

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 10/29/2024
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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34208</p> <p>This citation has two deficient practices.</p> <p>Deficient Practice #1</p> <p>This citation pertains to intake #MI00147354.</p> <p>Based on observation, interview, and record review, the facility failed to ensure resident's rights related to the appropriateness of placement on a locked, secured unit for one resident (R702) of three residents reviewed for resident's rights, resulting in feelings of frustration after being moved to a locked, secured unit. Findings include:</p> <p>A complaint was received by the State Agency that alleged resident's who were not appropriate for placement on a locked, secured unit were placed there.</p> <p>On 10/28/24 at 10:02 AM, a review of R702's clinical record revealed they admitted to the facility on [DATE] and most recently readmitted on [DATE] with diagnoses that included: bipolar schizoaffective disorder, dementia, falls, and major depressive disorder. R702's most recent Brief Interview for Mental Status score was 9, indicating moderately impaired cognition. A review of the resident's census tab in the electronic medical record revealed that on 8/3/24, R702 had been moved from the 2 South unit to the 2 North unit, a locked, secured unit for dementia care.</p> <p>R702's progress notes were reviewed and revealed the following:</p> <p>A nursing note dated 8/3/24 at 2:58 PM that read, .Resident was moved to (Room # on the 2 North unit). Guardian and family notified.</p> <p>A Social Services progress note dated 8/6/24 at 9:54 AM that read, .Writer spoke with guardian on the phone and discuss recent room change. Guardian requested that resident be moved back to previous room.</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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A nursing note entered into the record from Former Director of Nursing (DON) 'E' on 8/6/24 at 10:00 AM that read, .Writer spoke with guardian regards to resident room change. Writer explained rt <sic> resident constantly on and off unit, resident forgets how to get back to her unit and have <sic> to be redirected by staff, Writer updated Guardian on situation and understand for the need for resident to be on secured unit. Writer explained to Guardian plans for wander guard (a device worn by a resident that alarms if they are too close to one of the sensors placed in the facility, such as near an exit door) and once placed we will assess resident to go back to room .</p> <p>A nursing note dated 8/6/24 at 12:56 PM that read, Resident ambulates unit at baseline. does not seek exits, attends activities with peers, no behavioral concerns.</p> <p>A Social Services Progress note dated 8/6/24 at 4:03 PM that read, .Spoke with individual. According to individual she reports that she is not happy. 'I want to leave' .individual reports that she does not like it here because she cannot move around like she normally does .</p> <p>A Social Services Progress note dated 8/7/24 at 2:04 PM that read, .Spoke with individual regarding care . 'I want to go back to the other side' (2 South). SW (Social Work) asked what's on the other side <sic>. Individual stated <sic> my bedroom. SW then asked what <sic> wrong with her new room individual reports that the room she is currently in (on 2 North) is not her room .</p> <p>A Social Services Progress note dated 8/8/24 at 1:25 PM that read, .spoke with individual regarding concerns of individuals (R702) move to another unit. Individual reports that she does not want to be on 2 north <sic> . 'I want (Nurse 'G', nurse on 2 South); I want to be back with her.' Individual also reports that her unit is too loud .</p> <p>An Interdisciplinary progress note dated 8/19/24 at 1:08 PM that read, .The writer did a follow up on the legal guardian for care conference. Guardian is concern <sic> about patient being on 2 north <sic> .</p> <p>A Social Services Progress note dated 8/20/24 at 4:56 PM that read, Per resident, she is still asking about her room.</p> <p>A nursing note entered into the record from Former Director of Nursing (DON) 'E' on 9/4/24 at 5:16 PM that read, Writer had meeting with guardian with regards to resident room change, Guardian express that she thought resident will return to prior room after wander (wander guard) placement. Writer explained to guardian that wander guard is an second entity as to prevent, however resident is at a high risk rt (related to) progression in dementia .Guardian . wanted to know if she had a decline .</p> <p>A Social Services Progress note dated 9/7/24 at 1:19 PM that read, .Individual request to see SW regarding her room status. According to individual she reports that she wants to go back to her room .</p> <p>A Social Services Progress note dated 9/17/24 at 2:16 PM that read, .: SW spoke to individual per individual request. Individual states she wants her old room back and states that she will stop eating if she cannot go back .</p> <p>A Social Services Progress note dated 10/23/24 at 2:19 PM that read, SW spoke to individual. Individual continues to display repetitive behaviors, however individual cognition has not change <sic> individual continues to display baseline cognition.</p> <p>(continued on next page)</p>		

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of R702's progress notes from May 2024 until October 2024 did not reveal any documented evidence of R702 exit seeking, entering other's rooms, or attempting to elope.</p> <p>R702's Documentation Survey Reports were reviewed and revealed the following:</p> <p>May 2024, no documented behaviors, all entries were coded as a 12-None of the above observed which indicated no behaviors including 2-repeats movements or 7-wandering.</p> <p>June 2024, no documented behaviors, all entries were coded as a 12-None of the above observed.</p> <p>July 2024, no documented behaviors, all entries were coded as a 12-None of the above observed, or N/A (not applicable).</p> <p>August 2024, 73 of 93 entries for the month were coded as 12-None of the above observed, two were coded as 7-Wandering and the remaining 18 entries were blank.</p> <p>September 2024, 10 of 90 entries were coded 7-Wandering, however; the follow up question for Which intervention was effective for this behavior? was documented as 4-Redirection.</p> <p>On 10/28/24 at 12:45 PM, an interview was conducted with R702 in their room. They were asked if they previously resided on another unit and said they had. They said they did not like their room and, Want to go back to their old room on the other side, on the 2 South unit. They were asked if they had their wander guard bracelet on their leg, said they did and pulled their sheet aside so the wander guard could be observed on their left ankle.</p> <p>On 10/29/24 at 10:55 AM, an interview was conducted with Social Services Director 'H'. They described R702 as a, minimum elopement risk. They were asked about R702's placement on the 2 North locked/secured unit and said they used to reside on 2 South but they would wander downstairs and sit in the lobby. They said during the week on day shift there was plenty of supervision but they were fearful R702 would elope and they changed her room to 2 North for her safety. They were asked if a wander guard was in place and said it was. They were then asked if the wander guard intervention alone had been tried prior to placing her on the locked/secured unit and said they did not think so. They were asked to provide any additional documentation of behaviors, exit seeking, or interventions attempted prior to placing R702 on the secured/locked unit, however; none were received by the end of the survey.</p> <p>On 10/29/24 at 11:17 AM, an interview was conducted with R702's Court Appointed Legal Guardian Caseworker who said they visited the resident minimum once a month. They were asked about R702's placement on the locked/secured unit beginning August 2024 and said, both her and R702's family did not believe R702 should be on the 2 North unit. They said there were a lot of staff in the building that cared for R702 and also told them R702 should not have been placed on that unit. The Caseworker further cited fear of R702's decline since moving to the 2 North unit. Finally, the Caseworker said they were told that after the placement of the wander guard R702 could be re-assessed for placement back to the 2 South unit but had been told with no explanation they were going to remain on the 2 North unit.</p> <p>(continued on next page)</p>		

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 10/29/24 at approximately 1:30 PM, a review of R702's elopement assessment dated [DATE] was reviewed and did not reveal a calculation of a measurable score to define the risk of elopement. It was further noted that despite the resident being marked yes for several, Potential Risk Factors/Resident Status R702 was marked No for an elopement while in the home, No for leaving the facility without supervision, and No for leaving the facility without staff. Section 3. of the assessment indicated Yes for resident is at risk and, Elopement/wandering risk as evidence by: Un Safe <sic> wandering. It was noted there were no follow-up elopement assessments after the placement of the wanderguard <sic> and room change to the 2 North unit</p> <p>On 10/29/24 at 1:58 PM, an interview was conducted with the facility's interim Director of Nursing (DON), and Regional Clinical Nurse Consultant 'I'. They were asked about the criteria for determining whether a resident is appropriate for placement on a locked/secured unit and indicated an assessment was done. They were asked if the assessment had a measurable score to calculate elopement risk and said it did not and the person conducting the assessment and Interdisciplinary Team (IDT) met to make the determination. They verbalized numerous behaviors witnessed by staff of R702 being an elopement risk, and were then asked why the behaviors were not documented, but had no explanation. Next, they were asked what other interventions (diversionary activities, increased supervision, wander guard, etc.) had been attempted prior to placing R702 on the locked/secured unit and said they didn't believe anything else had been attempted. They were then asked why the wander guard and placement on their old unit had not been attempted and had no response. Finally they were asked if the resident had been re-assessed after the wander guard was placed for movement back to their old unit and said they had just begun a process for re-assessing residents for placement on that unit.</p> <p>A review of an undated facility provided document titled, Memory Care Unit Criteria was reviewed, however; the policy did not address the assessment or placement criteria for assignment to the locked/secured unit.</p> <p>A review of a second facility provided titled, Promoting/Maintaining Resident Dignity was conducted and read, It is the practice of this facility to protect and promote resident rights and treat each resident with respect and dignity as well as car for each resident in a manner an in an environment, that maintains or enhances resident's quality of life by recognizing each resident's individuality .</p> <p>Deficient Practice #2</p> <p>This citation pertains to intake #MI00147408.</p> <p>Based on observation, interview, and record review the facility failed to ensure treatment in a dignified manner for one resident (R711) of three residents reviewed for dignity. Findings include:</p> <p>A review of a facility provided policy titled, Promoting/Maintaining Resident Dignity was conducted and read, It is the practice of this facility to protect and promote resident rights and treat each resident with respect and dignity as well as car for each resident in a manner an in an environment, that maintains or enhances resident's quality of life by recognizing each resident's individuality .</p> <p>(continued on next page)</p>		

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 10/29/24 at 9:10 AM, R711 approached the surveyor and said they were looking for some socks they believed were left in the shower room on the 2 North unit. R711 was accompanied to the shower room and an observation of the shower room revealed a housekeeping cart in the doorway to the shower room blocking entry. Housekeeper 'J' emerged from the shower room to the cart and was asked if they had seen any socks in the room. They exasperatedly threw their hands/arms in the air, shrugged their shoulders and in a rude and short tone said, I don't know. They were informed R711 was looking for some socks they believed they left in there and in another short and rude tone said, I just got here. They were then asked if they could look since they were in the shower room cleaning and for a third time in a rude and short tone said, I don't see any, I'm just a housekeeper. They then turned their back and retreated back into the shower room to resume their duty. This exchange was witnessed by R711. R711 was informed a nurse would be alerted regarding their missing socks.</p> <p>On 10/29/24 at 9:15 AM, R711 approached the surveyor and said, I heard her, see how rude she is, as they pointed to housekeeper 'J'. They further went on to say staff are Rude, and Cold, and Make you want to get out of here real quick.</p> <p>On 10/29/24 at 9:41 AM, an interview was conducted with Housekeeping Supervisor 'K'. They were asked about the expectation when responding to resident requests and said staff should assist if they can, if not they were expected to get a nurse or an aide. The exchange witnessed by R711 was discussed with Supervisor 'K' and they said they would be addressing the concern.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34275</p> <p>This citation has two deficient practices.</p> <p>Deficient practice #1</p> <p>This citation pertains to Intake #MI00147275</p> <p>Based on interview and record review the facility failed to ensure adequate staffing and proper bed mobility were provided to prevent a fall for one (R701) of four residents reviewed for falls. Findings include:</p> <p>A complaint was made to the State Agency (SA) that alleged R701 slipped out of bed and noted that the resident was a two person assist for bed mobility and transfers and a Certified Nursing Assistant (CNA) attempted to change the resident on their own.</p> <p>A review of R701's clinical record revealed the resident was initially admitted to the facility on [DATE] with diagnoses that included: end stage renal failure, type II diabetes and a pressure ulcer of sacral region. A review of the resident Minimum Data Set (MDS) dated [DATE] noted the resident had a Brief Interview for Mental Status (BIMS) score of 00/15 (severely cognitively impaired).</p> <p>The resident's Care Plan documented, in part, Focus: Resident has an ADL (activities of daily living) self-care performance deficit related to Dx (diagnosis) Muscle weakness .Bed Mobility: 2 person assist (date initiated 6/13/24) .Toileting: 2 person assist (6/13/24) .</p> <p>A review of the facility's Incident/Accident (IA) report read as follows: Fall during staff assist .Date 9/28/24 . Resident: R701 .Incident description .writer informed that resident slid out of bed while ADL care was being . Statements: Name: Nurse B Nurse states when she assess situation noted .CNA reported that resident slid out of bed doing ADL (activities of daily living) care .Name: Nurse Aide (NA) C reported that during ADL care resident slid out of bed .</p> <p>An attempt to contact NA C was made on 10/28/24 at approximately 3:00 PM. A second attempt was made at 3:09 PM. No return call was made by the end of the survey. It should be noted that NA C was no longer employed by the facility.</p> <p>On 10/29/24 at approximately 9:50 AM, a phone interview was conducted with Nurse B. When asked about the fall incident that occurred on 9/28/24, Nurse B reported that they were not assigned to the resident that day, but NA 'C' let her know that the resident had slipped out of bed. Nurse B stated that they went into the resident's room and helped get them back in to bed. Nurse B reported that that the resident was a two person assist for bed mobility and transfers.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 10/29/24 at approximately 10:29 AM, an interview was conducted with the acting Director of Nursing (DON). The DON reported that after the fall, NA C re-enacted how R701 fell . They showed the DON how they had rolled her in an incorrect way. At that time the DON asked NA C if they had checked the Kardex (plan of care for nurse aides) to determine the proper way to assist the resident during a brief change. NA C indicated that they did not. The DON also indicated that NA C should have worked directly with another CNA as they had not yet received their CNA license.</p> <p>A review of the facility policy titled, Falls-Clinical Protocol (11/2/23) revealed, in part: Policy Explanation and Compliance guidelines .Based on the assessment an initial plan of care will be developed and implemented to address identified risk .Goals of the place of care may include the interdisciplinary team, physician, resident and responsible party when possible .Interventions should be developed and implemented . Residents abilities and deficits .interventions for direct care givers should be placed on the CNA care card or similar format .</p> <p>Deficient Practice #2</p> <p>Based on observation, interview and record review the facility failed to ensure an environment free from hazards for one (R707) out of two residents reviewed for the environment. Findings include:</p> <p>On 10/28/24 at approximately 9:34 AM, R707 was observed lying in bed. The resident was alert and able to answer all questions asked. A long orange extension cord was observed plugged in behind the resident's bed and extended to their roommate's low air loss mattress. When asked about the extension court, R707 noted they were not sure why it was there. They noted that a week or so ago the extension cord was plugged into a different location and extended out to the hall. When asked about further environmental issues, R707 noted that there was a flood in their bathroom that caused problems with them using the bathroom.</p> <p>On 10/29/24 at 10:50 AM, a room observation and interview were conducted with Maintenance Director A. Maintenance Director 'A' was asked as to the facility's policy/protocol regarding extension cords in residents' rooms. Maintenance Director A reported that there had been a power outage at the facility about a week or so ago and the cord was plugged into a different plug and extended into the hallway. They noted that after the power outage had resolved the extension cord should have been removed.</p> <p>The facility policy titled, Electrical Safety (1/1/22) documented: Policy: It is our policy to provide a safe and healthful environment .Extension Cord Safety: Extension cords shall be used for temporary use only my maintenance personnel .extension cords shall not be used as a substitute for fixed wiring of a structure . extension cords shall be removed immediately upon completion of the purpose for which they were used .</p>		