| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 235293 | A. Building<br>B. Wing | 06/25/2025 |

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| Medilodge of Farmington | 34225 Grand River Ave<br>Farmington, MI 48335 |

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| F 0600<br><br>Level of Harm - 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** This citation pertains to intake #MI00153092 and MI00153719<br><br>Based on interview and record review, the facility failed to protect the resident ' s right to be free from sexual abuse by a resident for one resident (R901) of four residents reviewed for abuse/neglect/mistreatment resulting in R901 shaking/trembling while their breast was being fondled without consent by R902. Findings include:<br><br>On 6/24/25 multiple complaints submitted to the State Agency for review which alleged R902 had sexually abused R901.<br><br>R901<br><br>On 6/24/25 the medical record for R901 was reviewed and revealed the following: R901 was initially admitted to the facility on [DATE] and had diagnoses including Dementia and Aphasia. A review of R901's MDS (minimum data set) with an ARD (assessment reference date) of 5/5/25 revealed R901 was dependent on facility staff for most of their activities of daily living. R901's BIMS score (brief interview for mental status) was six indicating severely impaired cognition. R901 was also noted to have a court appointed public legal guardian.<br><br>On 6/24/25 at approximately 10:36 a.m., R901 was observed in their room, laying in their bed. R901 was queried regarding if they had felt uncomfortable by any male residents in the facility and they started talking with unintelligible speech. Further in-depth conversation was attempted regarding how they were feeling in the facility, and they were noted to be unable to follow the conversation and were incomprehensible.<br><br>A review of R901's progress notes revealed the following:<br><br>4/27/2025 at 16:08-Nurses' Notes-Resident was observed in the dining area resting in Geri chair covered with sheets. Male resident was observed with right arm resting between female resident legs. Resident was moved near nurses station for close observation. Admin (Administrator) and DON notified. Will continue to closely monitor resident.<br><br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0600<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | 6/5/2025 at 23:33-Nurses' Notes-CNA (Certified Nursing Assistant) informed nurses that she had observed [R902] with his hand under the resident's shirt. Nurses removed resident from activity area and took her to her room .Nurses contacted Administrator, DON (Director of Nursing), Resident's doctor (MD), and Guardian. No new orders by MD at this time, but requested nurse to log in Dr's book. 15 minute checks in place for resident per DON<br><br>6/6/2025 at 15:33-Social Services Progress Notes-Writer met with resident today. Resident is alert and responsive. Her cognitive skills for daily decision making abilities are impaired<br><br>R902<br><br>On 6/24/25 the medical record for R902 was reviewed and revealed the following: R902 was initially admitted to the facility on [DATE] and had diagnoses including Multiple Sclerosis. A review of R902's MDS (minimum data set) with an ARD (assessment reference date) of 6/11/25 revealed R902 was independent on facility staff for most of their activities of daily living. R902's BIMS score (brief interview for mental status) was 12, indicating moderately impaired cognition.<br><br>A review of R902's progress notes revealed the following:<br><br>4/27/2025 at 15:01-Orders-General Note from eRecord-Resident observed resting right arm on female resident's wheelchair. Resident educated on resident safety. Resident informed of resident privacy and was compliant with nurse's request to remove his arm.<br><br>4/27/2025 at 16:02-Orders-General Note from eRecord-Resident observed for the second time with hand resting between female residents' legs. Resident had been informed that it was an invasion of privacy. resident stated, She likes it, she asked me to do it . Male resident was moved to different area of unit to separate him from female residents. DON notified administrator notified for further instructions .<br><br>6/5/2025 at 19:54-Nurses' Notes-CENA (Certified Nursing Assistant) came to writer to let writer know that resident was fondling another resident's chest under her shirt in dining room. CENA said she walked in dining room to see resident in wheel chair next to female resident and when she walked closer, she seen his hand in her shirt. CENA screamed for him to take his hand out of her shirt and separated him from the female resident by wheeling him outside the dining room Both residents immediately separated. Statement taken from witness. DON notified. Administrator notified. Guardian notified via voicemail. 15 minute visual checks implemented on resident to insure other residents safety.<br><br>On 6/24/25 a form titled Statement of Witness pertaining to the sexual abuse allegation on 6/5/25 involving R901 and R902 was reviewed and revealed the following: Name and Position of Witness [CNA O] .Date and time of Incident: 6-5-25 Statement of Witness-I seen [R902] was behind [R901]. She was in Geri Chair. I seen [R902] hand in [R901] shirt. [R902] was behind her chair, her chair was lean back and his hand was in her shirt. She was shaken .What did you do? I call his name [R902] he jump and [R901] stop shaken. I told him to leave out of the day room. He rolled himself by the door of Nursing station and he sat there What did you do next? I went to the Nursing station keeping close observation of [R902] and reported to the Nurse .<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | On 6/24/25 at approximately 12:40 p.m., the Administrator was queried regarding the incident between R901 and R902 on 6/5/25. The Administrator reported that CNA O had witnessed R902's hand inside R901's shirt on their breast and that the CNA had separated the residents and brought R901 to their room and notified the Nurse. The Administrator indicated the Nurse called them to inform them of the incident to speak to CNA O at that time on the phone. The Administrator indicated that after the incident they assigned the resident a 1:1 supervised staff member to supervise R902 and that R902 has had 1:1 supervision since then.<br><br>On 6/25/25 at approximately 1:20 p.m., Nurse R was queried regarding the incident between R901 and R902 on 6/5/25 and they reported that CNA O had came and told them that R902 had been fondling R901's breast and had their hand down R901's shirt. Nurse R reported that they took R901 down to their room and R901 was visibly shaking/trembling. Nurse R reported that in the dining room where the incident occurred, water was observed to be around the residents and they did not know if R901 had been trying to fight off R902 which may have caused the water spillage. Nurse R reported that 15 minute visual checks were implemented for R902 for the rest of the shift and after that, they had a 1:1 sitter.<br><br>On 6/25/25 at approximately 2:19 p.m., CNA O was queried regarding their witnessing of the incident between R901 and R902 on 6/5/25. CNA O indicated that they had snuck up behind R902 to see what was happening and observed R902 was behind and to the side of R901 and they were folding R901 breasts underneath R901's shirt. CNA O indicated that R901 was trembling and appeared to be frightened. CNA O said the shouted R902's name and they stopped and left the room. At that time, R901 stopped trembling. CNA O was queried if they had been made aware of any other issues between R901 and R902 and they reported they thought there was an earlier issue in which R902 had put their hand in between R901's legs and that had been why R902 was moved to the 2nd floor for awhile. CNA O did not know why R902 was moved back down to the first floor where R901 resided.<br><br>On 6/5/24 a facility document titled Abuse, Neglect and Exploitation was reviewed and revealed the following: 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 Sexual Abuse is non-consensual sexual contact of any type with a resident |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake #MI00153595<br><br>Based on observation, interview and record review, the facility failed to ensure an allegation of poisoning was reported to the Abuse Coordinator and State Agency in a timely manner for one resident (R903) of four residents review for abuse/neglect/exploitation. Findings include:<br><br>On 6/24/25 a concern submitted to the State Agency was reviewed which indicated R903 went to the hospital because they alleged their roommate [R904] had poisoned them.<br><br>On 6/24/25 at approximately 11:18 a.m., R903 was observed in their room, up in their wheelchair. R903 was queried regarding their allegation that they were poisoned by their old roommate [R904[They indicated that they had called the police about it and that they had felt dizzy and that previously R903's roommate (R904) said they wanted them to sleep. R903 was queried how they felt that they were poisoned by the roommate and they reported they didn't know they were just poisoned. R903 reported that after they had returned from the hospital they were moved down to the first floor of the facility and felt safer.<br><br>On 6/24/25 the medical record for R903 was reviewed and revealed the following: R903 was initially admitted to the facility on [DATE] and had diagnoses including Chronic obstructive pulmonary disease, Schizoaffective disorder and Anxiety. A review of R903's MDS (minimum data set) with an ARD (assessment reference date) of 5/13/25 revealed R903 needed assistance from facility staff for lower body dressing. R903's BIMS score (brief interview for mental status) was 15 indicating intact cognition.<br><br>A review of R903's progress notes revealed the following:<br><br>5/31/2025 at 07:48-Nurses' Notes-At approximately 2240, police officers arrived to unit stating resident called emergency services requesting transfer to the hospital. Upon entering resident's room resident claimed to feel unwell and dizzy, stating she believes her roommate poisoned her. Writer provided the resident with reassurance. Resident stated she still wanted to go to the hospital Resident exited facility at approximately 2250. Transferred to [Name of local hospital] .<br><br>A review of the facility investigation form titled Statement of Witness by Nurse S revealed the following: Witness and Position of Witness [Nurse S]. Resident Name [R903]. Date and Time of Incident: 5/30/25. Statement of witness-Around 10:40 p.m., we saw police come in saying [R903] called saying she needed to go to the hospital she thinking someone drugged <sic> .When I went into the room I heard her telling the officer that her roommate was trying to kill <sic> 'I took a sip of my water and felt dizzy.' Then she stated her roommate and [name of old roommate] was trying to kill her .I told her that I didn't believe that was true as neither of them can get out of bed. [R903] then stated 'that doesn't mean they are not paying the staff to hurt me' .The office asked if she wanted to to go she said 'yes'. She asked for pain meds (medications) before she left, the cop told her no if you think you were drugged it's not wise to get more. The ER (emergency room) will assess her and see .<br><br>(continued on next page) |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | A review of the facility reported investigation in the Michigan Facilty Reporting program (MIFRI)revealed the initial report of the allegation to the State Agency was not made until 6/2/25 at 3:58 PM.<br><br>On 6/24/25 at approximately 12:40 p.m., during a conversation with the facility Administrator (abuse coordinator) , the Administrator was queried regarding the delay in the reporting time of the allegation that R903's roommate had poisoned them. The Administrator indicated R903's Nurse did not notify them of the allegation and they were made aware of it a few days later in a morning clinical meeting. The Administrator indicated that they had to complete education with Nurse S on notify in the Administrator of any allegations immediately so they could report it to the State Agency.<br><br>On 6/25/25 a facility document titled Abuse, Neglect and Exploitation were reviewed and revealed the following: 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 Reporting/Response: A. The facility will have written procedures that include: 1. Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (e.g., law enforcement when applicable) within specified timeframe's: a. Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or b. Not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury. |

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| F 0635<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide doctor's orders for the resident's immediate care at the time the resident was admitted.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake #'s MI00153092 and Intake #MI00153425.<br><br>Based on interview and record review, the facility failed to ensure an appropriate admission per facility policy including physician orders and care directives for one Resident (R905) of one resident reviewed for admission. Findings include:<br><br>Review of an Intake received by the State Agency on 5/30/25 revealed on 5/28/25 at 7:30 p.m., the complainant reported R905 was admitted to the facility from the hospital on 5/28/25 and received no medication during their stay, as the facility staff allegedly lost their paperwork from the hospital. The report revealed R905 said they watched an EMS (Emergency Medical Services) worker hand over their paperwork to facility staff, who reported it was not received. The complainant reported R905 had to leave the following morning when they did not receive their medications. The complainant reported the facility discharged R905 (AMA - Against Medical Advice) despite no medications being administered during their stay. R905 reportedly had to find their own transportation back to the hospital to receive their medications and transfer their wheelchair and walker back also. The complainant reported R905 was readmitted to the hospital on [DATE] and was being discharged to another nursing home.<br><br>Review of R905's facility census confirmed they were admitted to the facility on [DATE] and discharged on 5/29/25.<br><br>Review of R905's profile revealed they were their own responsible party.<br><br>Review of R905's diagnosis page revealed their primary diagnosis was hypoplasia and dysplasia of the spinal cord (conditions related to abnormal development of the spinal cord), a fall, cervicalgia (neck pain), chronic pain syndrome (persistent pain), atherosclerotic heart disease (hardening of the arteries), depression, and a history of myocardial infarction (heart attack).<br><br>Review of R905's physician orders revealed no medications.<br><br>Review of R905's medication and treatment administration records (MAR/TAR) revealed no medications were listed and no medications or treatments were administered during their stay.<br><br>Review of R905's Electronic Medical Record (EMR) revealed no Care Plan was initiated, or any care directives including a Kardex for the nursing direct care staff to follow.<br><br>Review of R905's MDS (Minimal Data Set) assessments had no complete pain assessments which showed if they had pain or their pain level.<br><br>Review of R905's vitals showed no logging of any pain/assessment including numerical representation or other standardized assessments.<br><br>Review of R905's progress note by Licensed Practical Nurse (LPN) V, dated 5/28/25 at 7:48 p.m., revealed R905 was admitted to the facility on [DATE] at 6:30 p.m The note showed, .(R905) did not arrive to facility with discharge summary or hospital paperwork There was no noted documentation of attempting to obtain the paperwork in this note.<br><br>(continued on next page) |

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| F 0635<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of R905's nursing progress note, by Registered Nurse (RN) T, dated 5/29/25 at 1:01 a.m., revealed RN T attempted to obtain a medication list from the hospital without success, and notified the Director of Nursing (DON) and Physician U, without a physician response noted.<br><br>Review of R905's EMR showed no physician visit or documentation.<br><br>Review of R905's progress note dated 5/29/25 at 11:07 a.m. revealed R905 decided to leave the facility AMA (against medical advice) . and refused to sign the AMA form. This note revealed a physician was notified of R905's discharge, without a response documented.<br><br>Review of R905's progress note dated 5/29/25 at11:20 a.m., revealed, Nurse came to writer regarding resident wanting to leave AMA. Nurse reported that resident stated that he did not want to wait for the doctor to send in medications, he just wanted to leave .<br><br>Review of R905's nursing assessment, dated 5/28/25, revealed an incomplete assessment. The pain assessment showed as not completed and was unable to be accessed by the survey team. The assessment was unlocked, remaining accessible for documentation.<br><br>Review of the EMR revealed R905's hospital discharge summary, including a discharge medication list, was not received by the facility until 5/29/25 at approximately 10:30 a.m., per fax receipt date and time.<br><br>On 6/24/25 at 11:57 a.m., Assistant Director of Nursing (ADON) A was asked about R905's stay at the facility. ADON A confirmed they met with R905 during their brief facility stay, per R905's progress notes. ADON A confirmed R905 was admitted to the facility on [DATE] without their discharge paperwork including physician orders and care directives. ADON A explained they could not use the referral paperwork from a few days prior (5/23/25), as this would not have been the accurate hospital discharge medications, as medications typically changed during a resident's hospital stay. ADON A confirmed they did not receive R905's hospital discharge paperwork until 5/29/25 at approximately 11:00 a.m., reportedly right after R905 left AMA and went back to the hospital. The ADON was asked if the facility assisted R905 in returning to the hospital. ADON A confirmed R905 was discharged AMA and thus was not assisted with their discharge to the hospital. The ADON A acknowledged R905 was under the facility's care with no admission instructions or physician orders during their stay, from 5/28/25 at approximately 7:00 p.m. until 5/29/25 until approximately 11:00 a.m., for about 16 hours. When asked if anything could have been done differently, ADON A responded the nurses who were caring for R905 did everything they could have done to obtain the paperwork. The ADON confirmed R905's physician had been notified on 5/29/25 at 1:00 a.m. they were in the facility without medication orders or care directives.<br><br>Review of the EMR showed there was no physician follow-up or visit documented after Physician U was notified R905's discharge paperwork and physician orders were not received.<br><br>(continued on next page) |

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| F 0635<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 6/24/25 at approximately 1:00 p.m., the (current) Director of Nursing (DON), with DON Z, was asked about R905's stay and no physician orders, care directives, or any skilled care received. The DON confirmed R905 was in the facility approximately 16 hours and conveyed they refused skin and nursing assessments and planned to leave. The DON confirmed R905 came into the facility without a medication list and their facility process was their physician could not prescribe medication without laying eyes on the resident. The DON clarified their policy was they would have received a discharge summary from the hospital including a medication list, and their process was they would not admit a resident without a medication list. The current DON reported they started their position at the facility on 6/06/25, after R905's admission, and understood R905 should have returned to the hospital without a medication list or care directives. The DON explained they were not aware of any skilled care provided to R905.<br><br>The DON reported their nurses tried to obtain physician's orders from the hospital and a complete discharge summary without success. The DON and DON Z confirmed R905 received no medications during their stay, including their blood pressure or pain medications.<br><br>On 6/24/25 at 1:42 p.m., the ADON and nursing management team brought a pain assessment form to the survey team dated 5/28/25 at 21:38 (9:38 p.m.), which showed R905's pain was 2/10 on the admission nursing assessment. Surveyors showed the ADON and nursing management this assessment remained inaccessible to the survey team in the EMR and showed as incomplete. The ADON explained they had other access to a Print function the survey team did not have. This Surveyor explained we needed access to all medical records. This form remained not accessible to the survey team during the survey in the EMR. This Surveyor asked for a time stamp of when this documentation was entered. The management team returned at 1:55 p.m., with a time stamped log which showed the pain assessment showed a date of closed on 6/02/25.<br><br>On 6/24/25 at 2:16 p.m., Registered Nurse (RN) T was asked during a phone interview about R905's stay. RN T explained they started their evening shift on 5/28/25 when R905 was under their care, and confirmed per their progress note they attempted to obtain R905's discharge paperwork. RN T reported they notified the Director of Nursing (DON) and Physician U, with no care directives or physician orders received. RN T stated, I could not provide treatment. There were no physician orders .(R905) was supposed to come (to the facility) with physician orders . RN T confirmed R905 was upset there were no physician orders as they wanted their medications, and said not to touch them without their medication orders. RN T stated R905 would not let them take their vitals or do any assessments without any physician orders.<br><br>On 6/24/25 at 2:30 p.m., Licensed Practical Nurse (LPN) V was asked during a phone interview about R905's facility admission. LPN V confirmed they were the nurse who admitted R905 from the hospital and stated, They had no paperwork at all (from the hospital) .(R905) did not have one piece of paper . LPN V reported there was nothing they could do for R905 without any discharge paperwork or physician orders, and stated R905 wanted to leave.<br><br>(continued on next page) |

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| F 0635<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 6/24/25 at 2:50 p.m., an interview was completed with the Medical Director, Physician W. This Surveyor reviewed concerns with Physician W related to R905 being admitted to the facility with no admission paperwork from the hospital including a discharge summary including care directives or physician orders, and nursing staff reporting they could not provide care to R905. Physician W reviewed the Electronic Medical Record (EMR) with this Surveyor and concurred there were no physician orders or care directives. Physician W reported any resident who was admitted to the facility would come with a discharge medication list, and their medications would be put into the EMR. Physician W conveyed they would have expected nursing staff and the physician to get any temporary orders, if the patient was alert and oriented, and obtain a verbal order by contacting the physician who discharged them from the hospital. Physician W was asked if they understood the concern with R905 being admitted without any care directives or physician orders for nursing staff to provide care and medications, and why R905 had not been sent back to the hospital, given they were in the facility about 16 hours. Physician W reported they understood the concern however they believed temporary orders could have been received by a Physician, and none were found in the EMR.<br><br>Review of R905's Hospital After Visit (Discharge) Summary, dated 5/20/25 through 5/28/25, showed the facility fax receipt was 5/29/25 at 10:29 a.m The hospital discharge diagnosis was back pain due to injury. Their discharge medications included a Lidocaine topical (pain) patch 5% daily, Metoprolol succinate (medication for high blood pressure) 25 mg (milligrams) daily, atorvastatin (cholesterol medication) 80 mg daily, acetaminophen (pain medication) 500 mg (2 tablets) twice daily as needed, clopidogrel (to prevent blood clots) 75 mg daily, Oxycodone (narcotic pain medication) 10 mg every 4 hours as needed, and Allopurinol (gout medication) 300 mg once daily. R905's new medications upon discharge, which were added during their stay, included Ibuprofen (pain anti-inflammatory medication) 40 mg once daily, methocarbamol (muscle relaxant medication) 750 mg three times daily, and prednisone (steroid for inflammation), tapered, beginning at 20 mg four times a day.<br><br>Further review of R905's hospital discharge summary showed they received a one-time dose of Dilaudid narcotic pain medication for severe neck pain on 5/27/25, and their LACE (a standardized assessment showing rehospitalization risk) score was 13/19, showing they were at high risk for rehospitalization.<br><br>On 6/25/25 at 2:48 p.m., the Nursing Home Administrator (NHA) acknowledged they understood the concerns, and R905 should have been sent back to the hospital without any medication orders or care directives.<br><br>On 6/25/25 at 9:58 a.m., the former DON, RN X, was asked about R905's stay at the facility from 5/28/25 through 5/29/25. RN X confirmed the facility received incomplete discharge documentation and no physician orders. RN X clarified Physician U was contacted, and they were not aware of any follow-up. RN X reported they were aware R905 wanted to leave AMA and would not allow staff to assess them including taking vitals. RN X acknowledged they were aware R905 did not receive their medications for 16 hours, and they were not aware if R905 had any pain.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 235293 | A. Building<br>B. Wing | 06/25/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Medilodge of Farmington | 34225 Grand River Ave<br>Farmington, MI 48335 |

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

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|---|---|
| F 0635<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 6/25/25 at 1:12 p.m., the Admissions Coordinator, Staff Y, was asked to describe the resident admission process. Staff Y explained they received the history and physical, and the hospital (or discharge) referral packet a few days prior to a resident's admission. Staff Y described although the referral packet may contain a medication list, nursing staff could not use this medication list, as medications and care directives changed prior to a resident's discharge. Staff Y explained typically the emergency medical transport team would provide the facility with a discharge packet including current medications and a discharge summary.<br><br>An attempt was made to reach R905 on 6/24/25 at 2:04 p.m., with no call returned during the survey.<br><br>Review of the policy, admission to the Facility, revised 1/01/2022, revealed, Policy: The facility will admit only those residents whose medical and nursing care needs can be met. This decision is based on both the needs of the community and the facility's clinical competencies. Admissions are accepted 24 hours a day, 7 days a week. Purpose of admission Policy 1. A primary purpose of our admission policies is to establish uniform guidelines for personnel to follow in admitting residents to the facility . 2. Prior to or at the time of admission, the resident's Attending Physician must provide the facility with information needed for the immediate care of the resident, including orders covering at least: a. Type of diet (e.g., regular, mechanical, etc.); b. Medication orders, including (as necessary) a medical condition or problem associated with each medication; and c. Care orders to maintain or improve the resident's function until the physician and care planning team can conduct a comprehensive assessment and develop a more detailed Interdisciplinary Care Plan. Applicability 3. Our admission policies apply to all residents admitted to the facility regardless of race, color, creed, national origin, age, sexual orientation, religion, handicap, ancestry, marital or veteran status, and/or payment source. Objectives 4. The objectives of our admissions policies are to: a. Provide uniform guidelines for admitting residents to the facility; utilizing the clinical review/admit guide b. Admit residents who can be adequately cared for by the facility c. Address concerns of residents and families during the admission process d. Review with the resident, and/or his/her representative (sponsor), the facility's policies and procedures relating to resident rights, resident care, financial obligations, visiting hours, etc.; and e. Assure that the facility receives appropriate medical records and financial documentation/authorization(s) prior to or upon the resident's admission .Responsibility 6. The Administrator, through the Admissions Department and admission Team, shall assure that the attending physician, resident and the facility follow applicable admission policies. |