, R28, R37) and 8 of 8 Residents in the confidential group, resulting in feelings of fear and anxiety when abuse was ongoing due to lack of action from administration. Findings include: Resident #15 According to Resident #15's face sheet, dated 3/11/20, he was a [AGE] year-old male admitted to the facility on [DATE] and had [DIAGNOSES REDACTED]. He was his own responsible party. Review of Resident #15's Minimum Data Set (MDS), nursing assessment tool, dated 12/27/19 revealed he had a [MEDICAL CONDITION]. His Brief Interview of Mental Status (BIMS) score was 13/15 (normal cognition) Resident #16 According to Resident #16's face sheet, dated 3/11/20, he was a [AGE] year old male admitted to the facility on [DATE] and had [DIAGNOSES REDACTED]. He was not his own responsible party. Resident #28 According to Resident #28's face sheet, dated 3/12/20, he was a [AGE] year-old male admitted to the facility on [DATE] and had [DIAGNOSES REDACTED]. He was his own responsible party. Resident #37 According to Resident #37's face sheet, dated 3/11/20, he was an [AGE] year-old male admitted to the facility on [DATE] and had [DIAGNOSES REDACTED]. He was not his own responsible party. During the confidential group meeting on 3/10/20 at 10:30 AM, 8 of 8 Residents said they were afraid of Resident #16 and #37. They said Resident #16 did not like men and he would yell and swear at them. They said he was a big man and they were afraid he would hurt them. They said the Nursing Home Administrator (NHA) and the Director of Nursing (DON) and several other staff were aware of the concern, but they were not doing anything. They said when they report things, they were in fear of retaliation. They are told they can find some place else for them to live if they do not like it here when they bring concerns to management's attention. They have also been denied care and yelled at by some of the care staff. When asked for staff names all 8 residents said Certified Nurse Aide (CNA) D has yelled at them and told them things like you can take care of that yourself. They said CNA D was not the only one that has refused to provide care or be rude. They said they had reported CNA D and she still works here, so they did not want to name other staff or report abuse to anyone as their care gets worse when they bring up any concerns. Eight (8) of 8 Residents said they are not able to use the dining room from 9:00 PM to 7:30 AM and said they had informed the DON and NHA and they (facility staff) insist on keeping them out of the dining room. They said they do not have anywhere to go outside their rooms during those hours other than the halls. During an interview with the NHA and DON on 3/10/20 at 12:05 pm at the nurses station, this Surveyor informed them that during the meeting with the confidential group they all reported being afraid of Resident #16 and #37 and were upset that they were not allowed into the dining room from 9:00 PM to 7:30 AM. They all said they were afraid of retaliation, so they were not wanting to discuss these concerns with the NHA or DON. The DON and NHA said they only had one report to the State Survey Agency about abuse related to Resident #37. They denied knowledge of abuse allegations for Resident #16. The DON initially denied the dining room was not available from 9:00 PM to 7:30 AM, as she had been there at 5:30 AM that day and had made sure it was open. When questioned further she did admit she made changes to the use of the dining room due to some resident behaviors. The DON was asked where the residents can get drinks and meet when the dining room was closed. The DON did not have a response. While we were discussing these issues Resident #15 was headed to the dining room for lunch and the DON and NHA yelled at him twice to come to the nurse's station. As the Surveyor was discussing the dining room access concern with the DON, the NHA started talking to Resident #15. The NHA interrupted the Surveyor's conversation saying to Resident #15, tell her what you just told me about the dining room. Resident #15 said he

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235284	A. BUILDING _____ B. WING _____	03/12/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MEDILODGE OF MIDLAND	4900 HEDGEWOOD DR MIDLAND, MI 48640

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 0610 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 8) was able to get into the dining room at 6:30 that morning. When the Surveyor asked if he had any problems normally getting in after 9:00 PM to 7:30 AM, he said staff normally would not let him in. The NHA made several comments to Resident #15 attempting to get him to change his answer to he was able to get into the dining room. But Resident #15 maintained he was not able to access the dining room on several occasions. This conversation was witness by another Surveyor. On 3/10/20 at approximately 12:30 PM, the Surveyor informed the NHA that all 8 residents in the confidential group reported CNA D had yelled at them and had refused to provide care. The NHA denied any concern forms or reports to the State Survey Agency related to CNA D (no report to the state for discipline for CNA D's abusive comments and behaviors were located). All 8 residents in the confidential group meeting had all said they had reported the abuse. On 3/10/20 at approximately 2:35 PM, the DON informed the Surveyor that Resident #16 was not capable of swearing and yelling at residents as he cannot speak clearly. She said he does not behave like that and said at lunch today Resident #28 (male resident) blew a kiss at Resident #16 (male resident) and Resident #16 just moved to another table and did not say anything. The Surveyor asked what the DON did when she found out about this situation. The DON said she told Resident #28 he can not do that and checked to see that Resident #16 was ok. The Surveyor went to Resident #16's room with the DON. Resident #16 was able to say yes to questions and nod his head no to questions. Resident #16 was able to say he wanted to call his sister and my girls. Other words were difficult to make out, but he did attempt to speak when asked questions. Resident #16 responded yes to did someone blow you a kiss today? and did it make you mad? When asked if Resident #28 had blown kisses at him before, he answered yes. When asked if he does it once a day or once a week, he nodded no. When asked if he does it once a month he said yes. Based on verbal response and facial expression it was clear Resident #28 upsets Resident #16. After leaving the room, the Surveyor asked the DON if that event was an allegation of abuse she said yes, I will report it now. During an interview with confidential staff (CS) CC on 3/10/20 at 3:20 PM, CS CC confirmed Resident #16 swears at the men and is sexually inappropriate with the female staff. CS CC said all staff and the residents are afraid of him. He is 240 pounds and gets very mad. CS CC said she reports it to the charge nurse and is told to have someone else take care of him when she is afraid. CS CC said she cannot chart the information. She can only chart on the two behaviors they have listed for him. On 3/10/20 at approximately 3:15 PM, the Surveyors reported the conversation and observation they had with the DON and NHA at 12:05 PM as intimidation to the Regional Director of Operations (RDO) X when he inquired about survey concerns. RDO X informed the Surveyors he was suspending the NHA pending investigation. During an interview on 3/12/20 at 9:30 AM, confidential employee (CE) DD said she was aware Resident #28 blew a kiss at Resident #16 the other day. CE DD said Resident #28 is a bully and does things like this to residents and staff frequently. Review of Resident #16's progress notes revealed a note dated, 3/10/20 at 19:09 (7:09 PM), (Name of resident) appears at psychosocial baseline, no impaired function noted, maintained his baseline routine. There was no indication why Resident #16 was being assessed and no indication of the event earlier in the day where Resident #28 had blown him a kiss and Resident #16 indicated it was not the first time and it made him upset. The note indicated Resident #16 was able to say, hope there's soup and You be here tomorrow. During the interview with the DON on 3/10/20 the DON said Resident #16 was not able to speak. Review of Resident #16's progress note, dated 3/11/20 at 6:00 AM, revealed, Behavior Displayed: -History of using inappropriate and racial slurs when speaking with staff. -History of being possessive over female staff as evidenced by following them and staring at them from a distance or sitting in wheelchair in front of staff offices. -Wandering in/out of others personal space/room without permission. Precipitation factors/events: - Resident has intellectual disability with impaired safety awareness and potential impulsiveness. Ect . Review of Resident #16's progress note, dated 3/11/20 at 13:58, revealed, (Name of resident) accepted at (name of another facility) Dementia unit, ect . Review of Resident #37's progress notes from 3/5/20 to 3/9/20 failed to indicate resident wanders or has any issues with other residents or goes into other resident rooms. Review of Resident #37's progress note, dated 3/10/20, revealed, IDT (interdisciplinary team) met today in regard to complaints from other residents of resident entering their room. Activity supplies provide to the table area near the nurse's station to offer distraction when the resident is up wandering. Resident enjoys ice cream, which is present in the refrigerator in the break room. Staff instructed to provide activities and snack to resident when wandering. Resident is easily redirectable. Social Services director contacting the resident's wife in regard to a possible transfer to a secured unit. Staff will monitor resident location when up in w/c and provide activities and snacks as needed. Review of Resident #37's progress note, dated 3/11/20 at 11:26 AM, IDT (interdisciplinary team) met to review resident will be increased supervision while awake resident will be 1:1 while awake at this time care plan reviewed and updated. Review of a facility reported incident (FRI), dated 3/3/20 at 1:15 PM, revealed Resident #37 hit a [AGE] year-old female resident. The [AGE] year-old female resident reported Resident #37 was in her room while she was in the bathroom. When she came out Resident #37 was taking her pens and pencils. When she told him to get out Resident #37 told her that he did not have to. When he left her room, he hit her in the left shoulder. Review of the facility video confirmed Resident #37 had been in the female resident's room. Facility staff helped remove Resident #37 from the female resident's room. Staff heard the female resident tell Resident #37 to get out of her room. Resident #37 had a history of [REDACTED]. The facility was not able to substantiate that the female resident was hit. There was no indication in this report, or in Resident #37's medical record, of interventions placed to prevent him from entering other residents' rooms and taking things that did not belong to him. No interventions were place until the Surveyor informed the facility that 8 of 8 residents in the confidential group meeting were afraid of Resident #37 and frustrated that he was allowed to continue to steal their belongings. Resident #15 A review of Resident #15's Admission Record, dated 3/11/20, revealed Resident #15 was a [AGE] year-old resident admitted to the facility on [DATE]. In addition, Resident #15's Admission Record revealed Resident #15 had multiple [DIAGNOSES REDACTED]. A review of Resident #15's Minimum Data Set (MDS) (a tool used for assessing a resident's care needs), dated 12/27/19, revealed Resident #15 had a Brief Interview for Mental Status (BIMS) (a scale used to determine a resident's cognitive status) score of 13 which revealed Resident #15 was cognitively intact. During an observation on 3/10/20 at approximately 12:15 PM, this Surveyor overheard another Surveyor discussing the dining room access concern that was mentioned in the confidential group meeting with the DON at the nurse's station. During the conversation between the other Surveyor and the DON, the NHA was observed talking to Resident #15. The NHA then turned to the other Surveyor and said, tell her what you just told me about the dining room to Resident #15. Resident #15 stated he was able to get into the dining room at 6:30 that morning. The NHA then stated, See he changed his story to the other Surveyor. The other Surveyor asked Resident #15 if he normally had any problems getting into the dining room and he stated the staff normally do not allow him in the dining room that early in the morning. The NHA then tried to get Resident #15 to say he normally can get in the dining before breakfast every morning, but he insisted that he could not. During an interview on 3/10/20 at 2:54 PM, Resident #15 stated the NHA had called him over to talk with him at the nurse's station while she was talking to a Surveyor (see above observation). He stated he wasn't upset that she had done it or that she had tried to get him to say he could access the dining room early in the morning when he really couldn't. Resident #15 stated he was just trying to advocate for himself and the other residents at the facility. Resident # 15 stated the residents want to use the main dining room to play board games or do puzzles during the day and at night. But they won't let us go in there. They say no one can be in there unsupervised and they don't have people to be in there to watch us. Resident # 15 stated he knew some residents can't be in there unsupervised because of behaviors. Resident # 15 stated there are residents who are independent and know what they are doing who should be able to use the main dining room to hang out in. He stated they can get drinks whenever and food whenever. But they just want to use the main dining room as a place to just sit and relax. During a review of the facility's video camera footage on 3/11/20 at 10:15 AM of the conversation between the other Surveyor, NHA, and DON on 3/10/20, the DON was observed waving, or signaling, to someone off camera as she was talking to the other Surveyor. Within a minute or two, Resident #15 was observed wheeling in his wheelchair up to the NHA and engaging in a conversation with her. During the conversation, the NHA was observed turning back and forth between the other Surveyor and Resident #15. There was no audio to the tape, so the actual words could not be heard, or verified. However, the video camera footage was consistent with the observation this Surveyor made on 3/10/20 at approximately 12:15 PM.
F 0622 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged.** **Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged.**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235284	A. BUILDING _____ B. WING _____	03/12/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MEDILODGE OF MIDLAND	4900 HEDGEWOOD DR MIDLAND, MI 48640

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 0622 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 9) **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to formulate a comprehensive physician recapitulation of stay for one resident (Resident #21) of 1 resident reviewed for discharge, resulting in the potential for lack of information being conveyed to the medical caregivers assuming the resident care. Findings include: According to a facility face sheet dated 3/12/2020 at 8:36 AM, Resident #21 was a [AGE] year-old admitted into the facility on [DATE] with the Diagnoses: [REDACTED]. Review of Resident #21's progress notes reflected that on 03/2/20 at 8:20 AM, Resident #21 transferred to another long-term care facility. Comments: (Name of Resident #21) and her family have okayed a referral to (Name of Long-Term Facility) where there is currently a private Medicaid bed available. (Name of [MEDICAL TREATMENT] unit) alerted as she will have to start going to a new location. On 3/11/20 at 4:34 PM during an interview with SW B, SW B confirmed that she (Resident #21) transferred. Resident #21 was her own person and family lived closer to that facility. She initiated the discharge. Resident #21 was very excited. Send MAR and TAR, CP, guardian. No notification of ombudsman, resident initiated. On 3/12/20 at 8:04 AM, the Regional Director of Operations (RDO) X was asked for discharge instructions and recapitulation of stay from all disciplines and the physician. On 3/12/20 at 8:50 AM during an interview with Corporate Staff (CS) Y, again a request for the physician recapitulation of stay was made. On 3/12/20 at 8:54 AM, CS W stated that she will look in physician progress notes [REDACTED]. She did not know why the physician signed the Discharge Summary yesterday (3/12/20) almost 2 weeks after Resident #21's discharge. On 3/12/20 at 12:48 PM during an interview and record review with MD U, he confirmed that he wrote the Brief Summary (a page long, handwritten note) of Resident #21's stay today (3/12/20). He stated he usually did not write that long of a recapitulation of stay. MD U stated his usual recapitulation of stay was usually a few lines on a sheet that stated when the resident admitted , what diagnoses, and how the resident was discharged . He revealed he wrote this note today because it had been requested.
F 0625 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to give the bed hold policy to one resident's representative (Resident #64) of 1 resident reviewed for hospitalization , resulting in the potential for unwanted charges to be accrued or loss of facility bed. Findings include: According to a facility face sheet dated 3/11/2020 at 12:50 PM, Resident #64 was a [AGE] year-old admitted into the facility on [DATE] with the Diagnoses: [REDACTED]. A progress note for Resident #64 dated 1[DATE]19 at 10:35 (AM) Nurses' Notes Note Text: Resident sent to ER (emergency room) for evaluation and treatment r/t (related to) altered mental status and labs indicative of [MEDICAL CONDITION] per NP (nurse practitioner) after reviewing. When asked questions resident is delayed to answer. Resident refused breakfast however did accept small amounts of fluids; 200 cc (cubic centimeter) water bloused via PEG (feeding tube).[MEDICAL CONDITION] care provided and thick dark mucus suctioned from trach, SaO2 (oxygen level) ranged from 90-92 % (percent) this am [MEDICAL CONDITION] place. Resident agreeable to being sent to the ER for further treatment as recommended by NP that was in facility. UM (Unit Manager) contacted residents daughter as well as her husband and informed them of transfer. Report called to (Name of Staff) in ER to explain recent events over the last 24 hours. Review of submitted documentation reflected a written notation at the bottom of the pages for bed hold and written reason for transfer that Resident #64's spouse was present during discharge to the hospital. On 10/12/19 an admission Minimum Data Set Assessment reflected that Resident #64 had a Brief Interview for Mental Status score (BIMS) 14 out of 15 indicating she was cognitively intact. The bed hold policy and written reason for transfer had a handwritten note at the bottom of the notification that Resident #64's spouse was present at time of transfer. There had been time for preparation of bed hold policy and written reason for transfer before the hospitalization transfer. The husband had been called and had arrived at the facility before the resident transfer. On 3/12/20 at 9:16 AM during an interview with Unit Manager (UM) P, she stated she was here the day that Resident #64 was transferred to the hospital and confirmed that the resident's husband was present. She stated she wrote the comment on the bottom of the bed hold policy. She stated the Human Resources employee made the notation on the bottom of the written reason for transfer. She confirmed that the documentation was prepared before transfer and she revealed she did not know why the spouse was not given the policy and had not signed the policy. Both documents were sent by registered mail on 12/30/19.
F 0656 **Level of harm** - Actual harm **Residents Affected** - Few	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement Care Plan interventions and timely revise the plan of care for one resident (Resident #13) of two residents reviewed for Care Plans, resulting in hospitalization of one resident and the potential for all facility residents to not have Care Plan interventions implemented preventing reaching their goals and highest practicable level of function. Findings: The facility face sheet reflected Resident #13 was initially admitted to the facility 1/11/19 with [DIAGNOSES REDACTED]. Review of the current and resolved Care Plan for Resident #13 reflected, pages 26 and 27 of 52, Focus(Resident #13) has (potential fluid deficit) related to (r/t) mobility status, dependent on staff for meals, acute blood loss. This area of care reflected a Cancelled goal of, The resident will be free of symptoms of dehydration and maintain moist mucous membranes, good skin turgor. The Care Plan reflected the goal was initiated on 1/14/19 and cancelled on 1/16/19. Although this area was titled Cancelled it included a revision date of 10/15/19. A current goal of, The resident will not experience fluid volume deficits as evidenced by skin turgor within normal limits, moist mucous membranes, and lab values within normal limits for resident's baseline, initiated 1/14/19 and revised 10/15/19. Interventions included: Monitor and document intake and output per facility policy, Monitor/document/report nurse /MD as needed (prn) any signs or symptoms (s/s) of dehydration: decreased or no urine output, .recent/sudden weight loss. Initiated 1/14/19, Obtain and monitor lab/diagnostic work as ordered. Report results to MD and follow up as indicated initiated 1/14/19. Page 29 of 52 reflected a Focus of (Resident #13 has Diabetes Mellitus II, initiated 1/15/19, with a Goal of The resident will have no complications related to diabetes through the review date initiated 1/15/19, revised 10/15/19, with a review date of 6/3/20. The interventions included, Monitor/document/report to MD prn any s/s of [MEDICAL CONDITION]: increased thirst .weight loss, fatigue stupor ., initiated 1/15/19. Review of the medical record reflected discharge documentation from the hospital dated 12/11/19. The hospital documentation for Resident #13 reflected on 1[DATE] Resident #13 was transported to the hospital with the chief complaint of abnormal lab results. Resident #13 was admitted to the hospital and treated for [REDACTED]. Review of the Electronic Medical Record (EMR) for Resident #13 reflected a document titled, Hydration Risk completed 10/21/19. The document reflected, Based on answers above resident who scores 8 or higher may be at risk for dehydration. The document reflected a score of 10 for Resident #13. Section 2, titled, summary of evaluation, reflected Resident #13 was not at risk for dehydration. The comments portion of section 2 did not provide clarification of why Resident #13, whose score was greater than the at risk threshold, was determined to not be at risk for dehydration. During an interview conducted 3/12/20 at 8:48 AM, Unit Manager (UM) K reported Resident #13 was identified as having decreased fluid intake and received an infusion 3380 milliliters (ml) of fluid on 12/5/20. UM K reported after the fluid infusion Resident #13 had labs drawn on 1[DATE]. Review of the Basic Metabolic Panel blood test results of 12/6/19, for Resident #13 reflected a Blood Urea Nitrogen (BUN) result of 135 milligram per deciliter (mg/ml). The BUN normal range is 9 to 20mg/ml. A blood glucose level of 324 mg/di with a normal range of 65 to 99mg/dl The sodium level of Resident #13 was 168 milliosmoles per liter (mOsm/l) which is outside the normal range of 137 to 145 mOsm/l. A review of the British Medical Journal (2015), revealed normal serum osmolality is 275 to <295 mOsm/kg (milliosmoles per kilogram), impending dehydration is 295 to 300 mOsm/kg, and current dehydration is >300 mOsm/kg (Diagnostic accuracy of calculated serum osmolarity to predict dehydration in older people: adding value to pathology laboratory reports; Hooper, et al.; BMJ 2015 5(10); retrieved on 3/19/20 at (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC 68/). Therefore, using Resident #13's lab test results, dated 12/6/19, Resident #13 had a calculated (2(na+) + (BUN/2.8) + (Glu/18)) serum osmolarity of 402.2 mOsm/kg which indicated severe dehydration. Review of the Doctor's Orders and Medication Administration Record [REDACTED]. The medical record also reflected that the physician was to be contacted with any blood sugar test result greater than 400 mg/dl. Review of the medical record for Resident #13 reflected an average daily blood glucose level of 344 mg/dl from 11/24/20 to 1[DATE]. The

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235284	A. BUILDING _____ B. WING _____	03/12/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MEDILODGE OF MIDLAND	4900 HEDGEWOOD DR MIDLAND, MI 48640

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 0656 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 10) record reflected 2 successive days of blood glucose levels greater than 400mg/dl (11/30/19 -494mg/dl and 12/1/19 -458 mg/dl.) the medical record did not reveal that the physician had been contacted and informed of the trend of blood sugars consistently greater than 300 mg/dl or that the physician was notified of the blood sugar test result of 494 mg/dl on 11/30/20. The medical record of Resident #13 reflected on 12/1/19, the physician was contacted, and the blood sugar result of 458 mg/dl was conveyed. However, the focus of the communication was regarding, Resident has bright red hot to the touch left arm from hand to shoulder. The physician was also informed of, low grade fever, decrease appetite, resident is in pain, and mental status changes. The medical record reflected the resident was placed on an oral antibiotic. During an interview conducted 3/12/20 at 11:29 AM, Medical Director (MD) U reported Resident #13 requires total care and his medical condition is, very serious. MD U reported that it is our responsibility (the facility) to provide care for Resident #13. During the interview the history of blood glucose results of November and December 2019 was viewed on the EMR by UM U. MD U reported that he should have been contacted with the trend of blood sugar test results greater than 300mg/dl. MD U reported these consistent results of high sugars were indicative of dehydration, and that the sustained high glucose levels act as an osmotic diuretic. (high glucose levels inhibit the retention of intracellular fluid (ICF) resulting in [MEDICAL CONDITION] (high sodium level) and increased water loss from the body. (https://www.merckmanuals.com/ ./electrolyte-disorders/[MEDICAL CONDITION])). MD U reported, blood sugars are an indicator of sickness and infection, and that dehydration can be corrected if we can pick it up in time. MD U stated it is, our job to keep an eye on this. reported that Resident #13 was nutrition at risk and had dysphagia, difficulty in swallowing. MD U stated, I insisted we document his intake. During an interview conducted in the Dining Room on 3/12/20 at 11:21 AM, Certified Dietary Manager (CDM) N and Registered Dietician (RD) EE both reported they were familiar with Resident #13. It was reported that the Certified Nurse Aide staff record resident intake and output (amount of food and fluid consumed and waste from the body). The intake and output documentation for Resident #13 from 11/20/2019 to 12/6/19 was requested. A follow up interview with RD EE was conducted in the Conference Room on 3/12/20 at 11:56 AM. RD EE reported, in general, a resident's fluid intake should be 25 to 30 milliliters (ml) per kilogram per day. No documentation of the intake and output for Resident #13 was provided at this time or by the time of survey exit. Resident #13 was the only specific Resident discussed during this interview. The EMR reflected on 11/20/19 Resident #13 weighed 180.2 pounds (lbs.) or 81.9kg. The calculation provided by RD EE indicated Resident #13 required a daily fluid intake of approximately 2047 ml (81.9 kg x 25 ml) Review of the EMR for Resident #13 reflected a Progress Note entry on 11/29/19 at 10:54 AM. The entry reflected Resident #13 had, 871 ml fluid intake on average x 7 days. This reflected an average shortfall of fluids of 1176 ml per day for the previous 7 days. This entry concluded with, No new recommendations at this time. Continue to monitor. The medical record also reflected a weight loss of 13.2 lbs. from 181.4 lbs. on 11/27/19 to 168.2 lbs. on 12/4/19. This Care Plan reflected the addition of a Focus area on 12/5/19, one day prior to hospitalization that reflected the administration of subcutaneous fluid and indicated 3380 ml received and completed. On 12/13/19 - started oral hydration encouragement (every)2 (hours), post-hospitalization . The Care Plan and medical record for Resident #13 did not reflect the status of Resident #13 had been monitored for changes as outlined in the Care Plan. The medical record did not reflect the documentation of: intake, blood glucose test results, weight loss, and signs and symptoms of [MEDICAL CONDITION] and fluid volume deficit had been noted and evaluated by skilled staff to keep the physician apprised of the Resident's status. The medical record did not reflect the Care Plan interventions had been timely reviewed, implemented, or revised.
F 0684 **Level of harm -** Actual harm **Residents Affected -** Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to identify, timely assess and monitor for dehydration for one vulnerable and physically compromised resident (Resident #13) out of 2 Residents reviewed for hydration, resulting in hospitalization and the potential for all facility residents to have dehydration unrecognized by skilled staff . Findings: The facility face sheet reflected Resident #13 was initially admitted to the facility 1/11/19 with [DIAGNOSES REDACTED]. Review of the medical record reflected discharge documentation from the hospital dated 12/11/19. The hospital documentation for Resident #13 reflected on 1[DATE] Resident #13 was transported to the hospital with the chief complaint of abnormal lab results. Resident #13 was admitted to the hospital and treated for [REDACTED]. Review of the Electronic Medical Record (EMR) for Resident #13 reflected a document titled, Hydration Risk completed 10/21/19. The document reflected, Based on answers above resident who scores 8 or higher may be at risk for dehydration. The document reflected a score of 10 for Resident #13. Section 2, titled, summary of evaluation, reflected Resident #13 was not at risk for dehydration. The comments portion of section 2 did not provide clarification of why Resident #13, whose score was greater than the at risk threshold, was determined to not be at risk for dehydration. During an interview conducted 3/12/20 at 8:48 AM Unit Manager (UM) K reported Resident #13 was identified as having decreased fluid intake and received an infusion 3380 milliliters (ml) of fluid on 12/5/20. UM K reported after the fluid infusion Resident #13 had labs drawn on 1[DATE]. Review of the Basic Metabolic Panel blood test results of 12/6/19, for Resident #13 reflected a Blood Urea Nitrogen (BUN) result of 135 milligram per deciliter (mg/ml). The BUN normal range is 9 to 20mg/ml. A blood glucose level of 324 mg/dl with a normal range of 65 to 99mg/dl The sodium level of Resident #13 was 168 milliosmoles per liter (mOsm/l) which is outside the normal range of 137 to 145 mOsm/l. A review of the British Medical Journal (2015), revealed normal serum osmolality is 275 to <295 mOsm/kg (milliosmoles per kilogram), impending dehydration is 295 to 300 mOsm/kg, and current dehydration is >300 mOsm/kg (Diagnostic accuracy of calculated serum osmolarity to predict dehydration in older people: adding value to pathology laboratory reports; Hooper, et al.; BMJ 2015 5(10); retrieved on 3/19/20 at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC 68/). Therefore, using Resident #13's lab test results, dated 12/6/19, Resident #13 had a calculated (2(na+) + (BUN/2.8) + Glu/18)) serum osmolarity of 402.2 mOsm/kg which indicated severe dehydration. Review of the Doctor's Orders and Medication Administration Record [REDACTED]. The medical record also reflected that the physician was to be contacted with any blood sugar test result greater than 400 mg/dl. Review of the medical record for Resident #13 reflected an average daily blood glucose level of 344 mg/dl from 11/24/20 to 1[DATE]. The record reflected 2 successive days of blood glucose levels greater than 400mg/dl (11/30/19 -494mg/dl and 12/1/19 -458 mg/dl.) the medical record did not reveal that the physician had been contacted and informed of the trend of blood sugars consistently greater than 300 mg/dl or that the physician was notified of the blood sugar test result of 494 mg/dl on 11/30/20. The medical record of Resident #13 reflected on 12/1/19, the physician was contacted, and the blood sugar result of 458 mg/dl was conveyed. However, the focus of the communication was regarding, Resident has bright red hot to the touch left arm from hand to shoulder. The physician was also informed of, low grade fever, decrease appetite, resident is in pain, and mental status changes. The medical record reflected the resident was placed on an oral antibiotic. During an interview conducted 3/12/20 at 11:29 AM, Medical Director (MD) U reported Resident #13 requires total care and his medical condition is, very serious. MD U reported that it is our responsibility (the facility) to provide care for Resident #13. During the interview the history of blood glucose results of November and December 2019 was viewed on the EMR by UM U. MD U reported that he should have been contacted with the trend of blood sugar test results greater than 300mg/dl. MD U reported these consistent results of high sugars were indicative of dehydration, and that the sustained high glucose levels act as an osmotic diuretic. (high glucose levels inhibit the retention of intracellular fluid (ICF) resulting in [MEDICAL CONDITION] (high sodium level) and increased water loss from the body. (https://www.merckmanuals.com/ ./electrolyte-disorders/[MEDICAL CONDITION])). MD U reported, blood sugars are an indicator of sickness and infection, and that dehydration can be corrected if we can pick it up in time. MD U stated it is, our job to keep an eye on this. reported that Resident #13 was nutrition at risk and had dysphagia, difficulty in swallowing. MD U stated, I insisted we document his intake. During an interview conducted in the Dining Room on 3/12/20 at 11:21 AM, Certified Dietary Manager (CDM) N and Registered Dietician (RD) EE both reported they were familiar with Resident #13. It was reported that the Certified Nurse Aide staff record resident intake and output (amount of food and fluid consumed and waste from the body). The intake and output documentation for Resident #13 from 11/20/2019 to 12/6/19 was requested. A follow up interview with RD EE was conducted in the Conference Room on 3/12/20 at 11:56 AM. RD EE reported, in general, a resident's fluid intake should be 25 to 30 milliliters (ml) per kilogram per day. No documentation of the intake and output for Resident #13 was provided at this time or by the time of survey exit. Resident #13 was the only specific Resident discussed during this interview. The EMR reflected on 11/20/19 Resident #13 weighed 180.2 pounds (lbs.) or 81.9kg. The calculation provided by RD EE indicated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235284	A. BUILDING _____ B. WING _____	03/12/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MEDILODGE OF MIDLAND	4900 HEDGEWOOD DR MIDLAND, MI 48640

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 0684 **Level of harm** - Actual harm **Residents Affected** - Few	(continued... from page 11) Resident #13 required a daily fluid intake of approximately 2047 ml (81.9 kg x 25 ml). Review of the EMR for Resident #13 reflected a Progress Note entry on 11/29/19 at 10:54 AM. The entry reflected Resident #13 had, 871 ml fluid intake on average x 7 days. This reflected an average shortfall of fluids of 1176 ml per day for the previous 7 days (2047ml - 871ml = 1176ml). This entry concluded with, No new recommendations at this time. Continue to monitor. The medical record also reflected a weight loss of 13.2 lbs. from 181.4 lbs. on 11/27/19 to 168.2 lbs. on 12/4/19. During a telephone interview conducted 3/10/20 at 11:08 AM, Responsible Party (RP) SS reported Resident #13 was hospitalized for [REDACTED]. RP SS stated, if (Resident #13) was being seen weekly by a Doctor, how could this have happened?. RP SS reported a belief that so much attention was being given to a chronic wound that hydration was ignored. RP SS stated that the hospitalization , Should not have happened.
F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**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** Based on observation, interview and record review, the facility failed to follow safety standards (prevent accidents) for 6 Residents (Residents #2, #35, #43. #45, #365, and #367), resulting in the potential for injury when residents were moved in wheelchairs without footrests, transferred without gait belts, transferred without all needed equipment in place, and safety equipment was not in place to prevent falls with injuries. Findings include: Resident #365 According to Resident #365's Minimum Data Set MDS) nursing assessment tool, dated 3/5/19, she was a [AGE] year-old female admitted on [DATE] and her [DIAGNOSES REDACTED]. Her Brief Interview of Mental Status (BIMS) score was 3/15 (severely mentally impaired). On [DATE] at 11:34 AM, Certified Nurse Aide (CNA) C was assisting Resident #365's husband transfer Resident #365 from her bed to her wheelchair. CNA C was going to get a lift to transfer Resident #365 but Resident #365 informed CNA C she was an assist of 2. CNA C and Resident #365 stood at the resident's side and lifted her from her armpits (no gait belt). When Resident #365 was in her chair CNA C said her gait belt must be in therapy. The gait belt was sitting in a chair in the resident's room. The Surveyor asked why CNA C did not know how Resident #365 transferred and she said she works nights and was not familiar with the Residents day routines. CNA C did not indicate she should have reviewed the Residents care guide. Review of Resident #365's activities of daily living care plan, revised on 3/4/20, revealed she was a transfer with 2-person assistance. During an interview with Corporate Consultant (CC) Y, CC Y confirmed a gait belt should have been used when assisting a resident transfer. CC Y was not able to locate a facility policy for gait belt use but confirmed it was a standard of care and staff are trained to use a gait belt with transfers. Resident #367 According to Resident #367's MDS, dated [DATE], she was an [AGE] year-old female admitted on [DATE]. She was coded as being severely cognitively impaired and unable to verbally communicate. Resident #367 was transferred from her bed to her wheelchair with the electronic lift and a full body sling. CNA's C and G did the transfer. The sling did not have the plastic supports in the head piece. The Surveyor asked CNA C and CNA G where the plastic supports for the head were located and they said they were in the shower room. The Surveyor asked when they should use the plastic supports and they said only for Residents that do not have head control. On 3/11/20 at 12:31 PM, the Surveyor asked the CC L for the manual on the use of the lifts with slings and to locate the instructions for when the plastic supports were to be used in the head section. CC L returned with a manual, but it did not give instructions or reference the plastic supports in the head section. CC L verbally confirmed that the plastic supports are to be used at all times and staff will be trained. Review of the manufacture instructions, dated 11/2019, for Passive Clip Slings located online instructions for sling use on page 5, Part Designation drawing referred to the plastic head pieces as Stiffeners and the diagram showed the stiffeners and the pockets for the stiffeners. The instructions read, If any part is missing or damaged - Do NOT use the sling. Confirms the plastic head supports or stiffeners are to be in the sling when ever it is in use. Resident #43 According to a facility face sheet, dated 3/11/20, Resident #43 was a [AGE] year-old admitted into the facility on [DATE] with the Diagnoses: [REDACTED]. On 3/11/20 at 5:26 PM during an observation of Resident # 43 in the D hall, Restorative Aide (RA) T was observed to be propelling the resident in her broda chair toward the nurse's station. No footrests were observed to be on the chair. On 3/11/20 at 5:27 PM during an interview with UM P, she confirmed that the resident observed was Resident #43. When asked, UM P confirmed that residents were not to be propelled in a chair without the footrests on. On 3/11/20 at 5:38 PM during an interview with RA T, he stated he thought Resident #43 was propelling with him with her feet. He stated he can propel a resident if walking alongside them. According to Mosby's Textbook for Long-Term Care Nursing Assistants 7th edition, in the Wheelchair Safety Section, Make sure the person's feet are on the foot plates (wheelchair footrests or pedals) before moving the chair. The person's feet must not touch or drag on the floor when the chair is moving. Never push a person in a wheelchair without feet resting on the footplate's (footrests or foot pedals). Resident #35 Resident #35 admitted to the facility on [DATE]. The Minimum Data Set ((MDS) dated [DATE], reflected Resident #35 was diagnosed with [REDACTED].#35 did not walk and was cognitively impaired. On [DATE] at 11:42 AM, Family Member (FM) PP was observed by the central nursing station pushing Resident #35 in a wheelchair that did not have foot pedals in place. FM PP reported the foot pedals were in a bag on the back of the chair. FM PP reported he was aware he is not supposed to push the wheelchair without foot pedals but does it anyway. Three staff members were present at the nursing station and appeared to be aware of the interaction with FM PP. Licensed Practical Nurse (LPN) M, who was at the nurse's station, reported Resident #35 did not like to have foot pedals on her wheelchair. LPN M did not voice a concern with residents being transported without foot pedals in place. Resident #2 Resident #2 admitted to the facility on [DATE], the MDS dated [DATE] reflected Resident #2 was diagnosed with [REDACTED]. The MDS reflected Resident #2 used a wheelchair and a walker and was cognitively impaired. On [DATE] at 11:39 AM, LPN Q was observed pushing Resident #2 in his wheelchair that did not have foot pedals in place. LPN Q pushed Resident #2 approximately twenty feet into his room. On 3/10/20 at 12:12 PM, Certified Nurse Aid (CNA) A was observed pushing Resident #2 from his room into the hall. The wheelchair of Resident #2 did not have foot pedals in place and the Resident's feet were sliding across the floor. Resident #43 Resident #43 admitted to the facility on [DATE], the MDS dated [DATE], reflected Resident #43 was diagnosed with [REDACTED]. The MDS reflected Resident #43 did not walk and was cognitively impaired. On [DATE] at 12:25 PM, CNA D was observed holding the hand of Resident #43 and was pulling her in her Geri chair into the Dining Room. The Geri chair did not have foot pedals or a leg rest in place and the Resident's feet were on the floor. CNA D was in front and facing forward as CNA D pulled Resident #43 into the Dining Area. . In an interview conducted on 3/12/20 at 8:48 AM, Unit Manager (UM) K reported that foot pedals are expected to be in place when transporting a resident. UM K reported that it was acceptable to push a resident whose foot pedals were not in place if the staff member walked beside the wheelchair and was watching the resident's feet.
F 0725 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure adequate staffing to meet the needs of twelve facility residents (8 of 8 Residents of the Confidential Group, Residents #47, #2, #365, and 1 confidential resident) and failed to monitor staff for burn out and for allowing to persist an environment of openly displayed frustration by staff resulting in undignified care, unmet resident needs, and the potential for all facility residents to have unmet needs. During an interview conducted 3/10/20 at 8:53 AM Certified Nurse Aide (CNA) RR reported the resident acuity is too high on the B Hall for staff to be able to meet the resident's needs. CNA RR reported that there two CNA's and twenty-eight residents on the B hall. CNA RR reported that she, can't expect the nurse to help because she has twenty-eight people to take care of and pass pills to. CNA RR reported the CNA's are told that the staffing meets the State minimums but that the residents don't get the grooming they should and may have to wait until later to get shaved or cleaned. CNA RR reported that, the residents that cannot speak for themselves just don't get the care they should get. Resident #2 The Minimum Data Set ((MDS) dated [DATE] reflected that Resident #2 was admitted to the facility 1/14/19.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235284	A. BUILDING _____ B. WING _____	03/12/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MEDILODGE OF MIDLAND	4900 HEDGEWOOD DR MIDLAND, MI 48640

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 0725 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	(continued... from page 12) Section C of the MDS reflects the Resident's cognition is severely impaired and resident is rarely/never understood. The MDS Functional Status section reflected Resident #2 requires extensive assistance with personal hygiene. On the B Hall on 3/10/20 at 12:12 PM, Resident #2 was observed to be in his wheelchair as he was pushed from his room and placed in the hallway. Resident #2 was observed to be dressed but was not shaved. During an interview conducted 3/10/20 at 12:14 PM, CNA A reported staff can mostly meet resident needs. CNA A reported that the administration and the Director of Nursing have been told more staff is needed, but never seems to get any better. During the recertification survey a telephone interview was conducted with Confidential Witness (CW) NN whose mother is a resident at the facility. CW N reported she preferred a telephone interview because she feared her mother would suffer retribution if she were observed talking to the survey team. CW NN reported she feels her mother is intimidated by staff to say what staff want to hear. CW NN reported an incident when CW NN felt intimidated by staff when she had a concern for her mother and raised it with two nurses. CW NN reported both nurses started yelling at her. CW NN reported the Director of Nursing (DON) came to her and yelled at her for the treatment of [REDACTED]. CW NN reported while in the hall during a visit a resident had asked a staff member to take her to the bathroom and that the staff member responded out loud, you're fifth in line. CW NN reported the facility does not have enough staff to meet the needs of the residents and highlighted her mother's needs. CW NN reported her mother used to be able to walk and was walked regularly. CW NN reported because of the demands on staff they do not have the time to regularly walk residents, this lack of exercise and range of motion has caused her mother to be, forced into a wheelchair. CW NN reported she has found her mother soiled and neglected and that she doesn't get regular showers. CW NN reported her mother's shower day frequently changes. On 3/11/2020 at 10:02 AM, Staff P was asked how the facility was staffed. Staff P stated, Terrible. Staff P revealed the same staff must stay over because of facility mandating staff to remain to have enough staff. Staff P revealed that resident needs were being met, but staff was unable to do the extra things because many residents were experiencing pain, had behaviors and had memory issues that required a lot of their time. On 3/11/2020 at 10:05 AM, Staff DD stated facility staffing was a struggle. Many of the nurse's aides (CNA) were working double shifts, multiple days in a row. Staff DD stated that call-in's (staff calling in sick) was a big problem. When asked if resident needs were being met, Staff DD stated the staff was doing the best they can. Staff DD stated that staffing was good until there were call-ins. Staff DD stated there was staff burnout, but they pull it together and care for the residents. On 3/11/2020 at 10:10 AM, during an interview with Staff GG when asked how the facility was staffed, she laughed. Staff GG stated they felt staff needed more assistance. Staff GG was observed to be busy redirecting a wandering resident (attempting to wander into other rooms) with dementia with a communication barrier. Staff GG stated it was just them and a nurse for the hall. On 3/11/2020 at 10:19 AM, during an interview with Staff HH she revealed that facility staffing was not adequate. Staff HH stated they didn't feel the basic needs of the residents were being met. Staff HH stated the past weekend, there was only 2 nurses instead of the usual 3. On 3/11/2020 at 10:22 AM, during an interview with Staff II, they revealed facility staffing was Poor, to be honest. Staff II revealed staff was staying over to the next shift. Staff II stated they stayed over during the weekend to help with showers. Staff II stated last weekend there was 2 nurses instead of the usual 3 nurses. Staff II stated that the restorative aide often had to be utilized to assist with showers. Resident #365 According to Resident #365's Minimum Data Set MDS), nursing assessment tool dated 3/5/19 she was a [AGE] year-old female admitted on [DATE] and her [DIAGNOSES REDACTED]. Her Brief Interview of Mental Status (BIMS) score was 3/15 (severely mentally impaired). During an interview with facility Social Worker (SW) B on 3/11/20 at 10:39 AM, Resident #365's advanced directive was reviewed. SW B confirmed Resident #365 was still listed as her own responsible party. The facility had assessed Resident #365 as being severely mentally impaired, but had not assessed her capacity to understand medical decisions or complex information. During an interview with Resident #365's husband on 03/10/20 at 08:52 AM, her husband said his wife has suffered from a [MEDICAL CONDITION] for the last [AGE] years and he was her medical decision maker (facility records did not have this information). When Resident #365's husband was asked about her care his only concern was staffing. He said it takes 2 people to take her to the toilet and there have been several times that it takes them too long and she soils herself with BM (bowel movement). Resident #47 A review of Resident #47's Admission Record, dated 3/11/20, revealed Resident #47 was a [AGE] year-old resident admitted to the facility on [DATE]. In addition, Resident #47's Admission Record revealed Resident #47 had multiple [DIAGNOSES REDACTED]. A review of Resident #47's MDS, dated [DATE], revealed Resident #47 had a BIMS score of 15 which revealed Resident #47 was cognitively intact. During an interview on [DATE] at 11:16 AM, Resident #47 stated he had reported an allegation that a nursing aide had been rude to him (told him to chill out) when he asked for assistance with personal care and threatened to knock over his flowers or crosses if she sees them on his bedside table. Resident #47 stated he reported it to management (the Director of Nursing (DON) and Nursing Home Administrator (NHA) when asked who specifically) and was told the nursing aides are really busy, have other residents besides him, and it's a big place for them to cover.
F 0726 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.** Based on interview and record review, the facility failed to assess two Certified Nurse's Aides (CNA's) (CNA C and D) for initial competency upon hire reviewed by a registered nurse, resulting in the potential for unmet learning needs for safe resident care. Findings include: On 3/12/2020 at 10:30 AM during an interview and record review with Human Resource (HR) S, it was revealed that CNA C completed her Certified Nursing Assistant Annual Competency Skills Checklist dated 7/23/19 was signed by a peer. HR staff S confirmed this. This document reflected competency checks on such topics as documentation, infection control, bathing, vital signs, nutrition and hydration, dressing and grooming, skin care, transfers and mobility, policies and procedures on nursing, changes of condition, safety and health, weighing and measuring of residents. On 3/12/2020 at 10:30 AM during an interview and record review with Human Resource (HR) S, it was revealed that CNA D completed her Certified Nursing Assistant Annual Competency Skills Checklist dated 7/31/19 was signed by a peer. HR staff S confirmed this. On 3/12/20 at 11:55 PM during an interview with corporate staff X, Y and Z, they reflected they were not sure if a Registered Nurse (RN) needed to sign the initial competency evaluation of Certified Nurse's Aide. The policy regarding assessment of CNA competency was requested. On 3/12/20 at 12:20 PM during an interview and record review with Corporate X, he presented a facility policy titled, Competency Based Orientation dated (no date) and he confirmed that a supervisor must sign Certified Nurse's Aides Competencies and that would be an RN. Review of a facility submitted document titled, Competency-Based-Orientation (no date observed) reflected, Nursing orientation is defined as a transition period when new staff members are assisted by various peer groups to accomplish certified objectives congruent with policies and procedures. This competency-based orientation is designed to enable the adult learner to base nursing practice on the philosophy of nursing and its standards of care. The nursing process is used to provide care to residents in a dynamic resident/family environment while allowing development as a professional nursing employee .Certified Nursing Aides: Demonstrate accountability and responsibility in the Nursing Assistant role .demonstrate skill in performing tasks designed in the Nursing Assistant job description .The end result is competent staff delivering quality resident care.
F 0732 **Level of harm -** Potential for minimal harm **Residents Affected -** Many	**Post nurse staffing information every day.** Based on interview and record review, the facility failed to update the facility staffing posting for each shift resulting in the inability for residents and visitors to ascertain how many facility staff was present for the facility census. Findings include: Review of two facility postings titled, Direct Care Staffing hours for 3/7 and 3/8/2020 reflected a prefilled document that did not contain any changes due to staffing change and resident census change for all 3 shifts. 3/8/2020 did not reflect the facility census for each shift, this was blank. On 3/12/20 at 9:56 AM during an interview and record review with Scheduler R, she was asked who updated the staffing report for each shift on the weekend? Schedule R revealed that nurses updated this posting. Scheduler R confirmed she prefilled the staffing document with registered nurses, licensed practical nurses and certified nurse's aides' numbers and hours. When asked, Scheduler R reviewed Saturday

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235284	A. BUILDING _____ B. WING _____	03/12/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MEDILODGE OF MIDLAND	4900 HEDGEWOOD DR MIDLAND, MI 48640

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 0732 **Level of harm** - Potential for minimal harm **Residents Affected** - Many	(continued... from page 13) 3/7 and Sunday 3/8/2020 posting and she confirmed it did not look like the postings had been updated. Review of these documents reflected no change in number of staff or hours of staff even though there had been staff call ins. Scheduler R stated an on-call nurse came in that weekend, but she wouldn't be reflected on the nursing hours.
F 0740 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure each resident must receive and the facility must provide necessary behavioral health care and services.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide the necessary behavioral health care services for 1 of 22 residents (Resident #369), resulting in Resident #369 not been assessed and monitored for his anxiety. Findings include: Resident #369 According to Resident #369's face sheet, dated 3/10/20, he was [AGE] year-old male admitted to the facility on [DATE] and had [DIAGNOSES REDACTED]. He was his own responsible party. Resident #369 was observed in bed on 3/9/10 at 3:51 PM. Resident #369 complained of anxiety and sleep problems. Resident #369 said he was not able to take the medications he was taking at home for his anxiety because of liver problems. Resident #369 said his anxiety was getting worse and he was not able to sleep well at night. During an interview with the facility Social Worker (SW) B on 3/11/20 at, SW B was aware Resident #369 had anxiety and the physician had started him on [MEDICATION NAME] (anti-anxiety medication) on 3/2/20. She was aware he was not happy with the dose he was provided as he had said he took 100 mg (milligrams) at home and was allowed 25 mg three times a day now. SW B was not able to locate a physician note that explained why [MEDICATION NAME] was started on 3/2/20 or any instructions or concerns with monitoring for the effectiveness of the [MEDICATION NAME]. SW B said she had not started any assessment or monitoring for the [MEDICATION NAME].
F 0745 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide medically-related social services to help each resident achieve the highest possible quality of life.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide social services for 10 of 22 residents (Resident #10, Resident #22, Resident #40, Resident #57, Resident #58, Resident #59, Resident #63, Resident #365, Resident #367, and Resident #370), resulting in family members or Durable Power of Attorneys (DPOA's) signing advanced directive/code status paperwork for residents that had not been deemed unable to make medical decisions, Resident #40's medical decision-making capability not being re-evaluated after a considerable amount of time, the facility not having medical DPOA documentation for residents (Resident #40 and Resident #63), the facility not knowing whether a resident's family has been to court seeking guardianship or where the guardianship process was for a resident (Resident #58 and Resident #370), and the potential for resident wishes/desires not being honored. Findings include: During an interview of 3/11/20 at 10:39 AM, Social Worker (SW) B stated the next of kin can sign a resident's code status paperwork, per their policy, even if the resident was their own responsible party. She stated she doesn't do the code status on admission. A nurse probably does that. During a second interview on 03/11/20 at 11:46 AM, SW B stated she could not locate the policy that stated next of kin can sign code status. SW B stated, It's the responsible party that signs the code status. SW B stated if the resident is their own responsible party, they should sign their code status. SW B stated the expectation was code status was reviewed during care conferences, on admission, and quarterly. She stated she reviewed those. Resident #40 A review of Resident #40's Admission Record, dated 3/11/20, revealed Resident #40 was an [AGE] year-old resident admitted to the facility on [DATE]. In addition, Resident #40's Admission Record revealed Resident #40 had multiple [DIAGNOSES REDACTED]. A review of Resident #40's Minimum Data Set (MDS) (a tool used for assessing a resident's care needs), dated 2/3/20, revealed Resident #40 had a Brief Interview for Mental Status (BIMS) (a scale used to determine a resident's cognitive status) score of 0 which revealed Resident #40 was severely cognitively impaired. A review of Resident #40's Durable Power of Attorney (DPOA) paperwork, dated 10/15/12, failed to specifically address specific medical powers (e.g. what to do in the event of respiratory and/or heart failure, make medical treatment decisions), except the DPOA may sign documents related to release of medical records and share those records with whomever they deemed appropriate. A review of Resident #40's Determination of Inability to Participate In Medical Treatment Decisions, dated 7/19/16, revealed Resident #40 was deemed unable to make medical decisions on 7/25/16 by a second physician or licensed psychologist (approximately 3 years and 8 months prior to this survey). During a second interview on 03/11/20 at 11:46 AM, SW B stated Resident #40 was not his own responsible party and the DPOA had been activated. SW B stated, As long as nothing changes, we don't have to do anything with it (re-evaluating medical decision-making ability). SW B was shown Resident #40's DPOA paperwork and verbally agreed medical decision-making abilities (except release of medical records) were not specifically addressed in this paperwork. SW B was requested to provide any documentation specifying Resident #40's DPOA could make medical treatment decisions for Resident #40. As of the time of the completion of the survey and exit from the facility, the facility failed to provide this requested documentation. Resident #57 A review of Resident #57's MDS, dated [DATE], revealed Resident #57 was a [AGE] year-old resident admitted to the facility on [DATE] with multiple [DIAGNOSES REDACTED].g. [MEDICAL CONDITIONS], hardening of the arteries). In addition, Resident #57's MDS revealed Resident #57 had a BIMS score of 15 which indicated Resident #57 was cognitively intact. A review of Resident #57's Advance Directives/ Medical Treatment Decisions form, dated 2/3/20, revealed Resident #57's DPOA had signed Resident #57 as a Do Not Resuscitate (DNR) (in the event Resident #57's heart or lungs stop working). A review of Resident #57's medical records, dated 2/1/20 (admission) to 3/11/20, failed to reveal that Resident #57 had been deemed unable to make medical decisions and Resident #57's DPOA had been activated. During a second interview on 03/11/20 at 11:46 AM, SW B stated, Resident #57 scores well on his BIMS. He's his own responsible party. SW B further stated, When I looked at it (Resident #57's Advance Directives/ Medical Treatment Decisions form), I believe his mother signed his code status paperwork (it was actually Resident #57's sister/DPOA). Resident #58 A review of Resident #58's Admission Record, dated 3/11/20, revealed Resident #58 was a [AGE] year-old resident admitted to the facility on [DATE] with multiple [DIAGNOSES REDACTED]. A review of Resident #58's MDS, dated [DATE], revealed Resident #58 had severely impaired cognitive decision-making skills. A review of Resident #58's medical record, dated 7/22/19 to 3/11/19, failed to reveal if Resident #58 had DPOA documentation or a designated person who could make medical decisions if Resident #58 was deemed unable to make medical decisions. A review of Resident #58's medical record, dated 7/22/19 to 3/11/19, failed to reveal if Resident #58 had been deemed unable to make medical decisions even though Resident #58 had severely impaired cognitive decision-making skills. A review of Resident #58's Advance Directives/ Medical Treatment Decisions form, dated 10/10/19, revealed an illegible signature, without a printed name, authorizing efforts to be made to prolong Resident #58's life and to provide life-sustaining treatment (Full Code). The signature did not appear to be consistent with Resident #58's name. During a second interview on 03/11/20 at 11:46 AM, SW B stated, Resident #58 was not their own responsible party. SW B stated the she's encouraged Resident #58's family to apply for guardianship. However, SW B stated she had no evidence that Resident #58's family had actually applied for guardianship through the courts or where in the process Resident #58's family was for guardianship. In addition, SW B stated Resident #58's fiance has been making medical decisions for him at this time and has been since his admission. SW B stated she could not read the signature on the Advance Directives/ Medical Treatment Decisions form, but assumed it was Resident #58's fiance's signature. Resident #63 A review of Resident #63's Admission Record, dated 3/11/20, revealed Resident #63 was an [AGE] year-old resident admitted to the facility on [DATE]. In addition, Resident #63's Admission Record revealed Resident #63 had multiple [DIAGNOSES REDACTED]. A review of Resident #63's MDS, dated [DATE], revealed Resident #63 had a BIMS score of 5 which indicated Resident #63 was severely cognitively impaired. A review of Resident #63's Advance Directives/ Medical Treatment Decisions form, dated 2/18/20, revealed Resident #63's daughter had signed Resident #63 as a Do Not Resuscitate (DNR) (in the event Resident #63's heart or lungs stop working). A review of Resident #63's medical record, dated 3/7/19 to 3/11/20, failed to reveal if Resident #63 had designated a medical DPOA (no medical DPOA documentation was located in Resident #63's medical record) in the event Resident #63 was deemed unable to make medical decisions. A review of Resident #63's medical record, dated 3/7/19 to 3/11/20, did revealed Resident #63's daughter was designated as his financial DPOA (able to make financial decisions) in the event Resident #63 was deemed unable to make financial decisions. A review of Resident #63's medical record, dated 3/7/19 to 3/11/20, failed to reveal that Resident #63 had been deemed unable to make medical, or financial, decisions. During a second interview on 03/11/20 at 11:46 AM, SW B stated she believed Resident #63 was his own responsible party. SW B stated she had requested Resident #63's daughter

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235284	A. BUILDING _____ B. WING _____	03/12/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MEDILODGE OF MIDLAND	4900 HEDGEWOOD DR MIDLAND, MI 48640

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 0745 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 14) provide a copy of the medical DPOA to the facility. However, SW B stated she did not have any evidence of when, or if, this had actually occurred. Resident #59 According to Resident #59's face sheet she was a [AGE] year-old female admitted to the facility on [DATE] and had [DIAGNOSES REDACTED]. Resident #59 was her own responsible party. During an interview with facility Social Worker (SW) B on 3/11/20 at 10:39 AM, Resident #59's advanced directive was reviewed. SW B confirmed Resident #59's last Brief Interview of Mental Status (BIMS) score was 12/15 (normal cognition) and Resident #59's face sheet was correct as she was still her own responsible party. The Surveyor asked why Resident #59 did not sign her own advanced directive and SW B said the facility policy is that the next of kin can sign the advanced directive. The Surveyor requested a copy of the facility policy and when SW B returned she said she was not correct and Resident #59 should have signed her own advanced directive. According to Resident #59's Advanced Directive/Medical Treatment Decisions she was made a Do Not Resuscitate on 2/14/20. However, the signature line for resident was blank and there was a signature (not Resident #59) on the line for Legal Representative was signed, but not by Resident #59. Resident #365 According to Resident #365's Minimum Data Set MDS) (nursing assessment tool), dated 3/5/19, she was a [AGE] year-old female admitted on [DATE] and her [DIAGNOSES REDACTED]. Her Brief Interview of Mental Status (BIMS) score was 3/15 (severely mentally impaired). During an interview with facility Social Worker (SW) B on 3/11/20 at 10:39 AM, Resident #365's advanced directive was reviewed. SW B confirmed Resident #365 was still listed as her own responsible party. The facility had assessed Resident #365 as being severely mentally impaired, but had not assessed her capacity to understand medical decisions or complex information. During an interview with Resident #365's husband on 03/10/20 at 08:52 AM, her husband said his wife has suffered from a [MEDICAL CONDITION] for the last [AGE] years and he was her medical decision maker (facility records did not have this information). Resident #367 According to Resident #367's MDS, dated [DATE], she was an [AGE] year-old female admitted on [DATE]. She was coded as being severely cognitively impaired and unable to verbally communicate. During an interview with facility Social Worker (SW) B on 3/11/20 at 10:39 AM, SW B said Resident #367 was still her own responsible party. SW B said Resident #367's daughter has applied to be her guardian, but she did not know when she did that and did not have any documentation to confirm the daughter had filed the correct paperwork. Resident #370 According to Resident #370's face sheet, dated 3/10/20, she was a [AGE] year-old female admitted to the facility on [DATE]. She was her own responsible party. During an interview with the SW B on 3/11/20 at 12:03 PM, SW B said Resident #370's Brief Interview of Mental Status (BIMS) score was 3/15. SW B said they are working with adult and child protective services for Resident #370. SW B was aware the hospital paperwork indicated Resident #370 had a family member as her guardian, but said that was not confirmed. SW B said the facility was working on guardianship, but did not have any documentation to show that had petitioned the court for guardianship. The facility did not have any documentation to show they had assessed Resident #370 for her capacity to understand information. Resident #10 Resident #10 was admitted to the facility 3/7/18 with [DIAGNOSES REDACTED]. Review of the Minimum Data Set ((MDS) dated [DATE] reflected Resident #10 had a Brief Interview for Mental Status (BIMS) score of 7 out of 15 which reflected the Resident was severely cognitively impaired. In a telephone interview conducted 3/10/20 at 3:12 PM Responsible Party (RP) KK for Resident #10 reported she has not been informed of any Care Conference meetings in quite some time. RP KK reported for the last Care Conference she had to search all over the facility before finding SW B and when she did RP KK reported SW B told her she forgot about the Care Conference. RP KK reported she does not recall any other discipline being represented at a Care Conference. On 3/11/20 at 10:34 AM Social Worker (SW) B reported an initial Care Conference is conducted shortly after admission to the facility and then quarterly after that. SW B reported the full Interdisciplinary Team (IDT) is invited to each Care Conference. SW B reported that she documents the Care Conferences and speaks to all disciplines in this documentation. SW B was asked to provide the documentation of the Care Conferences for Resident #10. During an interview conducted 3/12/20 at 8:48 AM Unit Manager (UM) K reported Nursing, along with Activities and Dietary, is always represented at Care Conferences. UM K reported she usually finds out during the morning meeting that a Care Conference is scheduled for that day. UM K did not report any problems of attending these Care Conferences despite the short notice. On 3/11/20 at 2:40 PM SW B provided Resident #10 documentation of an initial Care Conference on 3/9/18, 6/28/18. and lastly, 3/28/19. No other documentation was provided of quarterly Care Conferences since 3/28/19. Review of the documentation for the Care Conference conducted 3/28/19 reflected that Social Services was the only disciple represented and no other discipline was present for the conference. Resident #22 Resident #22 was originally admitted to the facility 2/3/11 with a [DIAGNOSES REDACTED]. Review of the Minimum Data Set ((MDS) dated [DATE] (the pertinent MDS for this citation) reflected Resident #22 was severely cognitively impaired. Review of the Advance Directive for Resident #22 reflected it was dated 4/10/2018 and witnessed by a Licensed Practical Nurse (LPN). The Advance Directive reflected the box was checked for I do not choose to formulate or issue any Advanced Directive at this time. On the signature line for the Resident were lines that went above the signature box with most of the writing below the signature line and off the page. These lines were indiscernible as a signature. However, the date of 4/10/2018 written on the Resident signature line was clear and matched the date written on the Facility Representative signature line that was signed by the witness. During an interview conducted 3/11/20 at 11:46 AM Social Worker (SW) B reported Advance Directives are reviewed quarterly. SW B reported this issue did not need to be revisited for Resident #22. SW B reported the Advance Directive documented in the medical record stands because Resident #22 was not declared incompetent until shortly after 4/10/18. While a default Full Code status is in place, SW B did not indicate that obtaining an illegible signature from a resident documented as severely impaired six days prior on an MDS assessment was of concern. Review of the Care Plan for Resident #22 reflected on page 2 of 9, a focus of , (Resident #22) has an activated DPOA (durable power of attorney), she is active in his care planning. This was initiated 12/16/15 and last revised on 11/7/20. The Care Plan reflects Social Work is to be active in each intervention of this Care Plan focus. During the interview conducted 3/11/20 at 11:46 AM, SW B was asked how she engaged the DPOA in care planning for Resident #22. SW B reported the DPOA completes the yearly Medicaid paperwork and she considers this the DPOA being active in Resident's #22 care planning.

F 0757 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure each resident's drug regimen must be free from unnecessary drugs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to monitor creatinine clearance and vital signs during antibiotic therapy for one resident (Resident #64) out of 6 residents reviewed for medication regimen monitoring, resulting in the potential for serious side effects such as kidney injury from medications that require creatinine clearance considerations and infections to escalate to [MEDICAL CONDITION] without monitoring of vital signs. Findings include: Resident #64 According to a facility face sheet, dated 3/11/2020 at 12:50 PM, Resident #64 was a [AGE] year-old admitted into the facility on [DATE] with the Diagnoses: [REDACTED]. During an interview and record review with Infection Control Nurse (IC) K on 3/11/20 at 1:01 PM, she revealed that Resident #64 was readmitted from the hospital on [DATE] on [MEDICATION NAME] 500 mg (milligrams) every 12 hours and [MED] (double strength) 800 mg every 12 hours from 12/20/19 to 12/23/19. Resident #64 had the [DIAGNOSES REDACTED]. The laboratory sputum results (from the lungs) reflected the infection was susceptible to both antibiotics meaning [MEDICAL CONDITION] would be treated by both antibiotics. IC K stated the facility physician approved use of both antibiotics prescribed from the hospital. IC K revealed the physician did not write a risk versus benefit for use of the two antibiotics. IC K stated she wouldn't expect a risk vs benefit to be written for use of two antibiotics. She believed an Infectious Disease physician saw the resident during the last hospitalization . [MEDICAL CONDITION]-resistant Staphylococcus aureus (MRSA) infection is caused by a type of staph bacteria that's become resistant to many of the antibiotics used to treat ordinary staph infections. [MEDICAL CONDITION] infections occur in people who've been in hospitals or other health care settings, such as nursing homes and [MEDICAL TREATMENT] centers. When it occurs in these settings, it's known as health care-[MEDICAL CONDITION] (HA-MRSA). (https://www.mayoclinic.org/diseases-conditions/mrsa/symptoms-causes/syc- 336) [MED] (double strength) required dosage modifications related to creatinine clearance (CrCl): CrCl > (greater than) 30 mL/min (milliliters per minute): Dose adjustment not necessary CrCl 15-30 mL/min: Decrease dose by 50% CrCl < (less than) 15 mL/min (milliliters per minute): Do not use (https://reference.medscape.com/drug/bactrim-[MEDICATION NAME]-[MEDICATION NAME]- 3) [MEDICATION NAME] 500 mg (milligrams, a fluroquinolone class antibiotic) required dosage modifications related to creatinine clearance (CrCl): CrCl 20-49 mL/min: 500 mg (milligrams) initially, then 250 mg once daily CrCl 10-19 mL/min .: 500 mg initially, then 250 mg every other day (https://reference.medscape.com/drug) The U.S. Food and Drug Administration is advising that the serious side effects associated with fluroquinolone antibacterial drugs generally outweigh the benefits for patients with acute sinusitis, acute [MEDICAL CONDITION], and uncomplicated urinary tract infections who have other treatment options. For patients with these conditions, fluoroquinolones should be reserved for those who do not have alternative treatment options. An FDA safety review has shown that fluoroquinolones when used systemically (i.e. tablets, capsules, and injectable) are associated with disabling and potentially permanent serious side effects that can occur together. These side effects can involve the tendons, muscles, joints, nerves, and central nervous system. (https://www.fda.gov/Drugs/DrugSafety/ucm 3.htm) During an interview and record review with Infection Control Nurse (IC) K on 3/11/20 at 1:01 PM, IC K was asked if creatinine clearance for [MEDICATION NAME] and [MED] was completed for Resident #64. IC K stated she did not think so. IC K revealed that the facility pharmacy did not contact them requesting laboratories for calculating creatinine clearance. IC K revealed she had recently started to calculate creatinine clearance for the residents in January 2020. IC K revealed that review of pharmacy reviews reflected there were no pharmacy recommendations made for Resident #64. IC K stated she assumed the hospital did creatinine clearances for the prescribed antibiotics. IC K was asked if vital signs were monitored while a resident was receiving an antibiotic. She stated, yes, at least temperature. IC K stated she was trying to get nursing staff to use [MEDICAL CONDITION] Tool. IC K stated 12/23/2020 was last day of administration of antibiotics. IC K stated Resident #64 did not have a history of [MEDICAL CONDITION] on the admission records. IC K revealed there was not a policy regarding monitoring of vital signs during an infection, it was a standard of practice, an expectation. [MEDICAL CONDITION] is a clinical syndrome of life-threatening organ dysfunction caused by a dysregulated response to infection. In septic shock, there is critical reduction in tissue perfusion; acute failure of multiple organs, including the lungs, kidneys, and liver, can occur. (https://www.merckmanuals.com/professional/critical-care-medicine/sepsis-and-septic-shock/sepsis-and-septic-shock) Review of Resident #64's temperatures from her readmission from the hospital on [DATE] on two antibiotics reflected her temperature was not obtained on 12/20/19. Two temperatures were taken on 12/21/19 at 3:40 PM- 99.9 degrees Fahrenheit and at 8:09 PM- 98.5 degrees Fahrenheit. No other documentation of monitoring of temperatures was recorded for Resident #64. Resident #64 was readmitted into the hospital on [DATE]. Review of a hospital record titled H and P (history and physical), dated 1[DATE]19, for Resident #64 revealed that she was readmitted to the hospital in acute renal (kidney) failure.
F 0761 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235284	A. BUILDING _____ B. WING _____	03/12/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MEDILODGE OF MIDLAND	4900 HEDGEWOOD DR MIDLAND, MI 48640

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 0761 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 15) Based on record review and interview, the facility failed to inspect and test annually in accordance with NFPA 101, 19.7.6, 8.3.3.1 and NFPA 80, Standard for Fire Doors and Other Opening Protective's 5.2, 5.2.3. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. This deficient practice could affect all occupants in the event of fire emergency. Findings Include: On (NAME)9, 2020 between 10:25 AM - 11:30 AM, record review revealed the facility failed to provide documentation the fire rated doors were inspected over the last 12 months per NFPA 101, 2012. The findings were confirmed by interview with the maintenance director at time of discovery.
F 0804 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.** Based on observation, interview and record review, the facility failed to provide palatable food to 8 of 8 Residents in the confidential group, resulting in lack of a satisfying meal and the potential for malnutrition. Findings include: On 3/5/20 at 4:51 PM, the Ombudsman was contacted via e-mail and the only concern she had was that residents were not satisfied with the food. During the confidential group interview on 3/10/20 at 10:30 AM, 8 of 8 residents complained about the food. When asked what the specific concerns were, they said the food was cold when they get tray service in their rooms. If they want to be served at mealtime with a hot meal, they must eat in the dining room. Several residents said the food was greasy, frequently boiled, and too soggy. They said they used to have special food meetings to discuss food issues, but the facility has not held these meetings in a long time. The consensus was the facility did not want to address their food concerns. During the meal tray pass observation on 3/11/20 at 1:36 PM, residents in the main dining room had all been served. Tray carts were passed to the resident rooms once residents in the main dining room had been served. The last tray on the E hall was temp'd (temperature taken of the food) at this time by Dietary Manager (DM) N. A cheeseburger was 132 degrees Fahrenheit. DM N said the food had been on the plate for about 20 minutes and it should be at least 140 degrees when it reaches the residents. DM N was asked if she had done any quality assurance temperatures of food from the trays this year and she said, no. DM N was asked if she routinely met with the residents about the food. DM N said she does attend resident council, but she had stopped having the special food meetings due to lack of attendance. DM N was asked if she was aware the residents and the Ombudsman had many concerns about the food palatability and DM N said, no.
F 0842 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to maintain complete and accurate medical records for 4 of 22 residents (Resident #28, Resident #40, Resident #57, and Resident #63), resulting in incomplete medical records, inaccurate medical records, and the potential for providers not having an accurate and complete picture of the resident's stay at the facility. Findings include: Resident #40 A review of Resident #40's Admission Record, dated 3/11/20, revealed Resident #40 was an [AGE] year-old resident admitted to the facility on [DATE]. In addition, Resident #40's Admission Record revealed Resident #40 had multiple [DIAGNOSES REDACTED]. A review of Resident #40's Minimum Data Set (MDS) (a tool used for assessing a resident's care needs), dated 2/3/20, revealed Resident #40 had a Brief Interview for Mental Status (BIMS) (a scale used to determine a resident's cognitive status) score of 0 which revealed Resident #40 was severely cognitively impaired. A review of Resident #40's Durable Power of Attorney (DPOA) paperwork, dated 10/15/12, failed to specifically address specific medical powers (e.g. what to do in the event of respiratory and/or heart failure, make medical treatment decisions), except the DPOA may sign documents related to release of medical records and share those records with whomever they deemed appropriate. During an interview on 03/11/20 at 11:46 AM, Social Worker (SW) B stated Resident #40 was not his own responsible party and the DPOA had been activated. SW B was shown Resident #40's DPOA paperwork and verbally agreed medical decision-making abilities (except release of medical records) were not specifically addressed in this paperwork. SW B was requested to provide any documentation specifying Resident #40's DPOA could make medical treatment decisions for Resident #40. As of the time of the completion of the survey and exit from the facility, the facility failed to provide this requested documentation. Resident #57 A review of Resident #57's MDS, dated [DATE], revealed Resident #57 was a [AGE] year-old resident admitted to the facility on [DATE] with multiple [DIAGNOSES REDACTED].g. [MEDICAL CONDITIONS], hardening of the arteries). In addition, Resident #57's MDS revealed Resident #57 had a BIMS score of 15 which indicated Resident #57 was cognitively intact. A review of Resident #57's Advance Directives/ Medical Treatment Decisions form, dated 2/3/20, revealed Resident #57's DPOA had signed Resident #57 as a Do Not Resuscitate (DNR) (in the event Resident #57's heart or lungs stop working). A review of Resident #57's medical records, dated 2/1/20 (admission) to 3/11/20, failed to reveal that Resident #57 had been deemed unable to make medical decisions and Resident #57's DPOA had been activated. A review of Resident #57's self-determination related to advanced directive care plan, dated 11/15/19 and revised on 2/3/20, revealed, (Name of Resident #57) has a guardian who wishes for (name of Resident #57) to be a DNR. During an interview on 03/11/20 at 11:46 AM, SW B stated, It's the responsible party that signs the code status. SW B stated if the resident is their own responsible party, they should sign their code status. In addition, SW B stated, Resident #57 scores well on his BIMS. He's his own responsible party. Resident #63 A review of Resident #63's Admission Record, dated 3/11/20, revealed Resident #63 was an [AGE] year-old resident admitted to the facility on [DATE]. In addition, Resident #63's Admission Record revealed Resident #63 had multiple [DIAGNOSES REDACTED]. A review of Resident #63's MDS, dated [DATE], revealed Resident #63 had a BIMS score of 5 which indicated Resident #63 was severely cognitively impaired. A review of Resident #63's Advance Directives/ Medical Treatment Decisions form, dated 2/18/20, revealed Resident #63's daughter had signed Resident #63 as a Do Not Resuscitate (DNR) (in the event Resident #63's heart or lungs stop working). A review of Resident #63's medical record, dated 3/7/19 to 3/11/20, failed to reveal if Resident #63 had designated a medical DPOA (no medical DPOA documentation was located in Resident #63's medical record) in the event Resident #63 was deemed unable to make medical decisions. A review of Resident #63's medical record, dated 3/7/19 to 3/11/20, did revealed Resident #63's daughter was designated as his financial DPOA (able to make financial decisions) in the event Resident #63 was deemed unable to make financial decisions. A review of Resident #63's medical record, dated 3/7/19 to 3/11/20, failed to reveal that Resident #63 had been deemed unable to make medical, or financial, decisions. During an interview on 03/11/20 at 11:46 AM, SW B stated, It's the responsible party that signs the code status. SW B stated if the resident is their own responsible party, they should sign their code status. In addition, SW B stated she believed Resident #63 was his own responsible party. SW B stated she had requested Resident #63's daughter provide a copy of the medical DPOA to the facility. However, SW B stated she did not have any evidence of when, or if, this had actually occurred. A review of the facility's advanced directive policy and procedure, dated 12/7/12, revealed, 4. Should the resident indicate that he or she has issued advance directives about his or her care and treatment, documentation must be recorded in the medical record of such directive and a copy of such directive must be included in the resident's medical record. Resident #28 According to Resident #28's face sheet dated 3/12/20 he was a [AGE] year old male admitted to the facility on [DATE] and had [DIAGNOSES REDACTED]. He was his own responsible party. On 3/10/20 at approximately 2:35 PM, the DON informed the Surveyor that Resident #16 was not capable of swearing and yelling at residents as he cannot speak clearly. She said he does not behave like that and said at lunch today Resident #28 (male resident) blew a kiss at Resident #16 (male resident) and Resident #16 just moved to another table and did not say anything. The Surveyor asked what the DON did when she found out about this situation. The DON said she told Resident #28 he cannot do that and checked to see that Resident #16 was ok. The Surveyor went to Resident #16's room with the DON. Resident #16 was able to say yes to questions and nod his head no to questions. Resident #16 was able to say he wanted to call his sister and my girls. Other words were difficult to make out, but he did attempt to speak when asked questions. Resident #16 responded yes to did someone blow you a kiss today and did it make you mad. When asked if Resident #28 had blown kisses at him before, he answered yes. When asked if he does it once a day or once a week, he nodded no. When asked if he does it once a month he said yes. Based on verbal response and facial expression it was clear Resident #28 upsets Resident #16. After leaving the room the Surveyor

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235284	A. BUILDING _____ B. WING _____	03/12/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MEDILODGE OF MIDLAND	4900 HEDGEWOOD DR MIDLAND, MI 48640

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 0842 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 16) asked the DON if that event was an allegation of abuse she said yes, I will report it now. During an interview on 3/12/20 at 9:30 AM, confidential employee (CE) DD said she was aware Resident #28 blew a kiss at Resident #16 the other day. CE DD said Resident #28 is a bully and does things like this to residents and staff frequently. Review of Resident #28's medical record revealed there was no indication that there was an incident with Resident #16 on 3/10/20 and no indication this had been an ongoing concern. There was no indication in Resident #28's care plan that he had behaviors that included bulling staff and residents.
F 0867 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action.** Based on interviews and record review, the facility failed to identify and implement appropriate plans of action to correct quality deficiencies necessary to assure residents attain and maintain the highest practicable level of wellbeing, resulting in the potential for serious negative physical and psychosocial outcomes for all 71 residents residing at the facility. Findings include: During the quality assurance task meeting on 3/12/20 at 10:28 AM with Corporate Directors X and Z the following concerns identified during the survey process were discussed: staffing, infection control, abuse, identify allegations of abuse, complete and accurate medical records, accident hazards, resident hydration, advanced directives, competency assessments, palatable food, ombudsman communication with the facility, delayed physician documentation and administration of facility resources. X and Y had no information to offer as to why the facility quality assurance process had not identified or addressed these concerns prior to the annual survey process. They did not offer any evidence that these concerns had been fully addressed prior to the start of the survey process. X and Y did offer many documents and requested a past noncompliance of most of the issues identified in the survey process. X and Z agreed that the facility was not in compliance of the regulations of concern at the start of the Survey on [DATE].
F 0868 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Have the Quality Assessment and Assurance group have the required members and meet at least quarterly** Based on interview and record review the facility failed to hold quarterly quality assurance meeting with all required personnel present every quarter, resulting in the potential for identifying and resolving problems that could affect the quality of life and care of the residents. Findings include: During the quality assurance meeting with Corporate Directors X and Z on 03/12/20 at 10:28 AM the quarterly sign in sheets were reviewed. They were not able to locate sign in sheets that accounted for all key personnel being in attendance every quarter.
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** Based on observation, interview and record review, the facility failed to maintain an effective infection control program for all of the facilities 71 residents resulting in the potential for the spread of infection by cross contamination of glucometers, lack of hand hygiene during medication pass and lack of screening of staff and visitors for a potentially serious [MEDICAL CONDITION] (COVID or Covid19). Findings include: On 3/11/20 at 1:01 PM during an infection control interview with Infection Control nurse (IC) K, she revealed she has done IC surveillance in long term care for [AGE] years. IC K was asked during medication pass, when is handwashing to be done? IC K revealed with each resident, in between residents, when gloves are applied or removed, when hands are visibly soiled then hand hygiene is to be done. She stated every medication cart had hand sanitizer, hall walls have hand sanitizer, every resident room had a sink with soap and water. IC K stated the facility had an annual skills training, but ,she was not sure if hand hygiene had been included. Review of an outline for February 2020, hand hygiene was completed with Certified Nurse's Aides (CNA) staff. December 2019 nursing training did include handwashing, and this included when to perform hand hygiene. During this interview and record review, IC K was asked about glucometer (blood sugar meter) cleansing expectations? She stated washing the meter with purple top wipes or Sani wipes. IC K stated to wipe the meter down, place on barrier tray and wait 2 minutes. Review of the label of the Sani wipes with IC K read and required wet time of 2 minutes is required and then let air dry. IC K stated that was her error. She was not aware of that. 03/11/20 01:38 PM during an interview with IC K, she was asked about the COVID 19 preparation. IC K stated there were signs on the doors, limitation for visitors if ill. IC K stated the staff was asking if sick if VISABLY ill. IC K stated the facility was not screening upon visitor arrival. IC K stated there were two family members that travel a lot and she had called and talked with them about visiting and they agree to not visit at this time by their choice. IC K stated the facility has followed CDC (Centers for Disease Control) guidelines. IC K stated the was no one in county with Covid19, as of this am, and now 2 cases in counties near Detroit as of today. IC K stated she had reached out to the local health department. IC K stated all back up supplies were on back order and she had discussed this with the health department. During this interview, IC K was asked if any staff exhibited symptoms? IC K stated CNA G but it was allergies [REDACTED]. CNA G had a tickle in her throat and stated she had a sore throat. CNA G did not have a fever. IC K instructed her she could work. IC K confirmed she did not assess if CNA G had been in areas of active COVID. Staff had worked past 5 days. On 3/11/20 at 4:46 PM during an interview with Regional Director of Operations (RDO) X, he revealed that IC K knew about the [DATE]20 CMS (Center for Medicare and Medicaid) letter about the current need for active surveillance. He stated that questionnaires were at the front of the facility near the visitor sign in book. RDO X confirmed that staff was not always talking with visitors as they arrive. RDO X stated he was not aware of the staff (CNA G) exhibiting coughing. RDO X stated the (NAME)9, 2020 S and C CMS instruction was in his email but he stated he did not send this new letter out to IC K. Review of the CMS letter RefQSO-20-14-NH dated (NAME)9, 2020 reflected, .Facilities should actively screen and restrict visitation by those who meet the following criteria: 1. Signs and symptoms of respiratory infection, such as a fever, cough, shortness of breath, or sore throat. 2. In the last 14 days, has had contact with someone with a confirmed [DIAGNOSES REDACTED]. 3. International travel within the past 14 days to countries with sustained community transmission . 4. Residing in a community where community-based spread of COVID-19 is occurring . Facilities should increase visible signage at entrances exist (sic), offer temperature checks, increase availability of hand sanitizer, offer PPE (personal protective equipment) according to current facility policy while in the resident room . Visitor reporting: Advise exposed visitors (e.g. contact with COVID-19 resident prior to admission) to monitor for signs and symptoms of respiratory infection for at least 14 days after last known exposed and if ill to self-isolate at home and contact their healthcare provider. Advise visitors to report to the facility any signs and symptoms of COVID-19 or acute illness within 14 days after visiting the facility. This letter goes on to state, How should facilities monitor or restrict health care facility staff? The same screening performed for visitors should be performed for facility staff. Health care providers (HCP) who have signs and symptoms of a respiratory infections should not report to work. Any staff that develop signs and symptoms of a respiratory infection while on-the-job, should: immediately stop work, put on a face mask, and self-isolate at home. Informed the facilities infection preventionist, and include information on individuals, equipment, and locations the person came into contact with; and contact and follow the health department recommendations for the next steps (e.g. testing). Refer to the CDC guidance for exposures that might warrant restricting asymptomatic healthcare personnel from reporting to work . On 3/11/20 at 4:55 PM during an observation of the front desk and interview with Corporate staff Y, she stated there was a sign at the front door about things visitors needed to report and a sign next to the sign in book about self-reporting symptoms. She also stated that RDO X had sent letters to families last week about COVID surveillance. Review of the POS [REDACTED]. There was no one observed to be at the front desk except a Restorative Aide (RA) T that was documenting on a computer with his back to incoming visitors. RA T stated Front Desk MM, the person who is at the desk runs around a lot. On 3/11/20 at 5:03 PM, RDO X stated letters were sent out to families today about COVID surveillance. Corporate staff Y had stated this was done last week. On 3/11/20 05:06 PM RDO X stated 36 letters had not been sent out in the mail yet informing families of the new Covid19 surveillance. RDO X also revealed this letter also contained a questionnaire about customer service. On 3/11/20 at 5:12 PM RDO X stated he had trained Front Desk MM and Medical Records staff I on active infection surveillance for visitors at the front desk. On 3/11/20 at 5:25 PM, Front Desk MM was observed at the front desk and stated she was given the letter to read about COVID screening. She stated before when she was at the desk, she instructed visitors to read the posting but did not have any acknowledgment

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235284	A. BUILDING _____ B. WING _____	03/12/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MEDILODGE OF MIDLAND	4900 HEDGEWOOD DR MIDLAND, MI 48640

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 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 17) that it had been read. She stated today she had been busy and away from the desk a lot of the day. Review of facility front door posting reflected, Attention Visitors. Due to risk associated with the flu and Coronavirus Stop. Do not visit if you are ill. If you have a cold, Respiratory or flu-like symptoms such as fever, runny nose, cough, shortness of breath or muscle aches, please do not visit until your symptoms are gone. If you do not have any of the above symptoms remember to wash your hands when you enter the facility, before you enter a resident's room, after you leave a resident's room, when you leave the facility. Alcohol rub is conveniently located for your use. Limit your visit to one person. Thank you for your cooperation. Review of the document at the desk left for visitors to read reflected, (No date) Please remain in this area and see the facility Administrator and/or a member of the management team before entering the facility care areas if: 1. You are having any flu-like/cold symptoms. 2. You have recently been in Contact with any individuals that are sick. 3. You have recently traveled outside of the United States. Your cooperation with matter (sic) would be greatly appreciated to assist us to provide the best care possible to all of your loved ones and to our staff. Signed by the facility Administrator. Review of a facility document titled, (Name of facility) visitors sign in and sign out reflected a spot for visitor name, resident that they were visiting, the date and time in and out. During the Medication Administration task conducted 3/10/20 at 6:56 AM Licensed Practical Nurse (LPN) Q was observed administering [MED] to Resident #28 behind a curtain in an alcove on the B Hall. LPN Q was observed to prep the injection site with an alcohol pad and administer the [MED] without wearing gloves. Following the medication administration LPN Q did not perform hand hygiene by either using hand sanitizer or by hand washing with soap and water. During the Medication Administration task conducted 3/10/20 at 12:01 PM LPN Q was observed conducting a glucometer blood sugar check on Resident #52 behind a curtain in an alcove on the B Hall. LPN Q was observed obtaining a sample of blood, obtaining a result, and discarding the glucometer strip in a sharps container. LPN Q did not wear gloves during this process nor did LPN Q perform hand hygiene following the procedure. LPN Q was observed wiping down the glucometer with the approved wipe (PDI Super Sani Cloth Wipes) then discarding the wipe and placing the glucometer on the top of the Medication Cart. During an interview conducted 3/11/20 at 12:45 PM, Registered Nurse (RN) JJ described the procedure for testing a resident's blood sugar using a glucometer. RN JJ reported the nurse should, wear gloves, obviously. RN JJ reported after the test, the glucometer is wiped down with the approved wipes, then wrap the moist wipe around the glucometer for one minute and then let dry. RN JJ reported she places the wrapped glucometer in a cup on the top of the medication cart. RN JJ reported hands are to be washed before and after wearing gloves. RN JJ reported she doesn't wear gloves when administering [MED]. RN JJ stated, I don't know if you are supposed to .well, I guess probably. Review of the policy provided by the facility titled , Blood Sampling - Capillary (Finger Sticks), last reviewed and revised 2/2018, reflected gloves were indicated to be used as a protective barrier, to prevent exposure to blood or body fluids. The section of the policy titled Steps in the Procedure, reflected,1. Wash hands and don gloves. 7. Follow manufacturer's instructions, clean and disinfect reusable equipment, parts after each use. 8 Remove gloves . 9. Wash hands. Review of the policy provided by the facility titled , Handwashing/Hand Hygiene, last reviewed and revised 2/2018, reflected, 5. Employees must wash their hands for twenty (20) seconds .under the following conditions . a. Before and after direct contact with residents, d. after removing gloves, e. After handling items potentially contaminated with blood, body fluids, or secretions . The policy continued with, 6, describing other situations when hand hygiene is to be performed and the methods that can be used. These other situations include, d. Before preparing and handling medications, and, g. After contact with a resident's intact skin. Review of the policy provided by the facility titled , Administering Medications, last reviewed and revised 5/2018, reflected, 14. Staff shall follow established facility infection control procedures (e.g. handwashing, antiseptic technique, gloves, isolation precautions, etc.) when these apply to the administration of medications. During an interview conducted 3/11/20 at 12:54 PM, acting Director of Nursing (DON) X reported the expectation is that nurses are to maintain infection control standards with handwashing and wearing gloves during blood sugar testing and administration of [MED]. Review of the manufacturer's instructions for use of the PDI Super Sani Cloth Wipes reflected, .wipe and thoroughly wet surface. Allow treated surface to remain wet for two (2) minutes. Let air dry.
F 0881 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Implement a program that monitors antibiotic use.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to maintain an antibiotic stewardship program for one residents (Resident #62) out of 1 residents reviewed for infections resulting in potentially un necessary antibiotics being administered, pain with a series of intramuscular injections, possible serious side effects such as [MEDICAL CONDITION] (a bacterial overgrowth in the colon resulting in dangerous diarrhea) and development of antibiotic resistance. According to a facility face sheet dated 3/11/202 at 2:33 PM, Resident #62 was a [AGE] year-old admitted into the facility on [DATE] with the Diagnoses: [REDACTED]. During an interview with Infection Control Nurse (IC) K on 3/11/20 at 1:01 PM, she revealed that Resident # 62 on 2/21/2020 experienced increased frequency, increased white blood cells in her urine. She stated the urinalysis was positive but only 50 to 100 bacteria was in her urine and no culture and sensitivity was done because it was not indicated. IC K confirmed Resident #62 was placed on [MEDICATION NAME] 1 GM (gram) daily for 7 days from [DATE]20 to [DATE]. Infection Control Nurse (IC) K stated she had talked to the physician and he chose to place the resident on antibiotics due to the positive urinalysis. She did not have a note about speaking to the physician about the lack of indication for a culture that had not indicated a need for antibiotics. She also didn't document speaking to the physician about the need to write a risk versus benefit for the use of an antibiotic that wasn't indicated by laboratory testing. Review of a Medication Administration Record [REDACTED]. Resident #62 was given the full course of the antibiotic intramuscularly. According to a facility policy titled, Infection Control Program - Antibiotic Stewardship dated (no date observed) reflected, This facility has established an infection prevention and control program that includes protocols to establish a system for antibiotic stewardship as well as the use and monitoring of adverse effects of antibiotics. Antibiotic Stewardship: A program that promotes the appropriate use of antimicrobials (including antibiotics), improves patient outcomes, reduces microbial resistance and decreases the spread of infections caused by multi drub resistant organisms .The basic tenants of an antibiotic stewards ship program include: Appropriate prescribing; appropriate administration; management practices to reduce inappropriate use to ensure that residents receive the right antibiotic for the right indication, right dose and right duration .core elements on an antibiotic stewardship program: facility leadership commitment to safe and appropriate antibiotic use; appropriate staff accountable for promoting and overseeing antibiotic stewardship; pharmacist review and monitoring of antibiotic use and stewardship; track antibiotic use, infectious agents, infection types, locality and any other trending within the facility .education of the staff and residents about antibiotic stewardship .Monitoring of antibiotic use: .antibiotics/[MEDICAL CONDITION] are placed on the infection control log Monday - Friday. Resident receiving antibiotics/[MEDICAL CONDITION] are reviewed din (sic) the daily interdisciplinary meeting to assure antibiotic stewardship procedures are utilized. Feedback is provided to the practitioner outside the norm. Involvement of the pharmacy and/or laboratory services for empiric therapy regimens/recommendations. Review of antibiotic stewardship activities at least quarterly through the facility's QAPI (Quality Assurance and Performance Improvement) program and medical director. Identified concerns should follow actions that may include, but limited to: .antibiotic prescribing practices .lab results, documentation of indications .notes in the record from practitioner if applicable .