STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235399	A. BUILDING _____ B. WING _____	08/19/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MEDILODGE OF PORTAGE	7855 CURRIER DR PORTAGE, MI 49002

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 0655 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake: MI 84 Based on interview and record review, the facility failed to develop and implement a baseline care plan in writing for 1 resident (Resident #102) of 4 residents reviewed for baseline care planning, resulting in falls, the potential for adverse events and a lapse in continuity of care. Findings include: Review of facility policy, Care Planning-Interdisciplinary Team revised July 2017, revealed, Policy Statement: Our facility's Care Planning/Interdisciplinary Team is responsible for the development of an individualized comprehensive care plan for each resident. Policy Interpretation and Implementation Development of the Care Plan: 1. A comprehensive care plan for each resident is developed upon admission and up to completion of the resident Minimum Data Set (MDS). This is a continual process. Care Planning/ Interdisciplinary Team: 2. Resident assessments are begun on the first day of admission and completed no later than the fourteenth (14th) day after admission. A baseline care plan will be developed within 48 hours of admission followed by A Comprehensive Care Plan that is developed within seven (7) days of completing the MDS. The Interdisciplinary team may consist of .b. The Registered Nurse who has responsibility for the resident .i . The Charge Nurse responsible for resident care .4 . The resident, the resident's family and/or the resident's legal representative/guardian or surrogate are encouraged to participate in the development of and revisions to the resident's care plan . Review of facility policy Falls - Clinical Protocol dated 6/2018, revealed, Assessment and Recognition: 1. As part of an initial and ongoing resident assessment, the staff will help identify individuals with a history of falls and risk factors for subsequent falling. This will be accomplished by the following task; a. The Falls Risk Evaluation is completed upon admission, quarterly, and with significant change in status. 1.(sic) Based on the assessment a care plan will be developed and implemented to address identified risk. This will be revised as necessary . 3. Goals of the plan of care may include the interdisciplinary team, physician, resident and responsible party when possible. a. Goals may include, but not limited to reduction of falls, minimize injury from falls, and/or prevent falls while maintaining and/or improving resident abilities and quality of life. 4. Interventions should be developed and implemented per the assessed needs. 5. In addition, interventions for direct care givers should be placed on the KARDEX or similar format. Comprehensive Care Plan 6. The care plan and KARDEX should be updated as interventions change . Post Fall Analysis/Treatment/Management . 3. Update the plan of care with the new or revised interventions. 4. Update the KARDEX or similar format with new or revised interventions. 5. Provide ongoing report at shift change regarding updates to the plan/s of care . Monitoring and Follow-Up . 1. The staff will monitor and document the individual's response to interventions intended to reduce falling or the consequences of falling. 2. Residents will be reviewed through Standards of Care at a determined time frame after new interventions are implemented to determine if effective or revision is necessary. 3. If interventions have been successful in preventing falling, the staff will continue with current approaches or reconsider whether these measures are still needed if the problem that required the intervention (for example, dizziness or musculoskeletal pain) has resolved . If the individual continues to fall, the interdisciplinary team should re-evaluate the situation and consider other possible reasons for the resident's falling (besides those that have already been identified) and will re-evaluate the continued relevance of current interventions . Review of intake information indicated Resident #102 admitted to the facility on [DATE] for rehabilitation following two falls resulting in a broken right hip and two surgeries after each fall. Resident #102 fell five times while at the facility. It was alleged the facility failed to properly supervise the resident and implement safety measures to prevent falls. Review of a Face Sheet revealed Resident #102 was a [AGE] year-old female, originally admitted to the facility on [DATE], with a pertinent [DIAGNOSES REDACTED]. Review of a Minimum Data Set (MDS) assessment for Resident #102, with a reference date of 7/31/2020, revealed a Brief Interview for Mental Status (BIMS) score of 3, out of a total possible score of 15, which indicated Resident #102 was severely cognitively impaired. Review of Resident #102's Fall Risk Evaluation V4 dated 6/19/2020 20:25 (9:25 PM) indicated the resident had a history of [REDACTED]. Resident #102 was documented as being confined to a chair with her balance not being steady while standing, sitting, and during transitions and only able to stabilize with physical assistance. Review of Resident #102's Incidents dated 6/25/2020 1745 (5:45 PM) indicated the resident was agitated with memory, physically, and decision-making impaired. The fall occurred in the resident's room unobserved. Review of Resident #102's Fall Investigation Report dated 6/25/2020 1745 indicated the resident had been alone and unattended, and lost her balance while attempting to self-transfer. Review of Resident #102's Care Plans revealed, Focus: The Resident is at risk for falls .Date Initiated: 06/27/2020 . Further review of Resident #102's care indicated Goals and Interventions were also not initiated until 06/27/2020, eight (8) days after her admission on 06/19/2020. By not having a focused fall care plan for Resident #102 at the time of admission that included interventions, staff were unable to implement for the prevention of falls and the ability to assess the effectiveness of the interventions. Review of facility QA & A 24-72 Hour Admit Confidential dated December 2018, revealed, .Complete on shift resident arrives .CARE PLANS .At Risk of Falls .Triggered care plans from admission assessments . During an interview on 8/13/2020 at 4:01 PM Resident #102 Family Member (FM) E stated, My mother was admitted to the facility due to a fall that broke her right hip. She went to another facility where she fell twice and rebroke that same hip and had to have a second surgery. After the surgery to fix the fracture she came to this facility. She was a fall risk due to [MEDICAL CONDITION]. She forgets she cannot get up. We told the facility that she needed to be monitored. Every single fall my mother had was from her getting out of her wheelchair. During an interview on 8/18/2020 at 3:49 PM Unit Manager (UM) P stated, When a resident is admitted there are four (4) basic main care plans that must be done. (Resident #102) was admitted on [DATE]th (2020) and the basic care plans for falls were not initiated from the RN (Registered Nurse) Admission Assessment. The ADL (activities of daily living including transfers, eating, bathing), skin, and pain care plans were done. The admitting nurse did not catch it at the end of the day. Bottom line. The nurse did not check the care plans and a fall care plan was not created on June 19th (2020). Review of Resident #102 Nursing Admission Evaluation dated 6/19/2020 with UM P revealed falls were not included as part of the assessment. UM P stated, The admissions nurse is supposed to initiate the basic main care plans which are ADLs/mobility, falls, pain, and skin. These care plans are supposed to be done upon admission. The admissions nurse did not ensure the fall care plan got done. The fall care plan was not done until June 27th (2020) by the MDS nurse. During an interview on 8/18/2020 at 5:20 PM, LPN J stated, I'm a Lead LPN Supervisor means I train other nurses. When an admission comes in, the admitting nurse does a fall assessment which would include if a resident has fallen in the past. When the hospital calls the facility with information about the admission, they would tell us the resident's fall history. I do remember admitting (Resident #102) but I don't remember doing a fall care plan. Nurses can initiate any care plans, including fall care plans. (Resident #102) was very impulsive. She did not understand having to ask for assistance or to use the call-light. I knew she had dementia when she was admitted . A care

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
	235399	A. BUILDING _____ B. WING _____	08/19/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MEDILODGE OF PORTAGE	7855 CURRIER DR PORTAGE, MI 49002

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 0655 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) plan should be initiated upon admission. The UM checks the admission care plans the next day or when they come in after a weekend and if one is needed, they do it. The care plans aren't hard do to. During an interview on 8/18/2020 at 12:20 PM, Unit Manager (UM) N stated, Care planning is important, it directs staff to know a resident's plan of care and treatment. The Kardex is triggered off the care plans. The admitting nurse will trigger the first care plans and the MDS and UM would add after the admit audit is done by the UM. If there is an incident, the floor nurse on duty would start a new care plan or update the interventions. The staff that does the incident follow-up care note, SOC or Standard of Care, makes sure the care plan has been done. During an interview on 8/18/2020 at 5:38 PM, LPN R stated, Admission care plans are to have the four main ones falls, pain, skin, and ADLs done within 24-hours. A care plan gets updated or developed upon a change in condition, or a fall happens a care plan intervention should be done when an order is placed. Everyone has a fall care plan upon admission. Every fall needs an intervention. When there is a fall the UM is called, and interventions are discussed and put in place. During an interview on 8/19/2020 at 8:31 AM UM N stated, A resident's admission process starts by the nurse checking in the resident and orienting them to the unit. Then the nurse starts the admission assessment which goes through each body system. Care plans are triggered 90% by the way the nurse answers questions on the admission assessment. The nurse must initiate a fall care plan. There are four (4) main care plans that every resident must have; they are the ADL (activities of daily living), pain, falls, and skin). Nurses received this in their training when first starting and there is a check-off list in the resident's admission chart. This is a reminder for the nurses what must be completed for the admission. The admission nurse is to initiate the check-off list and make sure the bulk of it is done upon admission. When a nurse is done with her shift, they pass off the admission check-off list to the next shift nurse. The UM audits the check-off list when they next come to work after an admission and make sure everything is done on the admission check-off list. I look to see if the assessments were done and what they scored; do they have what is needed to trigger a care plan and what is needed to be resident specific. During an interview on 8/19/2020 at 11:59 AM RN M stated, The admission assessment checklist is used more by the UMs to audit a new resident's medical chart to make sure all items are completed. There are four (4) required care plans that need to be done for an admission; ADLs, falls, skin and pain. A fall care plan should always be done for an admission. This is a 24-hour facility so if admission paperwork is not completed it should be passed on to the next shift nurse. Nurses do verbal and walking reports along with a 24-hour shift report that are given to the oncoming nurse. A care plan also can be initiated by a nurse when they go into the resident's electronic medical records. The area of care plans has a section of foci to choose from, but it also says REQUIRED after the four (4) main ones. The admitting nurse must do basic care plans so the CNAs know how to care for the new residents. A Kardex is populated from the care plan to tell the CNA what the care needs for the resident are. How else would the CNAs know how to care for the resident? The care plans must be done for resident safety. After every fall, a fall care plan should be updated depending on the intervention that is being added. During an interview on 8/19/2020 at 1:08 PM LPN X stated, Care plans are generated when an admission assessment is done. Nurses have do care plans upon admitting a resident. There are four (4) basic care plans, ADLs, fall, pain, and skin. If care plans are unable to get done during a shift, the nurse reports it to the next shift nurse. During a telephone interview on 8/19/2020 at 1:10 PM, Resident #102 FM F stated, The date I went to the facility to have a window visit with my wife who was a resident at the facility, was June 28th (2020). She was laying on the floor of her room when I looked in the window. I had told the facility countless times prior to this visit to keep her safe because she fell a lot. They told me they could not prevent her falls, yet they agreed to admit her. The facility did not discuss many ways to help my wife. They could have used a lap tray when I asked but the facility never tried. I asked them what they could do when we talked about helping my wife and they said they could not keep her from falling. They did not do everything they could have. I would have paid for a sitter. During a telephone interview on 8/19/2020 at 1:15 PM, Licensed Practical Nurse (LPN) L stated, I work 2nd shift as a floor nurse. I never do care plans. If a nurse gets an admit on the shift before me and does not get the care plans done, I do not do them. That is up to the unit managers to get them done. I have never done a care plan since I have worked at the facility. I've never been told I've had to do them.
F 0656 **Level of harm -** Minimal harm or potential for 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** This citation pertains to intake: MI 806 Based on observation, interview, and record review, the facility failed to develop and/or implement care planned interventions for resident's individualized needs in 1 of 4 residents (Resident #101) reviewed for implementation of care plan interventions, resulting in the potential for unmet care needs. Findings include: Review of facility policy, Care Planning-Interdisciplinary Team revised July 2017, revealed, Policy Statement: Our facility's Care Planning/Interdisciplinary Team is responsible for the development of an individualized comprehensive care plan for each resident. Policy Interpretation and Implementation Development of the Care Plan: 1. A comprehensive care plan for each resident is developed upon admission and up to completion of the resident Minimum Data Set (MDS). This is a continual process. Care Planning/ Interdisciplinary Team: 2. Resident assessments are begun on the first day of admission and completed no later than the fourteenth (14th) day after admission. A baseline care plan will be developed within 48 hours of admission followed by A Comprehensive Care Plan that is developed within seven (7) days of completing the MDS. The Interdisciplinary team may consist of .b. The Registered Nurse who has responsibility for the resident .i . The Charge Nurse responsible for resident care .4 . The resident, the resident's family and/or the resident's legal representative/guardian or surrogate are encouraged to participate in the development of and revisions to the resident's care plan . Review of facility policy Falls - Clinical Protocol dated 6/2018, revealed, Assessment and Recognition: 1. As part of an initial and ongoing resident assessment, the staff will help identify individuals with a history of falls and risk factors for subsequent falling. This will be accomplished by the following task; a. The Falls Risk Evaluation is completed upon admission, quarterly, and with significant change in status. 1.(sic) Based on the assessment a care plan will be developed and implemented to address identified risk. This will be revised as necessary . 3. Goals of the plan of care may include the interdisciplinary team, physician, resident and responsible party when possible. a. Goals may include, but not limited to reduction of falls, minimize injury from falls, and/or prevent falls while maintaining and/or improving resident abilities and quality of life. 4. Interventions should be developed and implemented per the assessed needs. 5. In addition, interventions for direct care givers should be placed on the KARDEX or similar format. Comprehensive Care Plan 6. The care plan and KARDEX should be updated as interventions change . Post Fall Analysis/Treatment/Management . 3. Update the plan of care with the new or revised interventions. 4. Update the KARDEX or similar format with new or revised interventions. 5. Provide ongoing report at shift change regarding updates to the plan/s of care . Monitoring and Follow-Up . 1. The staff will monitor and document the individual's response to interventions intended to reduce falling or the consequences of falling. 2. Residents will be reviewed through Standards of Care at a determined time frame after new interventions are implemented to determine if effective or revision is necessary. 3. If interventions have been successful in preventing falling, the staff will continue with current approaches or reconsider whether these measures are still needed if the problem that required the intervention (for example, dizziness or musculoskeletal pain) has resolved . If the individual continues to fall, the interdisciplinary team should re-evaluate the situation and consider other possible reasons for the resident's falling (besides those that have already been identified) and will re-evaluate the continued relevance of current interventions . Review of intake information indicated Resident #101 fell while at the facility sustaining a facial laceration requiring sutures. It was alleged staff failed to assess and monitor a resident following a fall. Review of a Face Sheet revealed Resident #101 was a [AGE] year-old female, originally admitted to the facility on [DATE], with pertinent [DIAGNOSES REDACTED]. Review of a Minimum Data Set (MDS) assessment for Resident #101, with a reference date of 7/16/2020, revealed a Brief Interview for Mental Status (BIMS) score of 3, out of a total possible score of 15, which indicated Resident #101 was severely cognitively impaired. Further review of the MDS indicated Resident #102 required the use of a wheelchair for mobility. Review of Resident #101's Care Plans revealed, Focus .removed 4WW(wheeled-walker) from room on 7/27/20 .Date Initiated 12/11/2018 .Goal . will not sustain serious through the review date .Revision Date: 8/13/2020 .Interventions .Anticipate and meet the resident's needs Date Initiated: 1/29/2016 .Review information on past falls and attempt to determine cause of falls. Record possible root causes. Remove any possible cause if possible. Educate resident/family/caregivers as to causes. Date Initiated 9/7/2018 . Review of Resident #101's Incidents dated 7/25/2020 at 0230 (2:30 AM) indicate the resident had memory, physical, and decision-making impairment. The fall

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235399	A. BUILDING _____ B. WING _____	08/19/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MEDILODGE OF PORTAGE	7855 CURRIER DR PORTAGE, MI 49002

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** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) occurred in the resident's room unobserved. When found, the resident was said to be in a sitting position with her walker in front of her, confused and unable to tell staff what happened. Review of Resident #101's Incidents dated 7/31/2020 at 8:15 AM indicated the resident had memory, physical, hearing/vision, and decision-making impairment. The fall occurred in the resident's room unobserved. When found, the resident was said to have her pants down to her thighs, confused and disoriented, with a laceration on her left eyebrow. Review of Resident #101's Care Plans revealed, Focus .at risk for falls r/t (related to) pain, .difficulty walking .resident refuses to ask or wait for assistance with transfers and ambulation, history of falls, removed 4WW (four-wheeled walker) from room on 7/27/2020 .initiated on 9/7/2018 Revision on 7/27/2020 .Goal .will not sustain serious injury through the review date. Date Initiated 1/29/2016 .Interventions .Anticipate and meet the resident's needs. Date Initiated 1/29/2016 .Be sure resident's call light is within reach and encourage the resident to use it for assistance as needed date initiated 1/29/2016 .Encourage .to wear non slip footwear or gripper socks for ambulation revision on: 10/10/2018 .Review information on past falls and attempt to determine source of falls. Record possible root causes. Remove any potential causes if possible. Educate resident/family/caregivers as to causes. Date initiated 9/7/2018 . Wheelchair to be locked at bedside when resident in bed. Date initiated 7/27/2020 . Review of Resident #101's Fall Investigation Report date of 7/25/2020 at 0230 indicated the factors contributing to the fall with the root cause was lost of balance and alone and unattended. The initial interventions to prevent future falls was to encourage resident to use call-light prior to ambulating so staff can assist resident. Review of the resident's care plan revealed this intervention had been put in place on 1/29/2016. Review of Resident #101's Fall Investigation Report date of 7/31/2020 at 8:15 AM indicated the fall description details were lost strength, appeared to get weak, and bed height not appropriate, during an attempt to transfer self while being alone and unattended. Root cause stated the resident was soiled and raised blood pressure of 184/100 when found with her bed at the lowest point which contributed to her hitting her head on the wheelchair/floor. Review of Resident #101's fall timeline provided by 8/18/2020 at 7:06 AM via email by Corporate Consultant (CC) HH indicated the resident had a fall on 7/25/2020 at 2:30 AM where she was observed on the floor with her walker in front of her. A new intervention that was to be implemented was to place a locked wheelchair at the bedside and not initiated until 7/27/2020, 2 (two) days after the incident. During an interview on 8/18/2020 at 12:20 PM, Unit Manager (UM) N stated, (Resident #101) had a gradual decline in condition. She was very independent and would walk to meals. Then she had a fall on July 25th (2020) because at that time she was still independent. Her walker was taken away to alleviate putting weight on the broken wrist, her bed was put against the wall, and the wheelchair was locked next to her bed in case she tried to get up. She kept trying to get up. She would not listen to education and continued to try and do things. That was about all we could do for her. We didn't really have anything else we could try. During an interview on 8/18/2020 at 12:55 PM Registered Nurse (RN) H stated, After breaking her (referring to Resident #101) hand, doctor wanted non-weight bearing and staff took away walker and gave her a wheelchair. She did not understand the concept of the wheelchair. She liked her walker and being able to walk. She never asked for help. She would not use the call-light. She was a check and change multiple throughout her shift. During an interview and record review of Resident #101's care plans on 8/18/2020 at 3:49 PM with UM P, UM P stated, (Resident #101) had a fall on July 15th (2020) and July 31st (2020). Care plans are updated any time there is a change of condition that would require a change in care or treatment. (Resident #101) care plan was updated on 7/27/2020, two days after the fall. On July 25th the care plan indicates someone revised the care plan with encourage resident to use call-light, resident non-compliant. I do not understand why this care plan intervention was even put in or who did it. The nurse could not come up with anything better than that? (Resident #101) did not use the call-light. That intervention would not work for her. That is why interventions were not revised until July 27th when management came back to work after the weekend and reviewed the incident report to figure out why she fell and add interventions that may work.
F 0689 **Level of harm** - Actual harm **Residents Affected** - Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intakes: MI 806 & MI 84 Based on observation, interview, and record review, the facility failed to implement safety interventions to prevent a fall with injury for 3 (Resident #101, Resident #102, & Resident #104) of 4 residents reviewed for falls, resulting in a fall with a facial laceration that required sutures for Resident #101, falls with fracture for Resident #103 & Resident #104, falls with bruising for Resident #102, and the increased potential for preventing further falls with injuries. Findings include: Review of facility policy Falls - Clinical Protocol dated 6/2018, revealed, Assessment and Recognition: 1. As part of an initial and ongoing resident assessment, the staff will help identify individuals with a history of falls and risk factors for subsequent falling. This will be accomplished by the following task; a. The Falls Risk Evaluation is completed upon admission, quarterly, and with significant change in status. 1.(sic) Based on the assessment a care plan will be developed and implemented to address identified risk. This will be revised as necessary . 3. Goals of the plan of care may include the interdisciplinary team, physician, resident and responsible party when possible. a. Goals may include, but not limited to reduction of falls, minimize injury from falls, and/or prevent falls while maintaining and/or improving resident abilities and quality of life. 4. Interventions should be developed and implemented per the assessed needs. 5. In addition, interventions for direct care givers should be placed on the KARDEX or similar format. Comprehensive Care Plan 6. The care plan and KARDEX should be updated as interventions change . Post Fall Analysis/Treatment/Management . 3. Update the plan of care with the new or revised interventions. 4. Update the KARDEX or similar format with new or revised interventions. 5. Provide ongoing report at shift change regarding updates to the plan/s of care . Monitoring and Follow-Up . 1. The staff will monitor and document the individual's response to interventions intended to reduce falling or the consequences of falling. 2. Residents will be reviewed through Standards of Care at a determined time frame after new interventions are implemented to determine if effective or revision is necessary. 3. If interventions have been successful in preventing falling, the staff will continue with current approaches or reconsider whether these measures are still needed if the problem that required the intervention (for example, dizziness or musculoskeletal pain) has resolved . If the individual continues to fall, the interdisciplinary team should re-evaluate the situation and consider other possible reasons for the resident's falling (besides those that have already been identified) and will re-evaluate the continued relevance of current interventions . Resident #101 Review of a Face Sheet revealed Resident #101 was a [AGE] year-old female, originally admitted to the facility on [DATE], with pertinent [DIAGNOSES REDACTED]. Review of a Minimum Data Set (MDS) assessment for Resident #101, with a reference date of 7/16/2020, revealed a Brief Interview for Mental Status (BIMS) score of 3, out of a total possible score of 15, which indicated Resident #101 was severely cognitively impaired. Further review of the MDS indicated Resident #101 used a walker as an aide for walking. Review of Resident #101's Incidents dated 7/25/2020 at 0230 (2:30 AM) indicate the resident had memory, physical, and decision-making impairment. The fall occurred in the resident's room unobserved. When found, the resident was said to be in a sitting position with her walker in front of her, confused and unable to tell staff what happened. Review of Resident #101's Fall Investigation Report date of 7/25/2020 at 0230 indicated the factors contributing to the fall with the root cause being lost of balance and alone and unattended. Review of Resident #101's Incidents dated 7/31/2020 at 0815 (8:15 AM) indicate the resident had memory, physical, hearing/vision, and decision-making impairments. The fall occurred in the resident's room unobserved. The resident when found was said to be confused, disoriented and with her pants down to her thighs. Further review of the report revealed the resident's blood pressure was 184/100 with a laceration over her left eyebrow. Review of Resident #101's Fall Investigation Report date of 7/31/2020 at 0815 indicated the factors contributing to the fall with the root cause being loss of strength, appeared to get weak, bed height not appropriate, soiled, and was alone and unattended while trying to self-transfer. Review of Resident #101's Care Plans revealed, Focus .at risk for falls r/t (related to) pain, .difficulty walking .resident refuses to ask or wait for assistance with transfers and ambulation, history of falls, removed 4WW (four-wheeled walker) from room on 7/27/2020 .initiated on 9/7/2018 Revision on 7/27/2020 .Goal .will not sustain serious injury through the review date. Date Initiated 1/29/2016 .Interventions .Anticipate and meet the resident's needs. Date Initiated 1/29/2016 .Be sure resident's call light is within reach and encourage the resident to use it for assistance as needed date initiated 1/29/2016 .Encourage .to wear non slip footwear or gripper socks for ambulation revision on: 10/10/2018 .Review information on past falls and attempt to determine source of falls. Record possible root causes. Remove any potential causes if possible. Educate resident/family/caregivers as to causes. Date initiated 9/7/2018 . Wheelchair to be locked at bedside when resident in bed. Date initiated 7/27/2020 . Review of Resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235399	A. BUILDING _____ B. WING _____	08/19/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MEDILODGE OF PORTAGE	7855 CURRIER DR PORTAGE, MI 49002

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 0689 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 3) #101's fall timeline provided by 8/18/2020 at 7:06 AM via email by Corporate Consultant (CC) HH indicated the resident had a fall on 7/25/2020 at 2:30 AM where she was observed on the floor with her walker in front of her. A new intervention that was to be implemented was to place a locked wheelchair at the bedside. The care plan for the resident to have the new intervention put in place was not initiated until 7/27/2020, 2 (two) days after the incident. During an interview on 8/13/2020 at 8:30 AM Family Member (FM) D stated, I am (Resident #101) DPOA (Durable Power of Attorney). My brother, (FM EE) are both DPOAs for (Resident #101). On July 31, 2020 I got a call from an ER doctor that he was stitching up my mother's eyebrow and she had multiple bruising on her body. My mother was admitted to the hospital and was there for 4 days. When I saw her, the bruising was bad. It was on both eyes, the right side of her head, and under her right jaw was a huge blood blister. Under her left breast around her rib cage and up her neck was a bruise all the way to her back. On her left arm there were a bunch of bruises like a hand. Her chest was bruised. My mother was not on blood thinners. She walked with a walker. I did not know she was in a wheelchair. She is very healthy for being 93. Her hearing is gone but hears on her right side. During an interview on 8/13/2020 at 10:20 AM Resident #102 FM EE stated, When I saw my mother in the hospital after her fall from her wheelchair, her eyes were swollen, her face was bruised and she had seven (7) stitches above her left eyebrow. Her elbow looked swollen. Hospital staff said she looked like she had been in a car accident. They said she fell out of a wheelchair at the facility. During an interview on 8/18/2020 at 12:20 PM, Unit Manager (UM) N stated, (Resident #101) had a gradual decline in condition. She was very independent and would walk to meals. She broke her hand sometime early this summer pushing a door open. Then she had a fall on July 25th (2020) because at that time she was still independent. Her walker was taken away to alleviate putting weight on the broken wrist, her bed was put against the wall, and the wheelchair was locked next to her bed in case she tried to get up. She kept trying to get up. She would not listen to education and continued to try and do things. That was about all we could do for her. We didn't really have anything we could try. UM M did not indicate whether increase supervision was implemented due to Resident #101's impulsivity and inability to comprehend education for a length of time due to a BIMS score of 3. During an interview on 8/18/2020 at 1:12 PM, Registered Nurse (RN) Mstated, I was not the nurse for (Resident #101) on July 31st (2020), (UM S) was. She had a big cut on her left forehead. When she broke her hand a few months ago and came back to the facility, I had her in the quarantine unit. She was impulsive. During an interview on 8/18/2020 at 2:57 PM, UM S stated, On 7/31/2020, (Resident #101) had a really bad fall. She was observed on the floor by staff. It looked like she fell out of bed transferring from bed to wheelchair. She had a deep laceration on her forehead over her left eye. The bleeding was stopped and sent her out to ER. Resident #102 Review of a Face Sheet revealed Resident #102 was a [AGE] year-old female, originally admitted to the facility on [DATE], with a pertinent [DIAGNOSES REDACTED]. Review of a Minimum Data Set (MDS) assessment for Resident #102, with a reference date of 7/31/2020, revealed a Brief Interview for Mental Status (BIMS) score of 3, out of a total possible score of 15, which indicated Resident #102 was severely cognitively impaired. Review of Resident #102's Fall Risk Evaluation V4 dated 6/19/2020 at 20:25 (9:25 PM) indicated the resident had a history of [REDACTED]. Resident #102 was documented as being confined to a chair with her balance not being steady while standing, sitting, and during transitions and only able to stabilize with physical assistance. Review of Resident #102's Incidents dated 6/25/2020 at 1745 (5:45 PM) indicated the resident was agitated with memory, physically, and decision-making impaired. The fall occurred in the resident's room unobserved. Review of Resident #102's Fall Investigation Report dated 6/25/2020 at 1745 indicated the resident had been alone and unattended, and lost her balance while attempting to self-transfer. Review of Resident #102's Incidents dated 6/28/2020 at 13:35 (1:35 PM) indicated the resident was confused and disoriented. The fall occurred in the resident's room unobserved. Review of Resident #102's Fall Investigation Report dated 6/28/2020 at 1335, indicated the resident had been alone and unattended, and lost her balance while attempting to self-transfer with the wheelchair not locked. During an interview on 8/18/2020 at 2:20 PM Housekeeping FF stated, I saw her (referring to Resident #102) on the ground in her room. I hollered at one of the CNAs to come help. Review of Resident #102's Incidents dated 7/10/2020 at 2200 (10:00 PM) indicated the resident was confused and disoriented with memory, physical, and decision-making impairments. The fall was witnessed by a staff who said the resident was standing up while in her room, lost her balance and sat down on the floor, scraping her arm on a table. Attempts to contact Certified Nursing Assistant (CNA) I on 8/13/2020 at 2:05 PM and 8/18/2020 at 9:30 AM were not answered nor returned. Review of Resident #102's Fall Investigation Report dated 7/10/2020 at 2200 indicated the resident had been alone and unattended in her room when she lost her balance while attempting to self-transfer. Review of Resident #102's Incidents dated 7/20/2020 at 18:00 (6:00 PM) indicated the resident was confused and disoriented with memory, hearing/vision, physical, and decision-making impairments. The fall occurred in a hallway and was unobserved. Review of Resident #102's Fall Investigation Report dated 7/20/2020 2200 indicated the resident's fall was witnessed but found on the floor unwitnessed. The resident was alone and unattended. The report further indicated the resident stood up from her wheelchair, began leaning to the left, lost her balance and fell to the floor. The witness statement revealed the fall was not observed but staff had heard the fall. Attempts to contact Licensed Practical Nurse (LPN) II on 8/13/2020 at 2:00 PM and 8/18/2020 at 9:20 AM were not answered. LPN II no longer was employed at the facility. Review of Resident #102's Incidents dated 7/26/2020 at 1235 (12:35 PM) indicated the resident was confused and disoriented, with memory, hearing/vision, physical, and decision-making impairments. The fall occurred in the resident's room while attempting to self-transfer and was observed. Review of Resident #102's Fall Investigation Report dated 7/26/2020 at 1235 indicated the resident's fall was witnessed as the resident lost her balance while in her room, alone, unattended, and attempting to self-transfer and pull up her pants. Witness statement made by Housekeeping JJ on 7/26/2020 at 1235, indicated Resident #102 was observed standing up to pull up pants and then began to lean and fell to the floor. Review of Resident #102's Incidents dated 7/29/2020 at 1315 (1:15 PM) indicated the resident was confused and disoriented when found in a hallway from an unobserved fall. Review of Resident #102's Fall Investigation Report dated 7/29/2020 at 1315 indicated the resident's fall was unobserved. She was found on the floor in a hallway, alone and unattended. While ambulating she became weak and lost her balance and fell to the floor. Witness stated made by Housekeeping FF on 7/29/2020 untimed, indicated Resident #102 was found on the floor. During an interview on 8/13/2020 at 4:01 PM, Family Member (FM) E stated, (Resident #102) was admitted to the facility due to a fall that broke her right hip. She went to another facility where she fell twice and rebroke that same hip and had to have a second surgery. After the surgery she came to this facility. She was a fall risk due to [MEDICAL CONDITION]. She forgets she cannot get up. We told the facility that she needed to be monitored. Every single fall my mother had was from her getting out of her wheelchair. Three times she fell in her room. She had no idea to use a call-light. She did not have the cognitive ability to function that way. We begged the facility to find a way to protect her. My dad told staff someone needed to stay with her or she would get up and try to get to him and fall when she they had window visits. So, my father had to stop window visits. My father had gone for a window visit in June (2020) and when he came to window, he saw my mother on the floor. During an interview on 8/18/2020 at 9:56 AM, FM F stated, I am the DPOA for (Resident #102) and (FM E) will step in when I can't. Our children would call ahead to arrange times to have window visits because if my wife saw us or knew we were coming she would get out of her chair and look for us. In June I had pre-arranged a time with facility staff to do a room window visit. I was on time. When I got there, she had fallen out of her wheelchair and was laying on the floor of her room. At that point we stopped window visits because it was too risky. My wife would know we were coming and fall. Because of the dementia, my wife is not aware of the whole situation. She does not have the capacity to remember anything. You must have eyes on her or else she will fall. She had 2 falls at the other facility prior to coming to this facility. I had decisions at the beginning before she came and right after she came to the facility because of the falls at the other facility where she broke a hip. The facility knew she was a fall risk. I had discussions with the unit manager, nurses, and therapists regarding her memory and her falls. They stated they could not protect her. I told them from the beginning what I would like for them to try and they did not use a wedge cushion to make it harder to get out of wheelchair. I begged for safety measures and we got nothing. I talked to (Unit Manager (UM) N) about the safety measures that could be taken with waivers, but the facility never went any further to try new interventions. The facility did not make any other accommodations to prevent her falls and keep here safe. My wife had bruising from the falls. They moved her to a room closer to an office, but that person was not there all the time and when they were in there they had to work. They could have done something. They did not. They could not protect my wife and admitted it. During a telephone interview on 8/19/2020 at 1:10 PM, FM F stated, The date I went to the facility to have a window visit with my wife who is a resident at the facility, was June 28th (2020). She was laying on the floor of her room when I looked in the window. I had told the facility countless times to keep her safe because she fell a lot. They told me they could not prevent her falls, yet they agreed to admit her. The facility did not discuss many ways to help (Resident #102). They could have used a lap tray when I asked but the facility never tried. I asked them what they could do

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235399	A. BUILDING _____ B. WING _____	**08/19/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MEDILODGE OF PORTAGE	**7855 CURRIER DR PORTAGE, MI 49002**

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 0689 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 4) when we talked about helping (Resident #102) and they said they could not keep her from falling. They did not do everything they could have. I would have paid for a private sitter. During an interview on 8/18/2020 at 2:09 PM, Waiver Aide (WA) GG stated, (Resident #102) was saying she saw her husband on the day of that fall (6/28/2020). She was in her room and I was with another resident giving care. The housekeeper saw her first. There was a sign by the resident's bed in big red lettering that said call for help. She knew her husband was coming. I knew (Resident #102) would do things she did not know she was not supposed to do from working with her. I don't know if it was on her Kardex. During an interview on 8/18/2020 at 2:30 PM, RN R stated, (Resident #102) was very impulsive and had quite a few falls. The fall in her room on July 10th (2020) I remembered thinking I had just seen her. Staff had just asked her if she needed anything and tried putting her down in bed. She just got up before you knew what was happening. Resident #104 Review of a Face Sheet revealed Resident #104` was a [AGE] year-old male, originally admitted to the facility on [DATE], with pertinent [DIAGNOSES REDACTED]. Review of a Minimum Data Set (MDS) assessment for Resident #104, with a reference date of 7/15/2020, revealed a Brief Interview for Mental Status (BIMS) score of 3, out of a total possible score of 15, which indicated Resident #104 was severely cognitively impaired. Further review of the MDS indicated Resident #104 required the use of a wheelchair for mobility. Review of Resident #104's Care Plans revealed, Focus . at risk for falls related to: hx recurrent falls with pain, [MEDICAL CONDITION], dementia, generalized muscle weakness, unsteadiness of feet, lack of coordination, impulsivity, anxiety, difficulty in walking, mood disorder, cognitive communication deficit, diminished vision, will transfer without assistance, resident to use wheelchair for locomotion in facility but prefers to not use devices at time and ambulate independently; hx of toileting self without staff assistance. Date Initiated: 04/20/2019. .Goal . To reduce the risk of serious injury in the event of a fall through the review date. Date Initiated: 04/20/2019 Revision on: 07/28/2020 .Interventions . Anti-rollbacks, Anti-thrust cushion, wheelchair cushion tilted back. Anti-tippers on w/c . RESOLVED: encourage resident to use call light and wait for assistance with transfers Date Initiated: 07/08/2019 Revision on: 07/20/2020 Resolved Date: 07/20/2020 . Resident should wear the following footwear for ambulation well-fitting hard sole shoes Date Initiated: 07/13/2020 Revision on: 07/13/2020 . Review of Resident #104 Incidents 7/9/2020 at 1425 (2:45 PM) indicated resident was confused and disoriented with memory, hearing/vision, physical, and decision-making impairments. Resident #104's fall was unobserved and unwitnessed, happening in a hallway while resident trying to get out of wheelchair. A STAT (NOW) x-ray was ordered for resident's right hand. Review of Resident #104's Fall Investigation Report 7/9/2020 at 1425 indicated the resident was found in B hall on the floor after he appeared to become weak and lost his balance while ambulating alone and unattended. Review of Resident #104's Progress Notes 7/20/20 at 1420 (2:20 PM) revealed, .unobserved fall on 7/9/2020 at 1425 in the hallway .noted bruising, swelling, and limited range of motion to the right hand thumb .STAT right hand x-ray .The x-ray showed acute first proximal phalanx base fracture with malalignment .sent to ER .returned with a soft cast placed to his right arm/hand . Review of Resident #104's Incidents 7/31/2020 at 1310 (1:10 PM) indicated the resident was confused and disoriented with memory, hearing/vision, physical, and decision-making impairments. The fall was observed while the resident was in his room attempting to place his feet on the bed and tipping over backwards in wheelchair hitting his head. Review of Resident #104's Fall Investigation Report 7/31/2020 at 1310 indicated the resident's wheelchair was unlocked and tipped backwards after attempting to put his feet on the bed. The resident was in his room alone and unattended and fell to the floor. No witness statement was provided to surveyor by exit. Review of Resident #104's Progress Notes 8/3/2020 1027 (10:27 AM) revealed, .Resident was in his room sitting in his WC (wheelchair). CENA (aide) entered room and observed resident attempting to out (out) his feet up on his bed causing his WC to lean backwards and tip over. Observed on 8/12/2020 at 12:15 PM observed Resident #104 self-propelling wheelchair by nursing station wearing a blue cast on right hand/lower arm. During an interview on 8/18/2020 at 2:43 PM LPN T stated, I remember (Resident #104) was on the floor face down. I did not see him fall. It was change of shift time. I sent him to the hospital. I knew his hand or wrist was broken the way it looked. During an interview on 8/18/2020 at 2:57 PM UM S stated, I was working on the floor when staff found (Resident #104). I was told he was attempting to put his feet on the bed, and he fell backwards. He moves around quite a bit. I assessed him and he had a small hematoma on his head.