| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
| --- | --- | --- | --- |
| | 235226 | A. Building<br>B. Wing | 03/13/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Medilodge of Grand Blanc | 11941 Belsay Rd<br>Grand Blanc, MI 48439 |

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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information) |
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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22348<br><br>This Citation pertains to Intake Numbers MI00151159, and MI00151404.<br><br>Based of observation, interview and record review, the facility failed to protect residents from abuse and neglect for two residents (R#703 and R#705) when the nurse aide on the midnight shift neglected to respond to their call lights prompty and did not provide nursing care as needed of a total sample of four (4) residents reviewed for abuse and neglect.<br><br>Findings include:<br><br>Resident #703 (R703):<br><br>R703 was [AGE] years old and admitted to the facility on [DATE] with a diagnosis of Acute Respiratory failure, Hemiplegia, and Hemiparesis following Cerebral Infarction affecting the right dominant side-type 2 diabetes and dependence on respirator (ventilator) status in addition to other diagnoses. According to the Brief Interview for Mental Status (BIMS) assessment performed on 2/14/25, R703's BIMS score was 15/15, indicating his cognition is intact. The Minimum Data Set under the GG section and Care Plan dated 2/13/2025 revealed that R703 has an ADL (Activities of Daily Living) self-care performance deficit related to acute respiratory failure (on vent). R703 required one person total assistance on bathing, dressing, eating, personal hygiene, two person total assistance on bed mobility, toileting, transfers.<br><br>On 3/12/25 at 4:47 PM, R703 was observed and interviewed in his room with his wife. R703 was awake and alert but had difficulty expressing words because of his tracheostomy. He could agree by saying yes or disagree and tried to explain clearly in brief and essential words. When asked about the incident with the aide, he revealed that it happened during the midnight shift, and he was left sitting for over 2 hours wet and soiled, and the aide wouldn't respond to the call light. He was in so much anger, disgusted, and neglected. R703 felt he was disrespected. R703 stated, I was very upset because of the disrespect received from the aide, and they made me wait a long time before they suctioned me and told me to pee on my diaper if I can't hold my pee. R703 admitted saying that he felt like killing himself at that moment. R703, while telling the story, was very anxious and agitated. R703 indicated that the aide, CNA D, told him to stop pressing his call button that night because her foot hurt and she was tired of answering his light. The aide told him he had a diaper and could go on it or hold it. He felt so hopeless, helpless, and embarrassed.<br><br>(continued on next page) |

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.

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | R703's wife was interviewed on 3/12/25 at 4:50 PM. She revealed that during the night or early morning (March 9 to March 10), she recalled getting multiple calls from R703. She stated, That night, his anxiety was off the roof! I had to call the facility twice, asking them to please check on him. She further explained, The first time I called was for R703 needed to be suctioned because he couldn't breathe, and the second time, R703 complained about laying on his urine and feces for hours and needed to be changed. Furthermore, she explained, my husband had to call me because his aide was not responding his call button when he was soaking wet. They would not change him. They waited until it was the end of the shift. R703's wife came in the morning and filed a grievance with the nurse manager. R703's wife revealed that this had been going on for weeks and only with the same aide when she was assigned to R703. My husband sleeps better since the girl isn't here assigned to him. No one had evaluated him since he's been at the facility. He has anxiety, and he has depression. His anxiety is very high now.<br><br>An interview with the Nurse Manager (RN C) was conducted on 3/12/25 at 4:09 PM. She indicated that she came through R703's wife upset in the hallway. The wife reported that she had been calling the facility all night to let the nurse know that R703 was not answering his light and had not been changed by his aide. The aide stated to R703 and told him to stop pressing his light because the aide's feet hurt, and he did not want to keep getting up to answer his call light all night. The nurse switched the aide around 3:00 AM. RN C admitted that R703 appeared very upset, although he was not crying and did not seem distraught. R703 was very upset, explaining that she should not be coming to work if she was hurting. After R703's interview, the nurse manager said she left R703's room, and the resident was calm about the issue.<br><br>The Facility Grievance/FRI report was reviewed on 3/13/25 at 12:30 PM.<br><br>DETAILS:<br><br>Type of Alleged Incident: Neglect<br><br>Date/Time Incident Discovered: 3/10/25 08:00 AM<br><br>Date/ Time Incident occurred: 3/10/25 (no time was noted)<br><br>Incident Summary: Resident reported to the nurse manager who then reported to the Abuse Coordinator that his third shift aide neglected to answer his call light for hours nor changed him timely and takes hours to answer his call light when she works. Upon notification to the Abuse Coordinator, the aide in question was suspended pending investigation.<br><br>An interview with the Administrator was conducted on 3/12/25 at 3:35 PM. The Administrator revealed they had filed a Facility Report Investigation (FRI) to the State of Michigan on 3/10/25 and provided a file number. However, because it just recently happened, they have not completed the 5-Day Follow-up Report. The FRI was about a resident (R703) who complained about a care issues nurse aide who did not respond to his call light, and he felt neglected during a third shift on 3/9/25 from the midnight shift to the early morning of 3/10/25. R703's wife arrived early in the morning and reported to the nurse manager (RN C). The Administrator indicated that the nurse (Nurse F) of R703, during the midnight shift, switched the aide assignment according to R703 and the resident's wife's request before the end of the shift.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The Nurse Manager (RN C) reported the grievance received by R703 and his wife to the Administrator) that the 3rd shift aide assigned to R703 neglected to answer his call light for hours. Upon notification to the abuse coordinator, the aide was questioned and suspended pending investigation. The aide (CNA D) continued to be off because the investigation had not been completed. The Administrator stated that the Social Worker was notified of the R703's allegation of neglect and was agitated on Monday, 3/10/25, because he did not want the aide to be assigned or care for him at all. The administrator stated the investigation is still in progress.<br><br>The Social Services Staff (SS B) was interviewed on 3/12/25 at 3:45 PM. The SS B revealed that to this date, she has not spoken to R703 at all since the allegation of abuse and neglect last 3/10/25. She stated, I was not told to see him, and I have not seen him, nor have I talked to him since the allegation. When the Social Service staff B was asked why? she stated, Because he was the source of the allegation; she interviewed other residents except him. When asked if she had assessed his psychosocial status immediately upon allegation? She replied, No. Does R703 have any behavior or psych diagnosis? She said, Yes. Can you tell me what they are? Depression, Anxiety Disorder, and Insomnia: Has the resident received any psych services since admission? The SS Staff SS B replied, No, he has not been referred to see psych services since admission on February 13, 2025. R703 receives Alprazolam 0.25 1 tablet via peg tube (3/5/25), Paroxetine (2/14/25), and clonazepam (2/14/25), The Psychological Services to evaluate and treat as indicated (ordered on 2/14/25). The SS Badmitted that there were no referrals to psychological services related to the incident, nor were they seen initially upon admission despite being ordered on 2/14/25. He recently signed for consent to see the ancillary services on 3/6/25, which includes psych services, but I only knew about it now as we speak.<br><br>Review of Social Services Notes was conducted on 3/12/24 at 4:00 PM revealed no updated or current notes were documented related to R703's allegation of abuse and neglect from R#703 on 3/10/25.<br><br>An interview with Midnight Nurse (Nurse F) was conducted by telephone on 3/13/25 at 9:53 AM.<br><br>She was R703's third shift nurse on 3/9/25, arriving early on 3/10/25 morning. R703 did not want the aide assigned to him, so I switched them. He did not want her in there. The wife called at least twice. The first time she requested to check on her husband's call light, it was not working or not being answered, and he needed immediate assistance and needed to be suctioned. The second time was about her husband was feeling anxious because he was not receiving care. R703 needed to use the bathroom and seemed worried he was not assisted. Nurse F admitted that she did not document or report what happened during her shift but recalled that she switched the two (2) nurse aide assignments. I did not report this to the incoming nurse or the nurse manager.<br><br>An attempt to interview Aide#D (CNA D) was made via telephone on 3/13/25 at 9:40 AM. The surveyor left a voice mail, but no reply was received.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The Aide #E (CNA E) was interviewed by phone on 3/13/25 at 10:15 AM. She revealed that she was asked by Nurse (Nurse F) with the other aide (CNA D) who was originally assigned to R703 at around 2:30 AM. R703 was very upset and stated, I have never seen him so upset before. R703 told CNA E, he did not want CNA D to be his aide anymore. When she asked why? R703 told her that CNAD told him rudely to stop using his call button because her foot was hurting from getting up. CNA E continued indicating she changed him and made sure his diaper, pad, and sheet were clean and made him comfortable. CNA E also told him she would contact the nurse manager in the morning. CNA E made sure R703 was comfortable when she left the room. CNA E added that there was another resident who was also upset and complained about CNA D that same night and was ignoring and not responding to the other resident call light besides R703.<br><br>R 703's Care Plan was reviewed on 3/13/25 at 12:00 PM. His (R703's) Care Plan on Activities of Daily Living (ADL) was initiated on 2/13/25 and revised on 3/3/25, specified to Encourage /remind the resident to use the call light when assistance is needed. (Date initiated 2/13/2025, Revision on 2/20/25) and to honor resident's choices and preferences whenever possible. (Date initiated 2/14/25). R703's Care plan is specific for incontinence episodes for the Bladder and Bowel related to CVA and VDRF. It had interventions to provide peri-care after each incontinent episode and apply house barrier cream after incontinence care. Lastly, a care plan for R703, who receives psychotropic/mood stabilizer medication for anxiety, antidepressant, and hypnotic use. Specifically referring to a psychologist/psychiatrist as needed. The ADL's and incontinence care Plan were not followed by staff, and the Social worker did not assess, evaluate, and refer the resident for a psychological evaluation after the episode of increased anxiety and expressed that he wanted to kill himself. These Care Plan interventions for R703 were not followed by staff and was not updated after the 3/10/25 incident.<br><br>The facility's Abuse, Neglect, and Exploitation (Date reviewed/revised: 01/10/2024) was reviewed on 3/13/25 at 11:30 AM,<br><br>Policy: It is the policy of this facility to provide protections for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation, and misappropriation of resident property.<br><br>Definitions:<br><br>. Abuse means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish, which can include staff to resident abuse and certain resident to resident altercations. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain, or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse, including abuse facilitated or enabled through the use of technology. Willful means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Mental Abuse includes, but is not limited to, humiliation, harassment, threats of punishment or deprivation. Mental abuse also includes abuse that is facilitated or caused by nursing home staff taking or using photographs or recording in any manner that would demean or humiliate a resident(s). Neglect means failure of the facility, its employees, or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress .<br><br>Policy for Promoting /Maintaining Resident Dignity (Date Reviewed/ Revised: 10/26/2023) was reviewed on 3/13/2025 at 12:30 PM.<br><br>Policy:<br><br>It is the practice of this facility to protect and promote residents rights and treat each resident with respect and dignity as well as care of each resident in a manner and in an environment, that maintains or enhances resident's quality of life by recognizing each resident's individuality.<br><br>Compliance Guidelines:<br><br>All staff members are involved in providing care to residents to promote and maintain resident dignity and respect resident rights .6. Respond to requests for assistance in a timely manner .9. Groom and dress residents according to resident preference. 10. Speak respectfully to residents; avoid discussions about residents that may be overhead .14. Each resident will be provided equal access to quality care regardless of diagnosis, severity of condition or payment source.<br><br>The Facility's Social Worker Job Description (undated) was reviewed on 3/13/25 at 12:00 PM.<br><br>Summary: Provides psychosocial support to residents and their families.<br><br>Essential Functions are:<br><br>Provides direct psychosocial interventions.<br><br>Performs residents assessments at admission, upon condition change and or annual.<br><br>Creates, reviews and updates care plan and progress notes.<br><br>Coordinates residents visits with outside services, dental, optical, etc.<br><br>Attends and documents resident counsel meetings.<br><br>Assists resident's families in coping with skilled nursing placement, physical illness and disabilities of the resident, and the grieving process .<br><br>Conducts in-service programs to educate staff regarding psychosocial issues and patient rights .<br><br>37771<br><br>Resident #705:<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | A review of Resident #705's medical record revealed an admission into the facility on [DATE] and re-admission on 5/15/23 with diagnoses that included acute and chronic respiratory failure, dependence on respirator status, Muscular Dystrophy and tracheostomy status. A review of the Minimum Data Set assessment revealed a Brief Interview of Mental Status score of 15/15 that indicated intact cognition, the Resident had limited range of motion of bilateral upper extremities and was dependent on helper for activities of daily living, mobility and transfers.<br><br>A review of the Facility Reported Incident investigation for Resident #703 of an interview written by Nurse C for Resident #705, dated 3/10/25 at 8:35 AM, that revealed: (Resident #705) asked for yankauer, she refused stating she doesn't do that you need to get respiratory to do it. I don't do respiratory job. (Resident #703) asked are you serious? She said yes and didn't do it. Then (Resident #705) asked her to cut the TV on and she mumbled to herself, This is f_____g bullshit, I been in this room a half hour what else do she want. Then said aloud What else do you need?<br><br>On 3/13/25 at 11:50 AM, an observation was made of Resident #705 lying in bed. The Resident was interviewed, answered questions and engaged in conversation. The Resident was asked if they had experienced any abuse from staff while at the facility. The Resident reported that she had an issue with a CNA (Certified Nursing Assistant) on Sunday night, Monday morning. The Resident explained that she had put the call light on, needing to go to the bathroom, CNA D had come in, put me on the bedpan and took me off, and stated, I told her I needed to spit. She said I don't do suctioning. I just needed to spit, I didn't need to be suctioned, and exclaimed she would not help me to spit, I can not do it myself. The Resident explained that the CNA said she would get respiratory and stated, She never got respiratory, she had asked the Respiratory Therapist later and they were never told to come down. The Resident reported that before the CNA had left, she had asked to put the TV on and stated, The CNA said 'This is F-N bullshit, I have been in this room for half an hour, what else does she F-N want', she was talking under her breath but I could hear her and she was swearing, the Resident indicated F-N was the swear word. The Resident reported she has had CNA D a few times and reported the CNA was unpleasant, rude, and that she doesn't like to talk to us, miserable person and stated, I don't converse with her, she tries to make me miserable, and She was swearing, loud enough I could hear it, I just asked to turn the TV on. The Resident was asked what she had to do for the built-up secretions in her mouth and the Resident stated, I had to swallow most of it, and reported she had put the call light back on when the Respiratory Therapist did not come in, the Respiratory Therapist answered the call light that's when I found out she never got the message from her (CNA D). The Resident was asked if she felt safe in the facility and the Resident stated, It's too stressful to have her as my CNA. I don't feel comfortable with her. She was acting crazy, swearing, she is intimidating and made me uncomfortable.<br><br>On 3/13/25 at 12:06 PM, an interview was conducted with the Director of Nursing (DON) regarding the interview and allegations from Resident #705. The DON reported that he had talked to the Resident about her concerns and that the Resident had said the same things to him. The DON was informed that the Resident reported feeling intimidated and uncomfortable. The DON reported the CNA was suspended and they will not be having her back and stated, I reassured her that the CNA will not be coming back. |