

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  07/10/2024
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 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from the wrongful use of the resident's belongings or money.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 32568</p> <p>This citation pertains to Intake Number(s): MI00145377.</p> <p>Based on interview and record review, the facility failed to ensure two (R806 and R812) of three residents reviewed for abuse, were free from misappropriation of their money and property, resulting in a staff member electronically transferring \$13.00 of R806's money to himself and \$142.00 to an unknown person using a mobile payment service application, and the same staff member stealing R812's cellular phone. Findings include:</p> <p>A review of a Facility Reported Incident (FRI) that was submitted to the State Agency revealed R806 alleged on 4/15/24 that while trying to order lunch with Certified Nursing Assistant (CNA) 'A', she tried to send money through a mobile payment service application on her cell phone. At that time, CNA 'A' asked R806 to give him her phone and said he had a faster way of doing it. The next day, R806 noticed all of her money was gone and was sent to a person (Person 'G') she did not know. R806 reported she did not send money to Person 'G'.</p> <p>On 7/10/24, the above allegation was investigated onsite.</p> <p>A review of R806's clinical record revealed R806 was admitted into the facility on [DATE] and discharged home on 6/11/24 with diagnoses that included: lupus. A review of a Minimum Data Set (MDS) assessment dated [DATE] revealed R806 had intact cognition.</p> <p>A review of an investigation conducted by the facility into the above mentioned allegation of misappropriation of R806's money revealed the following:</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 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An Investigation Summary noted, On 5/29/2024, (R806) stated to her nurse that on April 14th, 2024, (CNA 'A') manipulated her (mobile payment service application). On April 15th, she stated CNA 'A' took \$129 from her (mobile payment service application) and set it to an unknown individual .Investigation .On 5/29/2024, (R806) reported to her nurse, on April 14th, she asked (CNA 'A') if he could pick up lunch for her. He stated yes he would. He came to (R806's) room to get the money. While trying to (use the mobile payment service application) from (R806's) phone, he (CNA 'A') stated 'Let me see your phone, I have an easier way to do it.' (R806) stated he then took her phone and used his phone to scan her phone for the (mobile payment service application) transaction. The next day, 4/15, (R806) noticed a transaction in the amount of \$129, was taken and set to an unknown individual named (Person 'G'). (R806) stated she has never sent money to anyone by this name, nor does she know how to utilize (mobile payment service application) to send money to an unknown person. (R806) was very adamant that (CNA 'A') was the individual that made the transaction. (CNA 'A') was interviewed and he did show the Administrator the (mobile payment service transaction) was sent by (R806) to his (mobile payment service application) on 4/14/24, in the amount of \$13 to pick up her food. Administrator informed (CNA 'A') that staff should never make any form of monetary transactions amongst staff and residents. (R806) stated that she did not mention this during the time that it happened because she in fear of retaliation and she wanted to wait until she discharged home this month .Conclusion . In conclusion, after a thorough investigation, which included resident interviews, staff interviews, the investigation did show that the facility was able to substantiate misappropriation. (R806) is a competent resident and very rarely has complaints against staff. (CNA 'A') did show the Administrator (mobile payment service) transaction between himself and (R806), in the amount of \$13 for the pickup of her food .(CNA 'A') was terminated from the facility on 5/30/24 .</p> <p>On 7/10/24 at 1:46 PM, an interview was conducted with Assistant Administrator 'C', who was the facility's Abuse Coordinator. When queried about how they found out about R806's allegation of misappropriation by CNA 'A', Assistant Administrator 'C' indicated R806 reported the incident to a nurse. Assistant Administrator 'C' explained the facility conducted an investigation and the misappropriation of R806's money through the mobile payment service application was substantiated. Assistant Administrator 'C' further explained they reviewed R806's phone and they were able to verify a \$13 transaction to CNA 'A' and a \$129 transaction to Person 'G' at the same time. When queried about what the facility did after they substantiated the misappropriation, Assistant Administrator 'C' reported they terminated CNA 'A', reimbursed R806, and interviewed other residents to identify any additional concerns with missing money. According to Assistant Administrator 'C', no further concerns were identified.</p> <p>On 7/10/24, a request for the police report was made to the local police department using the case number provided by the facility. The records bureau at the police department explained there was no police report for R806 under that case number, but there were notes regarding a theft related to another resident at the facility.</p> <p>A review of incident notes provided by the police department revealed on 5/28/24, R812 reported her phone was stolen when she was at physical therapy (PT). It was documented R812 said her (cellular phone) was taken at 11AM yesterday and noticed it gone at noon .</p> <p>(continued on next page)</p>		

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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of the State Agency's electronic system for reporting allegations and incidents of abuse revealed the facility reported an allegation of misappropriation regarding R812 that noted, On 5/27, resident (R812) stated her phone was missing Resident's room was searched, laundry was searched on 5/27. On 5/28/24 when surveillance cameras were able to be reviewed, Admin (Administrator) saw staff member (CNA 'A'), entering and exiting the room. A review of the facility's investigation submitted to the State Agency revealed the following notation, On 5/27/2024, (R812) reported to the Therapy Manager that when she came back from therapy, she noticed her phone was missing. Staff searched her room for the phone and checked laundry for the phone. On 5/28, Administrator queried (R812). (R812) stated before she went to therapy, she had her phone on the bed and when she came back, the phone was gone .During the investigation, it was identified by camera surveillance, during the timeframe of (R812) being in therapy, that (CNA 'A') was observed looking suspicious, before entering her room. When (CNA 'A') exited the room, it was observed, he reached into his pocket as he walked back toward his unit. According to the schedule, (CNA 'A') was a CNA that was assigned to (a different unit than where R812 resided). Nurses and CNAs were queried that worked on (R812's unit) during this time frame. Staff stated, (CNA 'A') would have had no reason to go into (R812's) room while she was in therapy .In conclusion, after a thorough investigation, which included resident interviews, camera surveillance review and staff interviews, the investigation did show that the facility was able to substantiate misappropriation .(CNA 'A') was terminated from the facility to ensure residents safety .</p> <p>A review of R812's clinical record revealed R812 was admitted into the facility on [DATE] with diagnoses that included: multiple sclerosis. A review of a MDS assessment dated [DATE] revealed R812 had intact cognition.</p> <p>A review of a facility policy titled, Abuse, Neglect and Exploitation, revised on 10/24/22, revealed, in part, the following, 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 . misappropriation of property . 'Misappropriation of Resident Property' means the deliberate misplacement, exploitation, or wrongful, temporary, or permanent, use of a resident's belongings or money without the resident's consent .</p> <p>During the onsite survey, past noncompliance (PNC) was cited after the facility implemented actions to correct the noncompliance which included terminating the staff, interviewing other residents, reporting the incident to the police and state agency, and monitoring for misappropriation. The facility was able to demonstrate monitoring of the corrective action and maintained compliance.</p>		