

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235296	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/13/2024
NAME OF PROVIDER OR SUPPLIER Medilodge of Southfield		STREET ADDRESS, CITY, STATE, ZIP CODE 26715 Greenfield Rd Southfield, MI 48076	

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)
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41415</p> <p>Based on interviews and record reviews the facility failed to ensure physician notification and follow-up for a resident with a change of condition for one (R701) of four residents reviewed for quality of care. Findings include:</p> <p>Review of a complaint submitted to the State Agency (SA) documented concerns of the facility's failure to provide timely medical care which resulted in the death of R701.</p> <p>Review of the medical record revealed R701 was admitted to the facility on [DATE], with diagnoses that included multiple sclerosis, asthma, and chronic kidney disease with heart failure.</p> <p>Review of a Nursing note dated [DATE] at 1:52 PM, documented in part . Resident informed nurse she feels as though she has food poisoning writer contacted DR (doctor), no answer or reply. Writer awaiting call back for further orders.</p> <p>Review of a Nursing note dated [DATE] at 10:14 PM, documented in part . upon making rounds at beginning of shift, resident daughter at her bedside stated her mother had not been feeling well today and she had brought her soup, soup was well tolerated. Vital <sic> obtained <sic> BP (blood pressure) ,d+[DATE], HR (heart rate) 71, Temp (temperature) 97.2 02 (oxygen saturation) 97%. Resident stated her back was hurting, Pain medication given, lidocaine patch applied. Rounding assignment resident was observed with no stimuli, Faint pulse, performed sternum Rub, No additional stimuli observed, called code blue, 911 called. Resident was taken to (hospital name and city), Family notified of transfer, Physician made aware.</p> <p>This note was documented more than nine hours after the initial attempt to notify the physician of R701's change of condition. There was no additional documentation of the facility nurses to have contacted the physician to inform them of the reported change of condition for R701.</p> <p>The vitals documented above were the same parameters documented in the vitals tab with the times ranging from 4:01 PM to 5:03 PM, with the exception of the resident's pain level to have been documented at a level 8.</p> <p>(continued on next page)</p>

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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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On [DATE] at 10:35 AM, an interview was conducted with R701's daughter (mentioned above in the nurses note) and they were asked how their mother was doing on the evening of their visit on [DATE]. R701's daughter said they called that day around 12:16 PM and talked to the day shift nurse assigned to R701, who explained R701 was not feeling well. The day shift nurse reported they contacted the doctor and were waiting for a response. R701's daughter explained they went to the facility and the evening shift nurse assigned to R701 informed them that R701 was sick, had diarrhea and vomited. R701's daughter said the evening shift nurse checked the computer and explained the doctor was notified, pending a response. R701's daughter reported when they visited R701 that evening, R701 said they felt like they had food poisoning, their stomach was bothering them so bad and R701 was throwing up with diarrhea. R701's daughter reported they spoke to the evening nurse to find out the status of the physician notification and the evening nurse said they were in the middle of assisting another resident who had a tracheostomy and a temperature of 105 (degrees Fahrenheit) and they would get back to R701's daughter. R701's daughter reported the evening nurse explained the physician never called back. R701's daughter reported they left the facility so their mother could get rest and a few hours later they received a call from the evening nurse that R701 was unresponsive, CPR was started, and they were being transferred to (hospital name). The evening shift nurse was later identified as Licensed Practical Nurse (LPN) K.</p> <p>Review of a hospital records revealed R701 had expired a short time after arriving to the Emergency Department.</p> <p>On [DATE] at 8:35 AM, a telephone interview was conducted with LPN K. When asked about R701 on the evening of [DATE], LPN K recalled receiving report from the off going nurse that R701 was feeling well, and they were waiting for a reply from the physician. LPN K was asked if they attempted to get in touch with the physician, as there was no documentation they attempted to follow up on the change of condition verbalized by R701. LPN K reported they attempted to reach out to the physician but had not received a reply as well. LPN K was asked the name of the physician they contacted being that [DATE] was on the weekend. LPN K reported they usually contacted the primary physician noted on the resident's record. LPN K was asked about the facility's protocol when the nurses were unable to reach the primary physician on the weekends and LPN K reported they would continue to attempt to follow up with the primary physician. LPN K was asked what symptoms were identified with R701 that made them not feel well and LPN K said they could not recall the exact details, however, did remember the resident had pain and loose stool.</p> <p>Review of the medical record revealed no documentation of additional monitoring or physician follow-up until the physician was informed of the resident's transfer to the hospital.</p> <p>On [DATE] at 2:11 PM, the Director of Nursing (DON) was interviewed and asked about the facility's protocol on notification to the physician of a change of condition on the weekends if the primary physician does not reply. The DON explained the nurses had multiple people, they could call including Nurse Practitioners and the Medical Director if the primary physician did not return their calls. The DON was then asked to provide any additional information or documentation that the physician was notified or responded to R701's change of condition on [DATE] and the directive given to the staff by the physician. The DON reported they would look into it and follow back up. The DON reported they could not find any additional information to provide.</p> <p>No further explanation or documentation was provided before the end of the survey.</p>		

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<p>F 0880</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41415</p> <p>This citation pertains to Intake(s): MI00144759 & MI00144593.</p> <p>Based on observations, interviews, and record reviews the facility failed to implement measures/restrictions implemented by the County's health department after the identification of a facility resident diagnosed with presumptive healthcare associated Legionella (a type of bacteria that causes pneumonia), failed to timely and accurately conduct surveillance of the facility's infections, and failed to ensure water management meetings were being conducted as documented in the facility's policy for three residents (R705, R706 and R708) of six reviewed for infection control. This had the ability to also affect 140 of 140 residents that resided in the facility at the time of the survey, resulting in non-compliance with the local Health Department/County's Epidemiologist restrictions and the risk of growth and spread of Legionella. The facility failed to maintain an effective infection surveillance program and failed to conduct water management meetings as indicated in the facility policy, which resulted in an Immediate Jeopardy (IJ).</p> <p>The IJ was identified on 6/13/24 at 1:00 PM.</p> <p>The IJ began on 5/21/24.</p> <p>The Assistant Administrator (AA) B who was the acting Administrator in the absence of the facility's Administrator during the survey was notified of the IJ on 6/13/24 at 4:10 PM, and a plan of removal was requested to remove the immediacy.</p> <p>The IJ was removed and verified on 6/13/24 based on the provider's implementation of removal. Although the immediacy was removed the facility's deficient practice was not corrected and remained widespread with the potential for harm that is not immediate jeopardy.</p> <p>Findings include:</p> <p>(continued on next page)</p>

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<p>F 0880</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Review of an email sent from the County's Epidemiologist (CE) A dated 5/15/24 at 12:10 PM, documented in part .Thank you for meeting with us today. As mentioned on the call, this case is what CDC (Centers for Disease Control and Prevention) considers a presumptive healthcare associated case in that the case spent the 10 days prior to symptom onset at the facility. The (county name) County Health Division will be completing an environment investigation at your facility (date and time) .While the investigation and environmental sampling are pending, the Health Division is making the following restrictions .Continue or immediately begin surveillance - order urinary antigen tests and a respiratory sputum panel with Legionella cultures for any resident with clinical presentation consistent with pneumonia. Ideally, the specimen collection for culture and urinary antigen tests should be done simultaneously, and if possible, before initiation of antibiotic therapy. Reporting a number of patients with those symptoms in the last six months and testing for those with symptoms in the last month will suffice. Please report any results back to me .Identify the water/plumbing system that serves the case's room. Begin bottled water and ice restrictions for all patient rooms/areas on the water system. Water and ice received through a filter of 0.2 microns can be used instead .It is imperative to order and install the filters as soon as possible in order to use the water system. Filters are recommended to be maintained and replaced according to manufacturer recommendations .Remove aerators from all sink faucets. Avoid using sinks in resident rooms until 0.2 micron filters can be installed on faucets . This email was addressed to the facility's Administrator and Corporate personnel.</p> <p>The survey team entered the facility on 6/12/24 for an unannounced survey and was escorted to a room with an attached bathroom. The bathroom sink did not have a filter on the faucet and there was no signage hung alerting the surveyors to not use the sink/water. The facility staff failed to inform the surveyors of the current Legionella restrictions implemented by the Health Department. There was no hand sanitizer or hand wipes provided.</p> <p>An initial facility observation was completed on 6/12/24 at approximately 11:00 AM. During this observation on the 2nd floor (North unit) locked unit that housed residents with cognitive impairments, multiple residents were observed ambulating with/without assistive devices and in their wheelchairs on the unit. Residents were observed walking in and out of their rooms and in the hallways. The faucet in the hallway to the dining room area was dripping and it did not have a filter installed on the faucet. There were no signs alerting residents/staff not to use the sink. The faucets were observed in the bathrooms of the following resident rooms: 204, 205, and 206. The faucets did not have any point of use filters and had running cold water. There were no signs near the faucets/in the bathrooms alerting residents/visitors not to use the water.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>During this observation an interview with CNA E (who was assigned to the unit) was conducted at approximately 11:15 AM. During the interview CNA E was queried if they were aware of any concerns related to the facility's water. They reported that they were aware of the water issues related to Legionella and they were using the water from jugs that were kept at the nursing stations. They pointed to a cart that had 5-gallon water jugs and a cooler with ice. They reported they were using the jug water to provide to the residents for hydration. They also reported that the facility had installed a filter on the shower, and they were giving showers to the residents. CNA E was queried how they were washing their hands (before, after and/or during the shower if need be). They reported that they were asked to use hand sanitizers and hand wipes. When queried what did they do if their hands were visibly soiled or had to wash after care, showers etc. and they had reported that they were using sanitizer and wipes. CNA 'E' confirmed that the shower room faucet did not have an appropriate filter and they were not able to wash their hands. CNA 'E' was questioned about the residents' rooms. They confirmed that the faucets in resident bathrooms were working and did not have any filters. They added that residents were not supposed to use the sinks and they did not understand why water supply to sinks were not shut down. When queried about the residents who needed close supervision due to their cognitive abilities who were ambulatory and how they were monitoring these residents to make sure they were safe and not using the water from the sinks, they reported that was a concern and they were doing their best to monitor. CNA 'E' reported that there were seven residents who were able to ambulate/move around in their wheelchair between rooms [ROOM NUMBERS]. There were also other ambulatory residents in the back of the hall.</p> <p>A follow up observation was conducted on the 1st floor shower room on the South hallway across from room [ROOM NUMBER] at approximately 1:00 PM on 6/12/24. The faucet on the hand wash sink did not have a filter. An unopened 5-gallon water container was observed on the floor near the sink. The shower room did not have hand sanitizer and/or hand wipes. There were no signs posted in the shower room alerting not to use the water from the sink.</p> <p>An interview with the Licensed Practical Nurse (LPN) D who was assigned to the 1-south hallway was conducted at approximately 1:05 PM. The surveyor accompanied the LPN to the shower room on the 1st floor on South Hall. LPN D was queried about how they were handling the water situation and providing care for the Residents. They reported that there was a filter in the shower, they were getting ice from outside, and they were using hand sanitizers. LPN D was queried on how staff were washing hands after a shower, they reported that they were using the sink and hand sanitizer. When queried further they reported that staff used bottled water to wash hands. When queried about the unopened 5-gallon bottle on the floor and how staff were able to lift the container, get water and wash their hands, LPN D did not provide any further explanation. LPN D was queried about how staff provided bed baths for their residents. They reported that staff were getting water from the showers into a wash basin and carried to the resident rooms. It must be noted that throughout these observations completed on 6/12/24 and 6/13/24, no staff members were observed taking water from the shower rooms to resident rooms for any bed baths/ADL (Activity of Daily Living) care.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>An interview with Registered Nurse (RN) F was conducted on 6/12/24, at approximately 1:15 PM. They were assigned to the 1-south hall. RN F was queried about how they were handling the water situation. RN F reported that there were filters in the shower rooms; they were using hand sanitizer and wipes to clean their hands. RN F was queried about the running water in the resident bathroom sinks and they reported that the hot water to the sinks were turned off and cold water was still on. RN F stated the residents knew they were not supposed to use the bathroom sinks, and they were provided with hand wipes. When queried further on how they were monitoring all the residents to ensure they were not using the sinks including residents who had cognitive impairment, RN F reported that most of their residents were alert and did not provide any further explanation.</p> <p>Follow up room observations were completed on 6/12/24, at approximately 4 PM on the same loop where the R708 (first resident identified with presumptive Legionella at the facility) resided to check the bathrooms sinks for filters. R708 resided in room [ROOM NUMBER], that had a shared bathroom with room [ROOM NUMBER]. The shared bathroom between rooms [ROOM NUMBERS] had a filter installed on the water line under the sink. There was water dripping from the filter. A pink wash basin was placed under the filter and there was puddle of water on the floor around the basin. There were no filters installed in any other resident rooms in the south hallway and the sinks had running cold water. There were no signs in the bathrooms alerting residents, staff, and visitors to not use the sinks. Several bathrooms did not have any hand sanitizers. During these observations residents were queried. Two residents reported they were using their bathroom sinks to wash their hands. One resident reported that they did not have hot water, but they were able to use cold water to wash their hands. One other resident reported, We can't even brush our teeth, it has been a while. An observation of a shared bathroom between room [ROOM NUMBER] and 128 had a large puddle of unknown white fluid under the sink.</p> <p>Observations made on 6/12/24 starting at 4:09 PM, of multiple rooms were conducted- 101 & 102 shared bathroom, 103, 104 & 105 shared bathroom, 106 & 108 shared bathroom, 107 shower/sink, 110 & 112 shared bathroom, 111 & 113 shared bathroom, 114 & 116 shared bathroom, 115, 118, 201, 202 & 203 shared bathroom, 204, 205 water visualized running, 206, 207, 208, 209 constant drip, sink visualized half full with water & 211 shared bathroom, 210 & 212 shared bathroom, 213 & 215 shared bathroom, 214 & 216 shared bathroom, 217, and 218 a constant drip from the bathroom sink was observed. None of the rooms contained filters on the sinks or shower. There were no hand wipes or source of water observed in any of the resident rooms to ensure good hand hygiene was maintained.</p> <p>An observation was completed on the 2nd floor south hallway on 6/12/24 at approximately 4:30 PM. There was one filter installed on the shower. There were no filters installed on the hand wash sink in the shower room. There was no bottled water and there was no hand sanitizer in the shower room. During a follow-up room observation in the same hall on 6/13/24, at approximately 9:30 AM, a water cup filled with water was placed over the bathroom sink in room [ROOM NUMBER] that read 6/13 - 223-1. There were no filters in any of the resident room bathrooms sinks on the unit. Most of the bathrooms on the unit did not have any hand sanitizers.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>An interview was completed with the Assistant Administrator (AA B) on 6/12/24 at approximately 12:40 PM. AA B was queried if they had any Legionella concerns at the facility and they had reported that they did. They added that one Resident (R708) was transferred to hospital from the facility and the facility was notified by the County Health Department that R708 tested positive for Legionnaires' disease at the hospital. AA B also added that the County Health Department team was onsite at the facility, and they gave recommendations. They also added that they were doing precautionary testing and following the recommendations from the County Health Department. The surveyor requested the recommendations they had received from the local County Health Department. AA B reported that they received it via e-mail, and they would share. Later AA B provided a copy of the letter from the County Epidemiologist (CE A). The letter was not dated and when queried AA B they reported that they had copied the information from the e-mail. The surveyor had requested AA B to share the email communication between the facility and local County Health Department. Facility did not provide the information; however, the information was received from the CE A via e-mail.</p> <p>A follow up interview was completed with AA B on 6/12/24 at approximately 12:50 PM, and they were queried about the current measures they had in place. They reported the shower rooms had filters and residents were able to take showers and there was a filter installed on the hand wash sink in the kitchen. They were using bottled water for cooking needs and for drinking since 5/15/24 and they had been in touch with the County Health department. AA B also added that Residents and families were communicated with via mail, and they were notified in person. AA B was queried if they had any water consultants assisting with the implementation of preventative/control measures and they reported that they had their internal team and did not have any third-party consultants and they were meeting monthly. They also reported that they believed the hand wash sinks in shower rooms were functional i.e. had appropriate filters in place. Later during rounds, it was observed that shower room sinks did not have any filters. They were queried if the residents/families were sent any follow up communication since the initial communication, and they reported that they had not sent any further communication.</p> <p>An interview with the CE A was completed via phone on 6/12/24, at approximately 1:45 PM. CE A were queried on presumptive Legionella case and their recommendations/follow up with the facility. CE A had reported that R708 who tested positive for Legionnaire's was a resident of the facility. R708 had remained in the facility for the entire incubation period (the time it takes for an infection to develop after an individual was exposed to disease causing organism such as Legionella bacteria) and had tested positive at the hospital. The facility was initially notified on 5/15/24 and an onsite environmental investigation and sampling was completed on 5/17/24. CE A stated their reports were pending, waiting for the test results. CE A had shared that the facility was provided with the measures they needed to implement immediately. They were queried if the facility's water was safe to use without the 0.2-micron filters on resident bathroom sinks, hand wash stations in the shower rooms etc. CE A confirmed that it was not safe to use the water without the filters and the facility was notified of the recommendation about three weeks ago. They had also followed up with a maintenance staff member (Senior Maintenance Director) SMD G from the organization on having the appropriate filters in place. They were unaware that the 0.2-micron filters were not in place in all locations as per their recommendations and reported that they would follow up with their facility contact, SMD G. After the telephone interview, CE A provided the surveyor the e-mail communications that was initially provided to the facility after the health department visit at the facility 5/17/24.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>A request was sent via e-mail to AA B to provide the receipts for the 0.2-micron filters that were currently installed in shower rooms, ice machine etc. Review of the facility provided document revealed that SMD G had placed the order for filters on 5/22/24; 7 days after the initial directive was received was received from the County health department. Further review of the receipt revealed the order was shipped via ground shipping. It was unclear on when the facility had received and installed the filters based on the information provided during the survey.</p> <p>An interview with the facility Director of Maintenance (DM H) was completed on 6/12/24, at approximately 2:10 PM. DM H was queried about the current process with the presumptive Legionella concern at the facility. They reported that the facility currently had 0.2- micron filters at the following locations, four in the shower rooms (one in each shower room x 4), two were in ice machines, one in the kitchen, one in the shared bathroom for rooms 120 & 121, and one in their dialysis unit. They added that they were using bottled water for drinking, cooking etc. When queried why they did not have any filters in Resident bathroom sinks and hand wash sinks in the shower rooms etc., DM H reported that they were just following the instructions from the management, and they understood the concern. They were queried further about the running water in the sinks and reported the hot water was turned off based on the information they had received that Legionella bacteria did not grow in cold water. They had confirmed that the facility management and the SMD G were involved and aware of the current facility process. They also added that first test recommended by the County health department was completed on 6/3/24 (16 days after the initial e-mail was sent to complete water sampling at 14 different locations at the facility) and the results were currently pending.</p> <p>A follow-up interview was completed via phone with CE A later that day (6/12/24), at approximately 3:35 PM. CE A was notified of the observations on running cold water in the resident room bathroom sinks, shower rooms etc. and queried if that was acceptable. CE A confirmed that was not safe and that was not their guidance provided to the facility. CE A also stated the facility should have signage posted on areas where the water was not safe to use, and they also stated the facility was highly recommended to use water management consultants who specialize in this area.</p> <p>An interview with RN I was completed on 6/12/24 at approximately 4:35 PM. RN I was assigned on the 2-south hall. RN I was queried on their process with the water situation and when providing care for their residents. They reported that they were using hand sanitizer and wipes. When queried further about handwashing/infection control, they reported that there was no place for staff to wash their hands and they had to use hand sanitizers and wipes. They added the process was not ideal and they were doing the best they can.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>An interview was completed with the Director of Nursing (DON) on 6/13/24 at approximately 9 AM. During part of this interview, the Regional Nurse Consultant (RNC J) was present. The DON was queried on how they had been handling resident care by following the infection control measures and recommendations from the County Health Department. They reported on the nursing end, staff were providing bottled water to the residents for drinking. The water from the shower rooms with filters were used for showers. The DON was queried about how nursing staff were doing bed baths, and they reported the staff were supposed to use water from the filtered showers. The DON was informed of the observations made by the surveyor on 1st and 2nd floor that staff were not getting water from the shower rooms as reported. During the interview, RNC J reported the local County Health Department guidance were recommendations based on presumptive case (R708) who tested positive at the hospital. RNC J stated (R708) was using a BiPAP machine (a device that helps with breathing) which could have been the potential source. When queried further that R708 had never left the facility prior to the hospital transfer (where they were diagnosed with Legionella) and why the facility had not implemented the County health department guidance/restrictions, they reported that they understood the concerns. RNC J was queried if they had a water management consultant assisting with their processes, RNC J reported that was just a recommendation and they had an internal team handling the situation. RNC J was queried further on who was their internal water management expert and they reported that they would find out and report back. No additional information was received by the end of the survey.</p> <p>On 6/13/24 at 12:39 PM, AA B and the DON were interviewed and asked why the sinks in the resident rooms did not have the 0.2 micron filters installed as directed by the County's Health Department and Epidemiologist. AA B stated the shower rooms on each floor had a filter attached to one shower head and they felt that was sufficient for each floor. At 3 PM, AA B and the DON were interviewed a second time and queried on where and how staff performed their hand hygiene. They reported that staff were supposed to use wipes and hand sanitizer. The DON confirmed that there was no handwashing sink for the nursing staff. They were queried on how they were monitoring the residents to ensure that they were not using the water from the bathroom as there was still running cold water. DON replied that staff were supposed to round and monitor. When queried further if it was practical and effective to monitor every movement of every resident in the facility with the staff, DON reported that they understood the concern. The DON was queried why the bathrooms in the resident rooms and common areas did not have any signage alerting not to use the water and the interview/observations were shared that residents were still using the sinks. The DON reported they should have signs and they would follow up.</p> <p>During an interview on 6/13/24 at 12:53 PM, SMD G was queried on why filters were not installed at each water source, as recommended by the Local Health Department, and SMD G stated it was being discussed at the upper management level. When inquired about protecting the residents from using water, SMD G stated the staff were supposedly going to monitor water usage on the resident halls.</p> <p>No additional explanation or documentation was provided by the end of the survey.</p> <p>INFECTION CONTROL SURVEILLANCE</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>On 6/12/24 at 9:12 AM, upon entrance into the facility, AA B was asked to provide the facility's Infection Control Surveillance program for the last six months. A second request was made at 10:56 AM. A third request was made at 11:43 AM. At 11:53 AM, the DON provided January to April 2024 surveillance and stated they were currently working on May and June 2024. When asked how they were currently working on May 2024 considering the current date of 6/12/24, the DON stated the Infection Control Nurse (ICN) was not in the facility today. When asked if the Infection Control documents were maintained in the facility, the DON confirmed they were. The DON was then asked to provide both the May and June 2024 surveillance in its current state.</p> <p>Review of multiple medical records identified R's 705 and 706, to have been symptomatic and diagnosed with Pneumonia in May 2024.</p> <p>R705</p> <p>A complaint received by the State Agency revealed that facility was not following infection prevention measures even after the facility water system was tested for Legionella. A document attached with the complaint revealed a letter sent from the facility dated 5/20/24 addressed to the residents, families and staff that read in part, .this letter is to provide information about a presumptive case of Legionnaires' disease at (Name of the facility omitted) and measures we are taking to protect the health of our residents, staff and visitors (Name of the facility omitted) is working closely with (name of county omitted) Health Department to investigate the source of this infection and take actions to prevent other people from becoming ill .we are taking a number of proactive measures in cooperation with (name of county omitted) Health Department .</p> <p>Record review revealed that R705 was a long-term resident of the facility. R705 was originally admitted to the facility on [DATE]. R705's diagnoses included dementia, mood disorder, depression, and history of falls. Based on the Minimum Data Set (MDS) assessment dated [DATE], R705 had Brief Interview for Mental Status (BIMS) score of 7/15, indicative of severe cognitive deficits.</p> <p>An observation was completed on 6/13/24, at approximately 10 AM. R705 was observed in their bed with their eyes closed. There was an oxygen concentrator sitting next to the bed and a Geri chair (recliner chair) was parked on the right side of the bed.</p> <p>Review of the Electronic Medical Record (EMR) revealed that R705 had a public guardian.</p> <p>Review of R705's progress notes revealed the following documentation:</p> <p>On 5/18/24 at 10:54 a nurses note read in part, Patient was having shortness of breath on arrival. I checked her O2, and it was 84%. I called the on-call doctor. They gave me new orders. They were put in for oxygen nasal canula 2 liters .Mucinex for 3 days every 12 hours chest x-ray 2 views .</p> <p>On 5/20/24 at 23:17 chest x-ray done at 4:45 PM.</p> <p>On 5/20/24 at 20:38 a note read in part, .called x-ray co .results patchy modest bilateral airspace disease, pneumonia should be considered in appropriate clinical setting. Recommended follow up .New orders to start doxycycline (antibiotic) 100 mg. BID (2 times/day) x 7 days .</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>On 5/21/24 at 12:22 a note read in part., writer call and spoke with pharmacy regarding doxycycline not available in back up. Pharmacy stated med is coming out this afternoon .</p> <p>On 5/21/24 at 21:38 a note read in part, Resident is on ABT (antibiotic) for respiratory infection .</p> <p>On 5/22/24 a practitioner note read in part, Reason for visit: E&M (Evaluation and Management) of PNA (pneumonia), .and multiple other medical conditions requiring monitoring .</p> <p>Nursing progress notes from 5/23/24, 5/24/24, 5/25/24, 5/26/24, and 5/27/24 revealed that R705 continued to receive antibiotics for pneumonia.</p> <p>Review of the physician orders and progress note did not reveal that R705 was ordered any respiratory sputum panels with Legionella cultures and urinary antigen tests as directed by the County health department due to recent positive case of Legionnaire's disease.</p> <p>An interview was completed with R705's Guardian on 6/13/24 at approximately 10:55 AM. The Guardian was asked if they had received any notification from the facility regarding Legionella. The Guardian had checked with the case worker for R705 and reported that they did not receive any notification from the facility.</p> <p>An interview was completed with the DON on 6/13/24, at approximately 9 AM. The DON was queried about the current testing process for any residents with respiratory symptoms. The DON reported they were using the swabs and urinary antigen testing based on the recommendations from the County health department. The DON was queried about tests that were completed for R705 who was diagnosed with pneumonia on 5/20/24 and had received antibiotics. The DON reviewed the EMR for R705 and confirmed that they did not complete a swab or urinary antigen test for the resident, and they were not sure how it was missed. They also added that facility infection preventionist (ICN C) was ordering the tests and following up on any resident with pneumonia symptoms.</p> <p>R706</p> <p>A review of R706's medical record revealed R706 was admitted to the facility on [DATE], with diagnoses that included: Dementia, Alzheimer's disease and chronic obstructive pulmonary disease and required staff assistance for all ADLs.</p> <p>Review of the progress notes revealed the following:</p> <p>On 5/15/24 at 3:06 AM, a Physician Progress Note documented in part . Seen for persistent cough .</p> <p>On 5/17/24 at 3:13 AM, a Physician Progress Note documented in part . Patient has been coughing lately and appears to be slightly lethargic below his baseline alertness .</p> <p>On 5/20/24 at 3:19 AM, a Physician Progress Note documented in part . Followed up for continued lethargy . Will repeat X-ray to make sure there is no acute process .</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>On 5/21/24 at 2:55 PM, a Nurses' Note documented in part . Advised NP (Nurse Practitioner) of recent new onset of generalized weakness, unable to transfer himself without assistance from staff, and continued on going cough .</p> <p>On 5/21/24 at 3:45 PM, a NP/PA (Physician Assistant) Progress Note documented in part . Patient seen and examined following complaint of wheezing, cough, weakness, and AMS (Altered Mental Status), will order CXR (chest x-ray) . ordered 1 gm (gram) rocephine (antibiotic) and prednisone taper (steroid medication) .</p> <p>On 5/22/24 at 10:37 PM, a Pertinent Charting-Infections/Signs Symptoms note documented in part . Site of infection: lungs . Patient had a positive CXR result for pneumonia, wheezing and coughing . Patient was placed on oral ABT (antibiotics) x 10 days . Patient is on droplet precautions . Patient started on oral ABT for pneumonia .</p> <p>On 6/12/24 at 1:04 PM, the ICN C provided the May 2024 Surveillance. ICN C was asked why May 2024's Infection Surveillance was not completed before today and ICN C explained they wait until the month was over to gather and put together the surveillance data and information. ICN C then stated they were currently working on June 2024 data to provide.</p> <p>Review of the May 2024 Infection Control Surveillance documents noted the following in part:</p> <p>INFECTION CONTROL SUMMARY May 2024 . We had a resident test positive for Legionella in the hospital which we have negative results for the facility quarterly water testing. We tested two residents that showed signs of respiratory symptoms, and all received back negative results for Legionella in urine and sputum . R's 705 and 706 were not identified as having signs/symptoms of Legionella.</p> <p>The line listing documented R705 to have treatment of doxycycline 100 mg (milligram- antibiotic), however the line listing did not document a diagnosis or symptoms. Further review of the line listing documented R706 to have pneumonia and to have the treatment of levofloxacin 750 mg (antibiotic).</p> <p>Further review of May's 2024 Infection Control documents revealed no urinary or sputum testing for Legionella for R's 705 & 706. The documents did contain three resident's sputum tests for Legionella, however no urinary testing was completed for the three tested residents as documented in the May 2024 summary.</p> <p>ICN C failed to identify all residents with signs/symptoms of Legionella and test as directed by the Health Department using urinary and sputum testing and failed to document and report findings to the Health Department Epidemiologist as directed.</p> <p>Review of a facility policy titled Infection Surveillance revised 10/26/23, documented in part . A system of infection surveillance serves as a core activity of the facility's infection prevention and control program. Its purpose is to identify infections, monitor adherence to recommended infection prevention and control practices in order to reduce infections and prevent the spread of infections . Infection surveillance refers to an ongoing systematic collection, analysis, interpretation, and dissemination of infection-related data . The facility will collect data to properly identify possible communicable disease or infections before they spread by identifying . Data to be collected, including how often and the type of data to be documented, including . The infection site, pathogen (if available), signs and symptoms, and resident location, including summary and analysis of[TRUNCATED]</p>		

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47283</p> <p>Based on observation and interview, the facility failed to maintain general repair and cleanliness of resident rooms, bathrooms, and common areas for all residents residing on 1st floor South unit, and 2nd floor North and South units, resulting in the potential for avoidable contamination and decrease in satisfaction of living.</p> <p>Findings include:</p> <p>An initial facility observation was completed on 6/12/24 at approximately 11:00 AM. During this observation on the 2nd floor (North unit) locked unit that housed residents with cognitive impairments, multiple residents were observed ambulating with/without assistive devices and in their wheelchairs on the unit. The faucet in the sink on the hallway to the dining room area was dripping water. There were six residents sitting in the dining room area. There were food crumbs and other debris on the floor. The dining room had a strong offensive odor. The hallway floors were sticky with multiple areas of dried fluid stains. There was a puddle of water on the floor next to a cart that had 5-gallon water container and cooler with ice that was located on the hallway across from the shower room entrance.</p> <p>The 2nd floor South hallway floors were sticky with multiple dried liquid stains outside rooms 225, 226, between rooms [ROOM NUMBERS]. A housekeeper was observed in the hallway. They were emptying the trash and mopping the rooms. The housekeeper did not clean the hallways. There was debris and stains along the hallways by rooms 232, 233, 237, 239, and dried up unknown liquid stains between rooms [ROOM NUMBERS]. A broken bedside table was observed in the hallway outside of room [ROOM NUMBER].</p> <p>Follow up room observations were completed on 6/12/24 later that day, at approximately 4:00 PM on the 1st floor South hallway. room [ROOM NUMBER] had a shared bathroom with room [ROOM NUMBER]. The shared bathroom between rooms [ROOM NUMBERS] had a filter installed on the line under the sink. There was water dripping from the filter. A pink wash basin was placed under the filter and there was a puddle of water on the floor around the basin. It must be noted that multiple observations had been completed during the survey. The floor was wet in that bathroom from the water leak and the pink basin was under the filter in the same area during all observations. The shared bathroom between room [ROOM NUMBER]/128 had a large puddle of unknown white fluid under the sink.</p> <p>A follow up observation was completed on the 2nd floor south hallway on 6/12/24 at approximately 4:30 PM. The debris and the stains that were observed during the initial observations (as noted above) were observed during the follow up observation. The hallway floors were sticky. It did not appear that anyone had cleaned the hallways.</p> <p>During a follow-up room observation in the same hall on 6/13/24, at approximately 9:30 AM, on the 2nd floor North hallway a large a dried-up unknown liquid stain was in the hallway across the shower room. There was debris in the hallway across from room [ROOM NUMBER]. There were four residents sitting and watching TV in the living room area of the North unit. Food and other debris were observed on the living room area floor. The 2nd floor South unit hallways had the same dried liquid stains and debris that were observed on 6/12/24.</p> <p>(continued on next page)</p>		

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A water cup filled with water was observed over the bathroom sink, in the shared bathroom between rooms [ROOM NUMBERS]. The writing on the water cup that read 6/13 - 223-1. It must be noted that facility was following the guidance from local County health department due to a presumptive Legionella positive from the facility and the water from bathroom sinks did not have the recommended filters and were not safe to use. The bathroom sink had two soiled towels. The trash can was overflowing with trash that included soiled briefs and there was trash on the bathroom floor. On the 1st floor, room [ROOM NUMBER]'s shared bathroom had unknown liquid was observed to be accumulating behind the toilet. The shared bathroom between room [ROOM NUMBER] and 128 had a large puddle of unknown white fluid under the sink as it was observed on 6/12/24.</p> <p>During an interview on 6/13/23 at approximately 2:40 PM, Housekeeper (HK L) was asked if they cleaned the hallway floors and stated, I don't do the hallways. Floor care does it. HK L continued to say that they were responsible for the resident room cleaning.</p> <p>An observation of the 1st floor south hallway was conducted with Assistant Administrator (AA B) and Director of Nursing (DON) on 6/13/24, at approximately 2:50 PM. An interview with AA B was completed during that observation as the housekeeping supervisor was unavailable. Dried liquid stains in the hallways, water leak in room [ROOM NUMBER]/121-bathroom, unknown liquid puddle on the shared bathroom between rooms 126/128 and the similar observations on the 2nd floor were shared. AA B was queried on who was responsible to clean the hallways, common areas etc. AA B stated that it was the housekeeper's role to make sure the resident rooms and hallways were clean. They added that housekeepers worked between 7:00 AM and 3:30 PM and the facility had floor technicians who worked daily after 7:00 PM. When the observations and concerns were shared with AA 'B', they reported they understood.</p> <p>A facility provided document titled Safe and Homelike Environment with a revision date 1/1/22 read in part, In accordance with residents' rights, the facility will provide a safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk.</p> <p>Definitions:</p> <p>Adequate lighting means levels of illumination suitable to tasks the resident chooses to perform or the facility staff must perform.</p> <p>Comfortable lighting means lighting that minimizes glare and provides maximum resident control, where feasible, over the intensity, location, and direction of lighting to meet their needs or enhance independent functioning.</p> <p>Comfortable and safe temperature levels means that the ambient temperature should be in a relatively narrow range that minimizes residents' susceptibility to loss of body heat and risk of hypothermia/hyperthermia and is comfortable for the residents.</p> <p>Comfortable sound levels mean levels that do not interfere with the resident's hearing, levels that enhance privacy when privacy is desired, and levels that encourage interaction when social participation is desired.</p> <p>(continued on next page)</p>		

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Environment refers to any environment in the facility that is frequented by residents, including (but not limited to) the residents' rooms, bathrooms, hallways, dining areas, lobby, outdoor patios, therapy areas and activity areas.</p> <p>A homelike environment is one that de-emphasizes the institutional character of the setting, to the extent possible, and allows the resident to use those personal belongings that support a homelike environment. A determination of homelike should include the resident's opinion of the living environment.</p> <p>Orderly is defined as an uncluttered physical environment that is neat and well-kept.</p> <p>Sanitary includes, but is not limited to, preventing the spread of disease-causing organisms by keeping resident care equipment clean and properly stored. Resident care equipment includes, but is not limited to, equipment used in the completion of the activities of daily living .</p>		