STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235296	A. Building B. Wing	01/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Southfield	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)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41415 This citation pertains to intake: MI00147960 & MI00147915. Based on observation, interview and record reviews the facility failed to notify the family of R707 of a fall and notify both legal guardians for R706 of an accident that resulted in an injury, for two of three residents reviewed for an injury of unknown origin. Findings include: R706 Review of a complaint submitted to the SA documented an allegation of the facility to have failed to have notified both legal guardians of an accident that resulted in an injury for R706. On 1/21/25 at 12:09 PM, R706 was observed laying back in a geri chair next to their bed. A blue sling for the hoyer was observed under the resident. A brief interview was attempted with the resident at that time. Review of a Letters of Guardianship form dated 2/6/24, documented Full guardianship appointed to two individuals for R706. The facility's medical record documented both of the appointed individuals as guardians. A review of a Nursing note dated 10/31/24 at 1:56 AM, documented in part . Writer was in <sic> informed by assigned CENA that during transfer with hoyer lift resident hit his head on lift resulting in hematoma of right forehead. Assessment by writer did not reveal any changes physically or mentally from resident's baseline . Reported to oncoming nurse that resident had hematoma to right forehead. Informing oncoming nurse how incident happened. Resident resting comfortably . Further review of the medical record revealed one of the two legal guardians for this resident was notified. A review of a facility policy titled Notification of Changes revised 08/29/2024, documented in part . The facility must inform . and/or notify the resident's family member or legal representative . when there is a change requiring such notification . Accidents . resulting in injury . Significant change in the resident's physical, mental or psychosocial condition such as deterioration in health, mental or psychosocial status . Circumstances that require a need to alter treatment . A change in resident rights . (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/22/25 at 8:59 AM, the Director of Nursing (DON) was interviewed and asked about the incident and the failure to notify both legal guardians of the incident with R706. The DON explained they were newly hired at the facility and was not the DON at the time of the incident. The DON stated their understanding is they would notify one of the guardians and that guardian would notify the other. The DON was asked if they considered that family dynamics to have played a role regarding this resident's care and if the facility considered that the two guardians were not cordial with each other and did not communicate with each other. If two individuals were legally appointed by the court to have dual guardianship over the resident, why then did the facility staff not notify both guardians of the resident accident that resulted in the injury. The DON stated they feel that both guardians should have been notified. No further explanation or documentation was provided before the end of the survey. R707 Review of a complaint submitted to the State Agency (SA) documented in part, . received a call from facility staff on 11/05/2024 . rushed to the facility . the social worker casually mentioned that the resident fell . The complainant states this was the first time she was told that the resident had a fall and staff never formally notified her . A review of the medical record revealed R707 was admitted to the facility on [DATE] with diagnoses that included: sepsis, end stage renal disease and dependence on renal dialysis. Review of the progress notes documented the following: On 11/5/24 at 4:13 AM, . Resident then rolled herself out of the bed and was observed on the floor. (physician made aware) . On 1/21/25 at 12:08 PM, the Administrator was asked to provide all I & A's (Incident and Accident report) for R707. An I & A was not provided for the 11/5/24 fall. A review of a Fall assessment completed on 11/5/24 at 3:56 AM, documented the follow up from the fall and the implementation of a fall mat. Further review of the medical record revealed no documentation of notification to the family. A review of a facility policy titled Fall Prevention Program revised 10/26/2023, documented in part . When any resident experiences a fall, the facility will . Notify physician and family . On 1/22/25 at 11:54 AM, the DON was interviewed and asked about the failure to notify R707's family regarding the fall noted on 11/5/24. The DON stated they were not employed with the facility at the time of the incident, however their expectation would be for staff to notify the physician, family and/or guardian for all falls. No further explanation or documentation was provided by the end of the survey.

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Plan the resident's discharge to meet the resident's goals and needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41415 This citation pertains to intake: MI00147960. Based on interview and record reviews the facility failed to coordinate effective discharge planning that met the needs and provided care giver support for one (R707) of two residents reviewed for discharges. Findings include: On 1/21/25 at 11:49 AM, during a telephone interview with the complainant, the complainant stated in part, . she was discharged on the 14th of December. She was supposed to received home health care and she still has not. Allegedly the doctor was supposed to complete paperwork and they didn't. She has a PEG (percutaneous endoscopic gastrostomy tube) tube and dialysis . open wounds . The complainant stated how they reached out to the facility Social Worker multiple times regarding their concerns with their loved one's discharge. Review of the medical record revealed R707 was admitted to the facility on [DATE] with diagnoses that included: sepsis, end stage renal disease, sacral pressure ulcer, dysphagia, dependence on renal dialysis, cognitive communication deficit and adult failure to thrive. A review of a Discharge to Home/Community . document dated 12/10/24 at 2:24 PM, failed to contain documentation in the following sections: Diet ordered by physician at the time of discharge, calorie information and special instructions, Dietary Recap, Cognitive needs, Communication Needs, Psychosocial Needs . Further review of the discharge document noted in part, . Social Services Recap . Individual has been engaged in services though <sic> her time at (facility's name). Individual will discharge to home with significant other. Individual will be sent home with home healthcare (home health care agency name, number and email). Resident requested a wheelchair. Resident will have medications sent home with her the day of discharge. Incident <sic> will discharge without incident. Resident has chair time of dialysis at chose place (dialysis center name) . Review of the progress notes revealed the following: 12/14/24 at 9:52 PM, . Resident discharged at 8:30 pm, accompanied by Daughter (name) . Resident at <sic> Daughter were given follow up paperwork and educated to call 911 in case of an emergency. 12/18/24 at 3:32 PM, a Social Services note documented in part . Individual insurance did not cover for requested walker. On 1/21/25 at 1:28 PM, the Social Service Director (SSD) A was interviewed and asked about the discharge planning and preparation for R707. SSD A replied they setup home health care for the resident and set up dialysis services in the community. SSD A was asked if they were aware that to this day (1/21/25) home health care has not provided services to the resident and/or care giver support. SSD A stated they were aware of an issue regarding the home health agency to have not received the correct prescription from the facility doctor. SSD A stated they remembered calling the doctor to inform them of the issue and the doctor stated they would take care of it. SSD A stated they did not know it was an ongoing issue because they did not hear anything else about the concern after that. SSD A stated they would look into it further and follow back up. (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/22/25 at 9:08 AM, a follow up interview was conducted with SSD A and Social Worker (SW) E was in attendance. SSD A stated they talked to the director of the home health care agency and the doctor did not follow up and the prescription needed for the home health services is still an issue. SSD A stated how they were unaware that it was still an issue because the last time they talked to the doctor, the doctor stated they would handle it. SSD A stated because they didn't hear anything back from the family, they assumed everything was okay. SSD A stated they probably should have followed up with the family. On 1/22/25 at 11:54 AM, the Director of Nursing (DON) was interviewed and asked about the lack of coordination of R707's discharge. The DON stated they were newly employed by the facility and was not the DON at the time of R707's discharge. The DON stated everyday the facility has a stand up meeting every morning and a stand down meeting every evening where the facility interdisciplinary team discuss discharges for the week and ensure the needed equipment and services are in place for discharge. The DON stated they believed the facility's discharge planning is effective, however was unsure of what happened in the case of R707's discharge. On 1/22/25 at 12:11 PM, the Administrator was interviewed and asked about the lack of coordination and services for R707's discharge and the Administrator replied they are usually informed of the facility's discharges for the week. The Administrator stated they are usually informed of any concerns or issues that involved discharges, however, was not informed of any concerns regarding R707's discharge. A review of a facility policy titled Discharge Summary and Plan of Care revised on 10/26/23, documented in part . It is policy of this facility to ensure that a discharge planning process is in place which addresses each resident's discharge goals and needs, including caregiver support and referrals to local contact agencies . No further explanation or documentation was provided by the end of the survey.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41415 This citation pertains to intake: MI00147759. Based on observation, interview and record reviews the facility failed to ensure staff consistently provided assistance with brief changes/toileting needs for one (R705) of three residents reviewed for Assistance of Daily Living. Findings include: Review of a complaint submitted to the State Agency (SA) documented the following in part . On Sunday October 20, 2024 . I found my sister laying in her urine and massive amounts of feces. I took pictures of how it looked. My sister had been laying there for quite some time that the feces dried up and stained her gown. It went through her brief, through the blue pad and on the fitted sheet. The feces had gone between her legs and upward. She had been laying there at least a few hours if not the whole day without being changed . I wrote up a complaint . dropped it off . (Nurse Unit Manager - NUM C name) called me to tell me that she will issue a write up for the aide and remove her (alleged aide that failed to provide care) from the set (set of care for R705) . Review of the medical record revealed R705 was admitted to the facility initially in 2022 and readmitted to the facility on [DATE]. R705 was admitted with diagnoses that included: acute respiratory failure with hypoxia, tracheostomy status, dependence on supplemental oxygen, quadriplegia and anoxic brain damage. On 1/22/25 at 1:25 PM, Nurse Unit Manager (NUM) C was interviewed and asked about the complaint from R705's family for the date of 10/20/24. NUM C stated they could not recall the incident. NUM C stated they would look into it and follow back up. At 1:48 PM, NUM C returned and provided a form. Review of the form titled Performance Improvement Form dated 10/22/24, documented in part . Reason for counseling/corrective action . Failing to provide care as stated on page 42 of the handbook. Date of 10/20/24 report . Written warning . Care will be provided on a professional level; Following the policy of this facility . The document had CNA G noted as the staff receiving the performance counseling. On 1/22/25 at 2:05 PM, Certified Nursing Assistant (CNA) G (the assigned dayshift aide for the shift of the alleged lack of care provided to R705) was interviewed and asked about the alleged incident of the failure to provide adequate care to R705 on 10/20/24. CNA G stated on that particular day (R705) had been having loose bowel that required them to be changed every two hours. CNA G stated the family of R705 had requested that the resident briefs were to remain opened and not sealed by the side sticky tabs that are used to close the brief. CNA G stated they had informed the nurse assigned to R705 of the resident loose stool all day. CNA G explained they changed R705 for the last time before going off shift and to their understanding the family of R705 found the resident with stool on them and their bed and hour and thirty minutes after they had left the facility. CNA G stated the staff was aware that the resident was having loose stool that day and questioned why the resident had not been check in the hour and 30 minutes past their shift. CNA G stated the unit manager did approach them with a written counseling regarding the incident however was unable to serve CNA G the counseling due to their union representative not being present. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/23/25 at 9:50 AM, a voicemail was left for CNA F (the CNA that was identified as the CNA assigned to R705 on 10/20/24, evening shift) to return the surveyors call. A call was not received by the end of the survey. No further explanation or documentation was provided by the end of the survey.