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No. 0938-0391

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 07/31/2024
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)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30675 This citation pertains to intake #MI00145602. Based on observation, interview and record review, the facility failed to maintain a safe, clean, comfortable and homelike environment, affecting multiple residents throughout the facility. Findings include: Review of a complaint submitted to the State Agency included allegations that the facility was not clean. On 7/29/24 at 10:10 AM, room [ROOM NUMBER] which had three residents in the room, was observed to have a warm air temperature. There were three residents in the room that were observed laying in bed, with blankets on. The residents all reported concerns with being too warm. One resident reported the facility staff took their fan to clean it a couple of weeks ago and never brought them back and they were very uncomfortable and hot. During this interview, there were several flying insects observed throughout the room. The resident in 220-3 did not have a privacy curtain. When asked about the lack of curtain, the resident reported it had been removed a while ago and was never put back up. (The privacy curtain remained missing the duration of the survey, until identified as a concern by the surveyor.) On 7/29/24 at 10:40 AM, room [ROOM NUMBER] which had three residents in the room, was observed to have very warm air temperature which was significantly warmer than in the hallway. On 7/29/24 at 10:50 AM, observation of the 2-north unit (secured memory care) revealed a hallway handrail secured to the wall across from room [ROOM NUMBER] had a missing end cap which exposed a sharp plastic and metal end. There were several residents observed walking throughout the hallways at this time. Additionally, a strong urine odor was observed throughout the 2-north lounge, however there were no residents, or tables in the area. The odor source was unable to be identified. On 7/29/24 at 10:57 AM, room [ROOM NUMBER] was observed to have soiled privacy curtains which were covered with a dark colored substance in several areas. (continued on next page)

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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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/29/24 at 11:00 AM, observation of room [ROOM NUMBER]'s temperature was conducted with the Maintenance Director (Staff 'B'). At that time, the room temperature was 80.8 degrees Fahrenheit. On 7/29/24 at 11:11 AM, and 1:50 PM, the privacy curtain in room [ROOM NUMBER]-3 was observed pulled down from the ceiling with only five hooks securing it to the ceiling. The two trash cans in the room did not have any trash can liners, but contained various garbage and debris. On 7/30/24 at 2:45 PM, an interview was conducted with the Maintenance Director (Staff 'B'). When asked about who was responsible for maintaining the facility's environmental needs, Staff 'B' reported they were helping out temporarily and were from a sister facility since the facility was currently without a Maintenance Director. At that time, Staff 'B' was requested to observe several rooms and areas throughout the facility and confirmed the same observations as above. Additional observations of the 2-north unit with Staff 'B' revealed several concerns with the flooring on the unit. The flooring was observed in multiple areas to have lifted seams and gaps which created potential accident/trip hazards. When asked about the missing and soiled privacy curtains, Staff 'B' reported that was the responsibility of housekeeping to ensure the curtains were cleaned and in place. On 7/31/24 at 8:30 AM, an interview was conducted with the Housekeeping & Laundry District Manager (Staff 'D') who reported they were interim Manager at this facility for a couple of months covering the manager that had been on medical leave. When asked about the housekeeper's duties in regard to privacy curtains, they reported that was something they should be looking for when they cleaned on a daily basis and if soiled, they would remove to wash then replace. When asked if they should identify if curtains were missing, or in need of repair, should that be identified and they reported yes and they also should be notified by staff when concerns came up. When asked if they had been aware of any concerns since Monday, they reported they had not since Monday. At that time, they were asked to observe room [ROOM NUMBER] and confirmed the missing privacy curtain. On 7/31/24 at 8:35 AM, upon observing room [ROOM NUMBER], Staff 'D' also confirmed the privacy curtain was pulled down from the ceiling and the trash cans were missing liners. At that time, a nurse aide entered the room and reported to Staff 'D' they caught the resident pulling that down on Friday (7/26/24). Staff 'D' confirmed they had not been made aware of that concern According to the facility's policy titled, Safe and Homelike Environment dated 1/1/2022: .Housekeeping and maintenance services will be provided as necessary to maintain a sanitary, orderly and comfortable environment .The facility will maintain comfortable and safe temperature levels .The facility should strive to keep the temperature in common resident areas between 71 and 81 degrees Fahrenheit . Report any unresolved environmental concerns to the Administrator . According to the facility's policy titled, Handrails dated 1/1/2022: (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	.Routine maintenance on handrails will be completed by the maintenance department .Handrails that are loose or incorrect in any way can be reported by visitors, residents, staff, etc. to any staff member .Staff members will report all handrail issues to the maintenance department.

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48680 Based on observation, interview, and record review the facility failed to ensure that one (R395) of one resident reviewed for abuse, was free from misappropriation of their social security money when the money was rerouted to the facility without consent of the resident. Findings include: On 7/29/24 at 9:40AM, R395 was observed in their room lying in bed reading a book. R395 was asked how their experience at the facility was. R365 stated that the overall experience had been pleasant however a few weeks ago the facility started to take their money because their payor source had changed and the money from social security income (SSI) was no longer coming to her, but to the facility. R395 stated, When it happened, I didn't know when it was going to occur because I didn't authorize them to do so, I wasn't able to pay my phone bill and my other monthly things that I've had to pay. So, it has been really frustrating. A record review revealed that R395 was admitted to the facility on [DATE] with a diagnosis of chronic obstructive pulmonary disease with acute exacerbation, cellulitis of the lower right limb and bipolar disorder. With a Brief interview for mental status score of 15, indicating an intact cognition. On 7/30/24 at 1:08PM, an interview with the Business Office Manager (BOM) was conducted.She was asked how R395's SSI check no longer going to the Resident, and how the facility receives it now. The BOM replied, My Assistant sent a request (for the SSI to since R395 was refusing the pay amount on their account. I told them that all those funds we would be receiving except for the 60 dollars because they refused to pay the balance. We filed for a direct payee request to SSI that the money comes directly to the facility. The BOM was then asked does a cognitively intact person have to consent to changing their payee information? The BOM replied no we do not need consent, it was a direct request made so that we be paid . Sometimes the Social Security Office approve it sometimes they don't. We have filed for several people and some of our request were approved and some were not. 7/30/24 at 1:28PM the Administrator was interviewed and asked do the facility need consent in order to may a payee change request to the Social Security office the Administrator stated we do not need consent we can just file it for them. 07/30/24 02:32 PM an interview was conducted with the administrator and the BOM and they were asked how do you determine if a competent person is incapable of handling their own funds? They replied, it is case by case bases. R395 refused to pay us and resident bragged about not paying us. R395 would do things like go to the store come back with big bags full of items and stated to us the it would be a cold day in hell before I give that money. They were then asked If a person doesn't want to pay you do they have that right not too, they replied no they don't have the right because they are in the nursing home we give them the 60 dollars and that they owe us the rest. The BOM stated she was given direction from her corporate office that filing for payee request was the next option. And when R395 leave the nursing home facility they will become come their own payee again. The BOM and admin were further questioned and asked, did R395 state that they were not going to pay their bill. They replied no R395 never stated that they were not going to pay us and that they were going to use funds from another spot once it was located. But that's not how it works. No additional information was provided by exit of survey.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30675 Based on interview, and record review, the facility failed to develop resident-specific comprehensive care plans for two (R137 and R246) of 29 residents reviewed for care plans, resulting in lack of identified mood, behavior, targeted symptoms and use of psychotropic medication for R137, and lack of hospice needs for (R246). Findings include: R137 On 7/29/24 at 1:10 PM, a phone interview was conducted with R137's legal guardian (LG). When asked about the resident's use of psychotropic medication and recent behaviors, the LG reported the resident had been recently diagnoses with Alzheimer's and seizures. The LG further reported the resident had a memory problem for a couple of years, but recently had gotten worse. The LG reported an incident at the hospital at night in which the resident tried to push past the guards and had been given medication to sedate. Review of the resident's current physician orders included: Risperdal oral tablet 1 MG (Milligrams) (Risperidone) give 1 mg by mouth in the evening for dementia. This was started on 5/23/24. Risperdal oral tablet 1.5 mg by mouth one time a day (ordered in the morning) for dementia. This was started on 5/24/24. Further review of the clinical record revealed R137 was admitted into the facility on [DATE] with diagnoses that included: encephalopathy, other seizures, and unspecified dementia unspecified severity, without behavioral disturbance, psychotic disturbance, psychotic disturbance, mood disturbance, and anxiety. Review of the documentation during R137's hospital stay just prior to their admission to the facility revealed R137 was receiving psychiatry follow up for dementia with behavioral disturbance and was receiving Risperdal 1.5 mg po (by mouth) am (in the morning), risperdal 1 mg po qhs (at bedtime), trazodone 100 mg po qhs (every night), lexapro 10 mg po qam, zyprexa 5 mg TID prn (as needed), zyprexa 10 mg IM (intramuscular) QD prn and also had a sitter due to elopement risk. None of these recent mood/behaviors were identified and/or reflected within the resident's assessments, or plan of care. According to the admission Minimum Data Set (MDS) assessment dated [DATE], R137 had severe cognitive impairment, had no potential indicators of psychosis such as hallucinations or delusions, had physical behavioral symptoms directed towards others which occurred one to three days, received antipsychotic medication on a routine basis with no indication noted. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to the psychotropic drug use care area assessment (CAA), .Currently using Escitalopram (antidepressant), Trazodone (antidepressant), Rirperdone <sic> (antipsychotic) and Olanzapine (antipsychotic) .Will Psychotropic Drug Use be addressed in the care plan? Yes . Review of the care plans revealed the care plans initiated were not specific to address the resident's targeted behaviors to warrant use of the multiple psychotropic medication and potential interventions that were specific to R137 and included: A psychotropic medication use care plan initiated on 5/23/24 with no further revision read: Resident takes psychotropic/mood stabilizer medication as evidenced by (blank). There was no specific details of the medication prescribed, or clinical rationale. A behavioral care plan initiated 5/23/24, last revised 5/24/24 read: [Name of R137] has behavior(s) related to Dx (Diagnosis): Dementia and Encephalopathy, Unspecified as evidenced by: physically <sic> aggression (attempting to use her <sic> cane as a weapon) towards staff during redirection attempts. Although there was a psych consultation on 6/12/24 that identified they were not considering a gradual dose reduction at that time due to target symptoms have not been sufficiently relived <sic> by non-pharmacological interventions, review of the care plans, assessments and progress notes revealed there were no resident-specific targeted behaviors identified to monitor. On 7/30/24 at 8:15 AM, an interview was conducted with the Director of Social Services (Social Worker 'A') who reported they had just started working at thr facility on 7/15/24, along with two other full-time social service staff. When asked about the facility's process for ensuring residents had targeted behaviors identified for use of psychotropic medication, they reported they were still in the process of completing chart reviews and making revisions as needed. When asked to review R137's clinical record and what their identified targeted behaviors were, they reported they didn't see any specific targeted behaviors, there was reference of agitation and hitting out at staff with his cane (noted as a one time incident at the time of admission), but confirmed the current order for the risperdal medication was for dementia. On 7/31/24 at 3:00 PM, an interview was conducted with the Director of Nursing (DON). At that time, upon review of R137's clinical record, the DON was informed of the concern for lack of resident-specific care plans and interventions to address their use of psychotropic medication and targeted behaviors. The DON expressed understanding and reported they would have to follow-up. According to the facility's policy titled, Behavior Management Program dated 10/27/2023: (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30675 Based on observation, interview and record review, the facility failed to ensure care plan reviews were completed with the required interdisciplinary (IDT) team for two (R246 and R137) residents, and ensure the care plan was revised to reflect the current status of the resident's post-fall interventions for one (R26) of 29 residents reviewed for care plan revisions, resulting in the lack of opportunity for the Residents, their legal representatives, and/or family members to participate in the discussion of treatment options and decisions which pertained to their care, and direct care staff being unaware of changes in the resident's care needs following a fall. Findings include: According to the facility's policy titled, Comprehensive Care Plans dated 6/30/2022: .The comprehensive care plan will describe, at a minimum, the following .The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being .The comprehensive care plan will be prepared by an interdisciplinary team, that includes, but is not limited to: a. The attending physician. b. A registered nurse with responsibility for the resident. c. A nurse aide with responsibility for the resident. d. A member of the food and nutrition services staff. e. The resident and the resident's representative, to the extent practicable. f. Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. Examples include, but are not limited to: i. The RAI (Resident Assessment Instrument) Coordinator. ii. Activities Director/Staff. iii. Social Services Director/Social Worker. iv. Licensed therapists. v. Family members, surrogate, or others desired by the resident. vi. Administration. vii. Discharge Coordinator. viii. Mental Health Professional. ix. Chaplain .The comprehensive care plan will be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly MDS assessment .Every effort will be made to schedule care plan meetings at the best time of the day for the resident and family .When a resident has no family, the ombudsman may be invited to attend the care plan meeting if desired by the resident .A summary of the comprehensive care plan will be given to the resident and/or representative and will include: A. the initial goals of the resident B. Summary of the resident's medications and dietary instructions C. Services and treatments D. Any updates completed at the care plan meeting. R246 Review of the clinical record revealed R246 was admitted into the facility on [DATE] and signed onto hospice on 7/18/24. Diagnoses included: malignant neoplasm of unspecified part of unspecified bronchus or lung, mild protein-calorie malnutrition, type 2 diabetes mellitus with unspecified complications, dysphagia, and unspecified diastolic heart failure. According to the significant change Minimum Data Set (MDS) assessment dated [DATE], R246 had intact cognition, and was not on hospice (although the resident signed onto hospice on 7/18/24). (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of the clinical record revealed no documentation that a care planning review conference had been conducted with the resident, family, or the required members of the interdisciplinary team. On 7/30/24 at 9:22 AM, the MDS Coordinator (Nurse 'C') was asked about when significant change MDS should be completed when a resident signs onto hospice. The MDS Coordinator reported as soon as they find out. When asked about R246, they reported they had completed a significant change MDS due to their decline, but had not completed one since signing onto hospice. Nurse 'C' further reported they thought the resident had come off and on hospice, but was informed the documentation indicated they had remained since signing on 7/18/24. When asked about the facility's process for care planning reviews with the residents and their families, Nurse 'C' reported they did have care conferences and just started documenting those under the assessment portion of the clinical record on the discharge to community assessment. When asked if that would be for all residents, including those that did not intend to discharge, Nurse 'C' indicated it was. They also reported some residents might have had a hard copy that was documented on in the past. When asked about R246 and whether they had a care planning conference conducted since their admission, Nurse 'C' reported they would review and follow-up. Nurse 'C' was asked who schedules the care conferences and they reported they did the scheduling of the meeting, but the Interdisciplinary Team (IDT) does the actual meeting. When asked if there were any concerns with scheduling/conducting these care planning reviews, Nurse 'C' declined to respond. They were asked to provide any further documentation that R246 had been offered or the facility had conducted a care planning review. On 7/30/24 at 9:35 AM, the Administrator reported there was no care conference scheduled or completed for R246. R137 Review of the Discharge Planning Evaluation-V4 assessment dated [DATE] documented a care planning review was completed with the resident's guardian, by phone and the sections for Attendee/Participant Information Care plan conference attendee/participant Name, title/relationship to resident, and method of attendance/participation (e.g., in person, email, phone, etc.) was documented as: [R137's name]-self (in person); [R137 legal guardian's name]-legal guardian/brother (in person); [Name of former Social Service Assistant (SSA 'Q')] (in person); and [Name of Business Office Manager 'R'] (in person). There was no documented evidence that all required members participated in this care planning review including the physician/extender, Certified Nursing Assistant (CNA) directly involved in their care, activities, or dietary. Further review of the clinical record revealed R137 was admitted into the facility on [DATE] with diagnoses that included: encephalopathy, unspecified dementia unspecified severity, without behavioral disturbance, psychotic disturbance, psychotic disturbance, mood disturbance, and anxiety; other seizures, unspecified atrial fibrillation, and essential hypertension. According to the admission MDS assessment dated [DATE], R137 had severe cognitive impairment. The clinical record identified R137 had a court appointed legal guardian. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	38271 R46 On 7/29/24 at approximately 12:19 p.m., R46 was observed in their room, laying in a low bed. A Floor mat (mat used to provide cushioning in case of falling) was observed up against their wall. R46 was queried if they had fallen out of their bed and they indicated they had. On 7/29/24 the medical record for R46 was reviewed and revealed the following: R46 was initially admitted to the facility on [DATE] and had diagnoses including Congestive heart failure and Acute embolism and thrombosis of unspecified deep veins of unspecified lower extremity. A review of R46's MDS (minimum data set) with an ARD (assessment reference date) of 6/30/24 revealed R46 needed assistance from facility staff with their activities of daily living. R46's BIMS score (brief interview for mental status) was 13 indicating intact cognition. A progress note dated 6/24/24 revealed the following: .Progress Note .after assessment staff heard resident ask for help and went into his room and noted him sitting on the floor left side of the bed stating he was trying to get the gum off his shoes. denies hitting head denied pain ROM (range of motion) completed no noted injury staff assist resident back to bed staff educated resident on risk vs benefit of getting out of bed without assistance, using call light and put bed in lowest position give call light and place mat at left side of bed. NP (Nurse Practitioner), Manager resident stated he was fine and no need to call siblings A review of R46's comprehensive careplan was reviewed and revealed the following: Resident is at risk for falls/injury related to generalized weakness Date Initiated: 06/25/2024. Further review of the careplan revealed no mat interventions noted on the plan of care. On 7/31/24 at approximately 12:57 p.m., Nurse Manager L (NM L) was queried why R46's mat to the left side of their bed was not added to their comprehensive plan of care and they indicated the Nurse should have updated the careplan to put the floor mat into it but only added the low bed intervention and forgot to add the mat. NM L was queried if the direct care staff review the Kardex (care guide) to ascertain what interventions should be in place and they indicated that they did and that the interventions come from the care plan.

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	235296	A. Building B. Wing	07/31/2024

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Medilodge of Southfield	26715 Greenfield Rd Southfield, MI 48076

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
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** 49272 Based on observation, interview and record review, the facility failed to provide activity of daily living care including timely brief change, associated peri-care and linen change for one (R29) resident of two residents reviewed for Activities of Daily Living (ADLs). Findings include: On 7/29/24 at 11:12 AM, R29 was observed sitting in a wheelchair, a strong urine smell was present, and the resident's bed had been striped of linens and remained unmade. R29 reported they were soiled and needed assistance getting changed as they had a big mess. R29 reported that the staff member that striped their bed was aware he needed to be changed but had not come back to assist him. On 7/29/24 at 1:13 PM R29 was observed once again sitting in their wheelchair in their room, they reported that they remained in a soiled brief and the bed was observed to remain unmade, strong urine odor still was present. R29 reported that they had went down to the dining room for lunch in their soiled brief. On 7/31/24 at approximately 10:00 AM, the DON was notified of R29 being left in soiled brief and the bed being left unmade. The DON was unable to offer any explanation at that time. Review of the clinical record revealed R29 was admitted to the facility on [DATE] with diagnoses that included: repeated falls, need for assistance with personal care and muscle weakness. According to the Minimum Data Set (MDS) assessment dated [DATE], R29 scored 15/15 which indicated intact cognition. Review of the facility's policy titled Activities of Daily Living (ADLs), updated 12/28/2023, documented in part A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38271 This citation has three deficient practices (DPS). DPS#1 Based on observation, interview and record review the facility failed to ensure a resident transfer was completed per the plan of care for one resident (R93) of six residents reviewed for accidents/hazards/supervision. Findings include: On 7/30/24 at approximately 11:14 a.m., Certified Nursing Assistant P (CNA P) was observed in R93's room doing a transfer with a mechanical lift (hoyer) with R93 up in the sling. R93 was observed suspended in the air for multiple minutes swinging in the sling while CNA P directed the lift and lowered R93 down into their chair by themselves. On 7/30/24 at approximately 11:20 a.m., CNA P was queried regarding the transfer for R93 and if the safety protocol was for two people to complete a mechanical lift transfer and they indicated that it was but that they could not find anyone to help them. CNA P indicated they knew a hoyer lift transfer required to people to be safe. On 7/30/24 a review of R93's medical record was reviewed and revealed the following: R93 was initially admitted to the facility on [DATE] and had diagnoses including Paraplegia and Muscle weakness. A review of R93's comprehensive plan of care revealed the following: Focus-[R93] has an ADL (activities of daily living) self-care performance deficit related to resident paraplegia Interventions-TRANSFERS: with 2 person assist AND use of mechanical lift (HOYER) and (size/color of sling). Date Initiated: 12/14/2023 . On 7/31/24 at approximately 12:57 p.m., Nurse Manager L was queried how many staff are needed to safely completed a mechanical lift transfer and they indicated that two staff should be completing the transfer with a hoyer lift. DPS #2 Based on observation, interview and record review the facility failed to ensure appropriate interventions to reduce injury from falling were in place for two residents (R41 and R46) of six residents reviewed for accidents/hazards/supervision. Findings include: On 7/29/24 at approximately 12:19 p.m., R46 was observed in their room, laying in a low bed. A Floor mat (mat used to provide cushioning in case of falling) was observed up against their wall. R46 was queried if they had fallen out of their bed and they indicated they had. On 7/31/24 at approximately 8:57 a.m., R46 was observed in their room, laying in their bed. R46 was observed without a mat next to their bed. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/29/24 the medical record for R46 was reviewed and revealed the following: R46 was initially admitted to the facility on [DATE] and had diagnoses including Congestive heart failure and Acute embolism and thrombosis of unspecified deep veins of unspecified lower extremity. A review of R46's MDS (minimum data set) with an ARD (assessment reference date) of 6/30/24 revealed R46 needed assistance from facility staff with their activities of daily living. R46's BIMS score (brief interview for mental status) was 13 indicating intact cognition. A progress note dated 6/24/24 revealed the following: .Progress Note .after assessment staff heard resident ask for help and went into his room and noted him sitting on the floor left side of the bed stating he was trying to get the gum off his shoes. denies hitting head denied pain ROM (range of motion) completed no noted injury staff assist resident back to bed staff educated resident on risk vs (verse) benefit of getting out of bed without assistance, using call light and put bed in lowest position gave call light and and placed mat at left side of bed. NP (Nurse Practitioner), Manager resident stated he was fine and no need to call siblings A review of R46 Comprehensive Careplan revealed the following: Resident is at risk for falls/injury related to generalized weakness Date Initiated: 06/25/2024 On 7/31/24 at approximately 12:57 p.m., Nurse Manager L (NM L) was queried why R46's mat to the left side of their bed was not observed to be in place or added to their comprehensive plan of care and they indicated the Nurse should have updated the careplan to put the mat into it but only added the low bed intervention and forgot to add the mat. NM L was queried if the direct care staff review the Kardex (care guide) to ascertain what interventions should be in place and they indicated that they did and that the interventions come from the care plan and that the mat should have been on it. NM L was queried regarding the facility policy for fall interventions and they indicated that an incident and accident report should be done with the interventions indicated on it and added to the plan of care. NM L was queried why R46 did not have an incident report for their fall on 6/24/24 and they indicated that one should have been completed but was not. 48680 R41 On 7/29/24 at 11:06AM R41 was observed in room sitting in wheelchair facing the window. R41's call light was observed on the floor. R41 was observed with a knot on their head. R41 was asked about the falls that were reviewed in their chart, and R41 stated, Yes, I've fallen a couple of times trying to reach for items. A record review revealed that R41 had fallen on the floor trying to reach for an item that had fallen on 7/14/24 and 7/22/24. Further review or the record revealed a knot found on 7/22/24 on R41's forehead. R41 was sent to the hospital for further evaluation. Review of the plan of care revealed the facility implemented an intervention for R41 to use a Reacher and to push call light to ask for assistance. On 7/30/24 at 12:03PM, the Unit Manager(UM) was interviewed and asked is if added or modified interventions should be implemented on the residents care plans. UM stated they should. The UM was informed that the call light was on the floor as well as Reacher. The UM explained that she would look into it. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	No additional information was provided by the exit of the survey. 47283 DPS #3: Based on interview and record review, the facility failed to provide adequate supervision for one (R22) of one resident reviewed for elopement (A resident with reduced impulse control, cognitive impairment, and history of wandering/elopement), resulting in the resident leaving the facility's premises without staff's knowledge and the increased potential for injuries from unsafe choices. R22 A review of the clinical record revealed that R22 was originally admitted to the facility on [DATE]. R22's admitting diagnoses included schizophrenia, bipolar disorder, major depressive disorder, and drug induced dyskinesia (involuntary, erratic movements of the face, arms, legs or trunk), urinary retention and diabetes. Based on Minimum Data Set (MDS) assessment completed on 5/19/24, R22 had Brief Interview for Mental Status (BIMS) score of 11/15, indicative of cognitive impairment. R22 was using a manual wheelchair and needed staff assistance to get in and out of their wheelchair as well as their Activities of Daily Living (ADLs) such as transferring to toilet, toilet/personal hygiene, dressing etc. R22 had a public guardian appointed by the court. An initial observation was attempted on 7/29/24 at approximately 10:15 AM. R22 was not in their room. The surveyor queried the Certified Nursing Assistant (CNA) M who was assigned to care for R22, they reported that R22 was outside smoking and added R22 was with a staff member. Approximately an hour later the surveyor attempted a second interview with R22, however they were not in their room. Later that afternoon at approximately 2 PM a third attempt was made and R22 was not in their room. An interview was completed with Licensed Practical Nurse (LPN) N on 7/29/24, at approximately 2:10 PM. LPN N was queried about R22 and they reported that a CNA was assisting R22 in the restroom and added that R22 goes out multiple times a day to smoke and reported that they signed out with the nurse when they want to go out to smoke. LPN N showed the surveyor a document that R22 used to sign in/out. A follow up observation was completed on 7/30/24 at approximately 8:30 AM. Staff were serving breakfast trays. R22 was not in their room. Surveyor queried LPN N and they reported that R22 was outside smoking with a staff member. When queried if they were always supervised by a staff member outside, they reported R22 had the supervision after they had the elopement. The surveyor went outside at approximately 9:05 AM and observed R22 smoking with three other residents in southwest corner of the building across from the facility parking lot. A staff member was observed (CNA O) with the residents. During this observation CNA O was queried about their role. They reported that they were providing supervision for R22. When queried further CNA O reported that they started providing 1:1 supervision after R22 had left the facility a few months ago and added they had changed the system. CNA O confirmed that R22 did not have any staff supervision prior to the recent elopement incident. It must be noted that the exit from the unsecured parking lot lead to a busy (four lane) road with speed limit of 40 miles per hour. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a summary of the facility reported incident submitted to the State Agency read in part, On 5/16/24 (R22 name omitted) signed (R22 gender omitted) out of the facility on an LOA at 8:30 AM then 10:10 AM then 11:07 AM and then at 1:07 PM . was also seen by the CNA around 5:00 PM. CNA noticed at 6:00 PM that she did not see the resident in (gender omitted) room for dinner and notified the nurse name omitted. A code yellow was initiated, and staff immediately started looking for the resident inside the facility and outside grounds of the facility the surrounding neighborhood and businesses were also searched .The police were notified. Guardian was notified and staff called the surrounding hospitals . The Resident was sitting in the lobby of the emergency room at (hospital name omitted) . Review of the psychiatry practitioner note dated 5/22/24 read in part, The patient indicates (gender omitted) is doing OK at this time and notes that (gender omitted) did go out to (hospital name omitted) on . own when his knee legs were hurting (gender pronoun omitted) was outside smoking and (gender pronoun omitted) legs were bothering (gender pronoun omitted) so (gender omitted) got on the bus and went there. Two police officers helped (gender pronoun omitted) get off the bus and get into (hospital name omitted). (gender omitted) was at the hospital .waiting for the doctor to evaluate legs when people from this facility came to help (gender pronoun omitted) return to the NH . The patient feels that he understands that (gender omitted) should not leave this property and he does accept the reasoning that he needs to remain here for safety. We need to keep (gender pronoun omitted) safe and if (gender omitted) departs, we won't know what is happening and we won't know if (gender omitted) is safe any longer. However, the patient does struggle with impulse control and rational thought. Review of R22's progress notes dated 7/26/24 at 22:56, (10:56 PM) read, risk of elopement remains on one on one and hourly safety checks. Sleeping at this time. A Progress notes dated 7/25/24 and 7/24/24 read that R22 was at risk for elopement and they were under 1:1 supervision. There were multiple progress notes between 5/17/24 and 7/24/24 that R22 remains to be a risk for elopement and they had 1:1 supervision from the staff member. A progress note dated 6/4/24 by assistant Nursing Home Administrator (NHA) revealed the meeting with R22's guardian. The note read in part, writer discussed with guardian since our facility is a non-smoking facility we were unable to meet accommodate his needs safely .Guardian started stating that she was never told that there was an issue with his smoking . A progress note dated 5/17/24 at 10:42 AM read in part, resident while up this morning, stayed by the elevator and double doors, wanting to leave the unit. Hourly monitoring ongoing, writer educated on Resident safety verbalized understanding, but continue to make attempts to leave the unit resident assigned 1:1. A social services progress notes dated 5/17/24 read in part, Resident was educated (BIMS 11/15) today on asking CNA for help when (gender omitted) needs help .Guardian agrees and submitted a letter to facility on August 25, 2023, stating that resident has been instructed not to leave the grounds of the facility and that resident understand (gender omitted) lose smoking privileges. Writer informed guardian /case manager honor resident's right to smoke continues to promote a non-smoking environment/facility and guardian must consent to resident smoking independently and resident must be safe to sign self out to smoke off the property of the facility, but not in the crossroads or crossing the street Guardian is aware that resident is an elopement risk and unsafe to smoke independently . (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of an elopement assessment dated [DATE] and prior revealed that R22 had exited the facility, had history of wandering with poor decision-making skills and they were a risk for elopement. A follow-up assessment dated [DATE] documented for R22 read IDT reviewed resident for elopement precautions. Resident does not exhibit behaviors of elopement activity. Resident removed from elopement precautions at this time. However, a smoking assessment dated [DATE] and the MDS assessment dated [DATE] revealed that R22 had memory and cognitive deficits. A psychiatry practitioner note dated 5/8/24 revealed that R22 had impaired insight, judgement and impulse control. It must be noted that R22 continued to sign themselves out to go out and smoke throughout the above noted time frames, without staff supervision, until 5/17/24 after the elopement incident. This was confirmed by record review and staff members during the interview. An interview was completed with LPN N on 7/30/24 at approximately 11:50 AM. LPN N was queried about R22 and how they had been handling the supervision of R22. They reported the sign out process had changed after R22 had an elopement. After the incident, R22 had required staff supervision when they went out to smoke. LPN N confirmed the facility had changed the sign out/sign in process after the incident. An initial interview was conducted with the Director of Nursing (DON) on 7/30/24 at approximately 11: 55 AM. The DON was queried about R22 and the elopement incident on 5/16/24. The DON reported that R22 used to sign out on their own and went out to smoke (when they elopement occurred) The DON stated R22 was assigned 1:1 staff supervision after the 5/16/24 elopement incident. An interview was completed with Nursing Home Administrator (NHA) on 7/31/24 at approximately 8:15 AM. NHA was queried regarding the facility's protocol/process for residents who leave to smoke and have cognitive impairments/impaired judgment for supervision in reference to R22. NHA reported that R22's guardian signed a consent for them to go out and smoke. When queried how their interdisciplinary team of clinicians determined that it was safe practice to let a resident with impaired cognition/judgement, with history of wandering and elopement, was allowed to sign themselves out, to go off the facility premises to smoke; no further explanation. The NHA reported an intervention was implemented for the 1:1 supervision for R22 after the incident. The NHA stated they sent referrals out to other facilities for a possible transfer. NHA stated they understood the concern and they were reviewing their facility processes. An interview with Regional Social Worker (RSW) K was completed on 7/31/24 at approximately 9:05 AM. When queried if it was safe to allow a resident with impaired cognition/judgement, with history of wandering and elopement, to sign themselves out, to go off the facility premises to smoke, RSW Kreported that the facility followed the guardian wishes. When queried about the potential for elopement prior to the 5/16/24 incident for R22 and what the facility process was to ensure that there was adequate supervision for residents with cognitive impairments. RSW K reported that they understood the concern and they would review the facility process with NHA. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted with NHA, DON, Regional Nurse Consultant's (RNC)-RNC U, and RNC V on 7/31/24 at approximately 9:35 AM. The surveyor explained the concern with the facility process on how R22 was allowed to sign in/out themselves with their cognitive impairments and the concern of R22 to not have adequate supervision while they were off the facility premises. RNC U and RNC V reported that they had reassessed all of the facility's residents and they had implemented 1:1 supervision for R22 after the incident. They reported that facility had implemented a process to provide supervision for residents with cognitive impairments and who wished to smoke after this incident. They also added that they had identified the concern with the current facility process and had started working on a plan. Later during the survey, the facility provided documents titled POC work sheet for elopement with an alleged compliance date of 7/26/24. A facility provide document titled Unsafe Wandering & Elopement Prevention with a revision date of 1/1/22 read in part, Every effort will be made to prevent unsafe wandering and elopement episodes while maintaining the least restrictive environment for residents who are at risk for elopement. Nursing personnel must report and investigate all reports of missing residents. Policy Explanation and Compliance Guidelines: 1. All residents who are at risk for harm because of unsafe wandering will be assessed by the interdisciplinary care planning team. 2. The residents care plan will be modified to indicate the resident is at risk for allotment episodes. Staff will be informed at shift change of the modifications to the residents' care plan. 3. Interventions for unsafe wandering and elopement attempts will be entered onto the residents' care plan and medical record. 4. Should an elopement episode occur the contributing factors, as well as the interventions tried, will be documented on the nurses' notes. 5. If the resident is discovered to be missing a search shall begin immediately. 6. It is the responsibility of all personnel to report any resident attempting to leave premises, or suspected of being missing, to the licensed nurse in charge as soon as practical .

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 49272 Based on observation, interview and record review the facility failed to ensure narcotic medication for discharged resident (R445) was disposed of in a timely manner. Findings include: On 7/30/24 at approximately 4:30 PM during a review of the medication cart, R445's narcotic log for Hydrocodone-APAP 5-325mg revealed that R445 had discharged (indicated by DC on the narcotic log) however 38 tablets remained in the narcotic drawer. LPN X reported that R445 had been discharged several weeks prior and that it was the responsibility of the director of nursing (DON) to dispose of medications for discharged residents. Unit Manager Y and LPN X reported that the DON was aware that R445 had discharged , and the medications needed to be disposed of. The DON was notified with this surveyor present and the medications were disposed of. The DON reported they would provide a copy of the facility policy that stated the appropriate timeline for when medications should be disposed of. On 7/31/24 at 9:56 AM, the DON was queried again about the facility's policy related to when/how discharged narcotics should be disposed of. The DON was unable to locate the answer during the interview but reported their current process is for the unit manager to pull the medications off of the medication cart and the unit manager and DON will destroy the medications together. The DON was unsure of where the communication breakdown occurred and reported that they were not aware of the medications needing to be disposed of prior to the survey. The DON further stated that they should not be left in the medication cart for two months following a discharge. Review of R445's clinical record indicated they were discharged from the facility on 5/27/24. The unused narcotic medications were discovered on 7/30/24, two months after R445 was discharged . Review of the facility's policy titled Medication-Destruction of Unused Drugs updated 1/18/24, documented in part Schedule II, III, and IV controlled drugs must be destroyed by the Director of Nursing services and another licensed nurse .

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49272 Based on interview and record review the facility failed to ensure that residents were free of any significant medication errors for one (R70) of one resident reviewed for medication errors. Findings include: On 7/30/24 at 10:12 AM R70 was interviewed and reported that they had not received their monthly migraine medication (Emgality) for several months. R70 reported the medication really helps with their migraines that they stated were linked to their Multiple Sclerosis diagnosis. Review of the clinical record revealed R70 was admitted into the facility on [DATE] with diagnoses that included: Multiple Sclerosis and headache syndrome. According to the Minimum Data Set (MDS) assessment dated [DATE], R70 had scored 15/15 on the Brief Interview for Mental Status exam, which indicated intact cognition. Review of R70's clinical record revealed an order for Emgality (galcanezumab) 120mg/ml (milligram/milliliter) Solution, inject 2ml subcutaneously one time every 28 days for migraine dated 2/1/2024. Further review of the clinical record, including R70's medication administration record (MAR) for Emgality, revealed: On April 20, 2024, it was documented 9-Other/See Progress Notes indicating the dose was not given. The associated progress note read Writer notified the pharmacy, pharmacy stated that they (sic) need an approval from the DON before sending the medication out .the approval was needed since January. On May 18, 2024, it was documented 9-Other/See Progress Notes indicating the dose was not given. The associated progress note read Pharmacy was contacted this morning pharmacy stated that (sic) need an approval from DON because this is an high cost medication. On June 15, 2024, it was documented 9-Other/See Progress Notes indicating the dose was not given. The associated progress note read Medication administration to be schedule to be administered by the physician Resident did not receive their monthly dose of Emgaility for three months (April, May and June). On 7/31/24, the DON was interviewed regarding the missing doses of Emgality. The DON reported having knowledge of a change in the pharmacy that supplied the medication but would need to follow up to determine why the resident did not receive the medication for three months. The DON confirmed that each missing dose should have been reported to the physician. The DON was informed that did not happen. No further explanation of the missing doses was received prior to the end of the survey. Review of the facility policy titled Medication Errors, updated 1/24/24, documented in part The facility shall ensure medications will be administered as follows: According to physician's orders .

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F 0776 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, approved x-ray services, or have an agreement with an approved provider to obtain them. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38271 Based on interview and record review the facility failed to ensure a Physician ordered diagnostic (duplex scan) was obtained per the physician's order for one resident (R46) of one residents reviewed for radiology diagnostics. Findings include: On 7/29/24 the medical record for R46 was reviewed and revealed the following: R46 was initially admitted to the facility on [DATE] and had diagnoses including Congestive heart failure and Acute embolism and thrombosis of unspecified deep veins of unspecified lower extremity. A review of R46's MDS (minimum data set) with an ARD (assessment reference date) of 6/30/24 revealed R46 needed assistance from facility staff with their activities of daily living. R46's BIMS score (brief interview for mental status) was 13 indicating intact cognition. A Physician progress note dated 7/2/24 revealed the following: chief complaints/History of present illness Complaining of swelling rt (right) arm/ hand. No Current Venous catheters in place Denies any pain - no swelling of face etc Review of systems Venous dopplers BUE (bilateral upper extremity)-->LEFT Basilic vein SVT (Superficial Thrombophlebitis) only. No Redness of arm VENOUS DOPPLERS -NEG (negative) for DVT (deep vein thrombosis)/ Basilic vein SVT + (positive) .Left basilic vein SVT/ Rt (right) arm swelling (likely dependent edema) - no IV cath (catheter) in place- No palpable thrombus or tenderness (nursing exam) - Tylenol for pain - NSAIDs if any sign of Supfthrombphlebitis appear. - REPEAT venous Dopplers on Monday 7/8/2024- to assess any progression of thrombosis esp into deep veins --> will treat appropriately if progression A Nurse Practitioner evaluation dated 7/5/24 revealed the following: 7/2/24: Duplex scan ordered by IM (internal medicine) for RUE (right upper extremity) edema. Results pending. -7/5/24: Results show L basilic vein SVT. IM aware. Plan to repeat on 7/8/24. Patient encouraged to elevate right arm as tolerated A Physician's order dated 7/3/24 revealed the following: Right upper extremity Venous Duplex to r/o (rule out) DVT one time only for r/t (related to) previous results on 7/2 until 07/09/2024 23:59 Further review of R46's medical record did not reveal any results of the repeat [NAME] Duplex diagnostic order. On 7/31/24 at approximately 12:57 p.m., during a conversation with Nurse Manager L (NM L), NM L was queried for the results of the venous duplex diagnostic that was supposed to be repeated on 7/8/24 and indicated that it was never done and they had to reorder it. On 7/31/24 a facility document titled Laboratory and Diagnostic Guidelines was reviewed and revealed the following: Policy: This guideline is set up to track the timely completion, reporting and monitoring of laboratory and diagnostic tests, results, and notifications which are used to monitor resident status and/or therapeutic medication levels. Policy Explanation and Compliance Guidelines: (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Medilodge of Southfield		STREET ADDRESS, CITY, STATE, ZIP CODE 26715 Greenfield Rd Southfield, MI 48076	

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F 0776 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. The facility may consider tracking laboratory (lab) and diagnostic test through various sources. The system is based on the lab provider and facility efficiency. a. Tracking log b. Electronic portal c. Calendar d. Other 2. Routine laboratory or diagnostic test may be placed on a calendar or schedule, or other mechanism. The mechanism should allow for ease of the facility staff to recognize upcoming lab and diagnostic tests. 3. Lab and diagnostic test ordered for future dates should also be placed in the same system, again to allow for ease of the facility staff to recognize. 4. Each Lab or entity will have its own process for requisitions. 5. When a new order for labs/diagnostic test is received the nurse should review previous orders for like test to determine if there is conflict, overlap, or rescheduling required. 6. Unless specifically ordered by the physician, routine orders that would fall on a Saturday, Sunday, or holiday may be drawn on the following business or lab day. 7. STAT labs may be obtained per physician order 7 days per week. 8. Orders which require more than one sample, for example stools for occult blood should be placed on a separate line on the log/calendar or per laboratory requirements. 9. The physician should be notified of all refused lab/diagnostic test orders and reason why. 10. The physician should be notified if the lab/diagnostic test is unable to be completed, reason why, and request for new orders. 11. The physician should be notified of all lab/diagnostic test results based on the below parameters. a. Critical lab results or urgent diagnostic should be called to the physician upon receipt. o If at any time the resident is symptomatic or if in the clinician's expert opinion the resident needs evaluation and there has been no response from a physician, the Medical Director will be notified. b. Non-critical or non-urgent test results that are abnormal should have physician notification within 24 hours unless the physician has provided specific notification parameters. Policy- Laboratory and Diagnostic Guidelines c. Normal lab/diagnostic results may be faxed to the physician to be reviewed during normal physician hours, unless the physician has ordered immediate reporting of the result. 12. All notifications, attempts at notifications, and response should be noted in the resident's medical record. 13. Results should also be reported to the resident and/or responsible party, including any new orders.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 22960 Based on observation, interview, and record review, the facility failed to maintain sanitary conditions in the kitchen. This deficient practice had the potential to affect all residents that consume food from the kitchen. Findings include: On 7/29/24 between 8:45 AM-9:15 AM, during an initial observation of the kitchen with District Manager E, the following items were observed: The handwashing sink located near the dish machine room was blocked by 3 carts and not accessible. The trash can near the handwashing sink had no liner inside, and when the lid was opened, numerous gnats flew out from inside the trash can. According to the 2017 FDA Food Code section 5-205.11 Using a Handwashing Sink, 1. (A) A HANDWASHING SINK shall be maintained so that it is accessible at all times for EMPLOYEE use. Pf In addition to the hand sink, there were gnats observed near the steam table, and there was a heavy concentration observed near the 3 compartment sink. Underneath the 3 compartment sink, there was standing water, and a swarm of gnats was observed on the floor tiles. When queried, District Manager E confirmed the gnats and stated that a pest control company had been in for the gnats approximately 3 weeks ago. In the chemical/mop room, there was a mop bucket with sludge on the inside bottom surface, and standing water on the floor. There were numerous gnats observed flying about in the chemical/mop room. District Manager E stated the mop bucket would get cleaned out right away. According to the 2017 FDA Food Code section 6-501.111 Controlling Pests, The PREMISES shall be maintained free of insects, rodents, and other pests. The presence of insects, rodents, and other pests shall be controlled to eliminate their presence on the PREMISES by: .4. (D) Eliminating harborage conditions. On the clean dishware rack near the 3 compartment sink, there were stacks of clean pans observed with visible water droplets/moisture on the insides. District Manager E confirmed the pans should have been dry before stacking. According to the 2017 FDA Food Code section 4-903.11 Equipment, Utensils, Linens, and Single-Service and Single-Use Articles, .(B) Clean equipment and utensils shall be stored as specified under (A) of this section and shall be stored: (1) In a self-draining position that allows air drying; . There was a steady leak of water from the discharge pipe underneath the dish machine. Standing water was observed on the floor. District Manager E stated they would let Maintenance know about the leak. According to the 2017 FDA Food Code section 5-205.15 System Maintained in Good Repair, A plumbing system shall be: (A) Repaired according to law; P and(B) Maintained in good repair. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	There was a stack of milk crates stacked up across from the ice machine. Inside one of the crates, was a container of cottage cheese and an unopened milk carton. District Manager E stated the items should have been discarded.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38271 Based on observation, interview and record review the facility failed to follow core infection control procedures for enhanced barrier precautions (EBP) for two residents (R93 and R297) of three residents reviewed for transmission based precautions. Findings include: Resident #93 On 7/30/24 at approximately 11:14 a.m., Certified Nursing Assistant P (CNA P) was observed in R93's room doing a transfer with a mechanical lift (hoyer) with R93 up in the sling. CNA P was observed to not be wearing any gloves or protective gown during the transfer. At that time, R93's door was observed to contain signage that indicated staff were be donning gloves and a gown when performing transfers. On 7/30/24 at approximately 11:20 a.m., CNA P was queried regarding the transfer for R93 and if the safety protocol was for them to have on gloves and a gown and they indicated that they should have been but had forgotten. On 7/30/24 a review of R93's medical record was reviewed and revealed the following: R93 was initially admitted to the facility on [DATE] and had diagnoses including Paraplegia and Muscle weakness. A review of R93's comprehensive plan of care revealed the following: Focus-Resident requires enhanced barrier precautions related to diabetic foot ulcer, dialysis, MRDO (multidrug-resistant organisms) HX (history). Date Initiated: 5/16/2024 Interventions-Use gown and gloves when providing direct care. Face protection may be needed if performing activity with risk of splash or spray. Date Initiated: 05/16/2024 Utilize Enhanced Barrier Precautions when providing high contact resident care activities (dressing, bathing, transferring, personal hygiene, changing linens, changing briefs/assisting with toileting, device care: central lines, urinary catheters, feeding tubes, tracheostomy/ventilators, wound care, dialysis) Date Initiated: 05/16/2024 . Resident #297 On 7/30/24 at approximately 9:48 a.m., R297 was observed in their room, laying in their bed being provided dressing care by CNA S. CNA S was not observed to have any gown on while proving the dressing care. R297's door was observed to contain signage that indicated R297 was on enhanced barrier precautions that included use of a gown when providing dressing assistance. On 7/30/24 at approximately 9:50 a.m., Nurse T was queried if R297 was on enhanced barrier precautions and if CNA S should be in the room assisting R297 with dressing without donning a protective gown and they indicated they should have a gown on. Nurse T was then observed reviewing R297's medical record and indicated that R297 had an order for enhanced barrier precautions and indicated they would have educate CNA S. On 7/30/24 the medical record for R297 was reviewed and revealed the the following: R297 was initially admitted to the facility on [DATE] and had diagnoses including Dependence on Renal Dialysis and Chronic obstructive pulmonary disease. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Physician's order dated 7/29/24 revealed the following: Use enhanced barriers while performing high-contact activity with the resident. every shift A review of R297's comprehensive plan of care revealed the following: Focus-[R93] requires enhanced barrier precautions related to pressure ulcer and surgical wounds Date Initiated: 07/29/2024 Interventions-Utilize Enhanced Barrier Precautions when providing high contact resident care activities (dressing, bathing, transferring, personal hygiene, changing linens, changing briefs/assisting with toileting, device care: central lines, urinary catheters, feeding tubes, tracheostomy/ventilators, wound care, dialysis) Date Initiated: 07/29/2024 . On 7/31/24 at approximately 12:57 p.m., Nurse Manager L was queried regarding the observations of CNA P and CNA S providing care for residents who required the use of enhanced barrier precautions and they indicated that they should have on gowns and gloves. On 7/31/24 a facility document titled Enhanced Barrier Precautions (EBP) was reviewed and revealed the following: Policy: It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms .Definitions: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Enhanced barrier precautions refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and gloves use during high contact resident care activities. Policy Explanation and Compliance Guidelines: 1. Recognition of need: a. Staff receive training on enhanced barrier precautions upon hire and at least annually. b. Staff receive training on high-risk activities and common organisms that require enhanced barrier precautions. c. The facility will have discretion on how to communicate to staff which residents require the use of EBP, as long as staff are aware of which residents require the use of EBP prior to providing high-contact care activities. 2. Initiation of Enhanced Barrier Precautions - a. Nursing staff may place residents with certain conditions or devices on enhanced barrier precautions empirically while awaiting physician orders. b. Even if the resident is not known to be infected or colonized with a MDRO, an order for enhanced barrier precautions will be obtained for residents with any of the following: i. Wounds (e.g., chronic wounds such as pressure injuries, diabetic foot ulcers, unhealed surgical wounds, and chronic venous stasis ulcers. Note: Wounds generally include chronic wounds, not shorter-lasting wounds such as skin breaks or skin tears covered with an adhesive bandage (e.g. Band-Aid(R)) or similar dressing. ii. Indwelling medical devices (e.g., central lines, urinary catheters, feeding tubes, tracheostomy / ventilator tubes). Note: A peripheral intravenous line (not a peripherally inserted central catheter) is not considered an indwelling medical device for the purposes of EBP. iii. Infection or colonization with a CDC (Centers for Disease Control and Prevention)-targeted MDRO when Contact Precautions do not otherwise apply. c. The facility will have the discretion in using EBP for residents who do not have a chronic wound or indwelling medical device and are infected or colonized with an MDRO (Multidrug-resistant organisms) that is not currently targeted by the CDC. 3. Implementation of Enhanced Barrier Precautions may include but is not limited to- a. Make gowns and gloves readily available near or outside of the resident's room. Note: Face protection may also be needed if performing activity with risk of splash or spray (i.e., wound irrigation Tracheostomy care). b. PPE for enhanced barrier precautions is only necessary when performing high-contact care activities and may not be needed to be donned prior to entering the resident's room. c. Ensure access to alcohol-based hand rub. d. Position a trash can for discarding PPE after removal, prior to exiting the room or before providing care for another resident in the same room. e. Provide education to residents and their visitors about enhanced barriers precautions. f. Do not restrict room placement or out-of-room activities due to enhanced barrier precautions. g. See Table 1 for implementing Contact versus Enhanced Barrier Precautions for more information. 4. High-contact resident care activities to consider include: a. Dressing b. Bathing c. Transferring d. Providing personal hygiene e. Changing linens f. Changing briefs or assisting with toileting g. Device care or use: central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes h. Wound care: for chronic wounds described above

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47283 Based on interview and record review, the facility failed to maintain an effective immunization program (for influenza and pneumonia) for two (R77 and R82) of five residents reviewed for vaccinations resulting in the potential for influenza and pneumonia infections. Findings include: R77 A record review revealed that R77 was a long-term resident of the facility and originally admitted to the facility on [DATE]. R77's diagnoses included respiratory failure, brain damage, diabetes, quadriplegia (paralysis of all four limbs) and seizures. R77 was breathing through a tracheostomy tube (an opening surgically created through the neck into the trachea/windpipe to allow air to fill the lungs) with supplemental oxygen. R77 received their nutrition via a PEG (Percutaneous Endoscopic Gastrostomy (PEG) is a tube surgically placed on the stomach to receive nutrition and hydration). R77 had a legal guardian. Review of R77's clinical record revealed an influenza consent dated 9/22/23 and they had received influenza vaccine. Further review of a clinical record revealed an immunization record revealed the following: Influenza vaccine administered on 9/22/22. Last pneumococcal vaccine - PCV23 administered on 11/7/22. Further review of the clinical record did not reveal that the facility had provided education on influenza vaccine and offered the influenza vaccine in 2023. Clinical records also did not reveal that R77/legal guardian was offered a dose of PCV15 or PCV20 as recommended by the Center for Disease Control and Prevention's (CDC) pneumococcal vaccine schedule for adults with immunocompromising conditions. R82 R82 was a long-term resident of the facility and originally admitted to the facility on [DATE]. R77's diagnoses included respiratory failure due to pneumonia, diabetes, quadriplegia (paralysis of all four limbs) and stroke. R82 was breathing through a tracheostomy tube (an opening surgically created through the neck into the trachea/windpipe to allow air to fill the lungs) with supplemental oxygen. R82 received their nutrition via PEG (Percutaneous Endoscopic Gastrostomy/PEG is a tube surgically placed in the stomach to receive nutrition and hydration). R82 had a legal guardian. Review of R82's clinical record reveled a pneumococcal vaccine consent signed by the guardian dated 12/16/21. Review of immunization records revealed that R82 that last pneumococcal vaccine-PCV23 administered on 3/1/22. Further review of clinical record did not reveal that R82/legal guardian was offered a dose of PCV15 or PCV20 as recommended by the CDC's pneumococcal vaccine schedule for adults with immunocompromising conditions. An interview with Director of Nursing (DON) was completed on 7/31/24, at approximately 1:40 PM. During the interview, the DON reviewed the clinical records for R77 and R82 and confirmed that R77 (influenza and pneumococcal) and R82 (pneumococcal) did not receive their vaccinations. When queried further they reported that both residents should have been offered/administered and they were not sure how it was missed. The DON reported that they would follow up with the facility's infection preventionist. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the document provided by the facility titled Influenza Vaccination with a revision date of 10/26/23 read in part, It is the policy of this facility to minimize the risk of acquiring, transmitting or experiencing complications from influenza by offering our residents, staff members, and volunteer workers annual immunization against influenza. Definitions: Medical Contraindication is a condition or risk that precludes the administration of a treatment or intervention because of the substantial probability to harm to the individual may occur. Policy Explanation and Compliance Guidelines: 1. It is the policy of this facility, in collaboration with the medical director, to have an immunization program against influenza disease in accordance with national standards of practice. 2. Influenza vaccinations will be routinely offered annually from October 1st through March 31st unless such immunization is medically contraindicated, the individual has already been immunized during this time period or refuses to receive the vaccine. If the influenza vaccine becomes available early and is released from the pharmacy, administration may take place prior to October 1st, in conjunction with CDC guidance. 3. Additionally, influenza vaccinations will be offered to residents upon availability of the seasonal vaccine until influenza is no longer circulating in the facility's geographic area. 4. Following assessment for potential medical contraindications, influenza vaccinations may be administered in accordance with physician-approved standing orders. 5. Prior to the administration of the influenza vaccine, the person receiving the immunization, or his/her legal representative, will be provided with a copy of CDC's current vaccine information statement relative to the influenza vaccination . Review of the facility provided document titled Pneumococcal Vaccine (Series) with a revision date of 10/30/23 read in part, It is our policy to offer our residents, staff, and volunteer workers immunization against pneumococcal disease in accordance with current CDC guidelines and recommendations. Policy Explanation and Compliance Guidelines: 1. Each resident will be assessed for pneumococcal immunization upon admission. Self-report of immunization shall be accepted. Any additional efforts to obtain information shall be documented, including efforts to determine date of immunization or type of vaccine received. 2. Each resident will be offered a pneumococcal immunization unless it is medically contraindicated or the resident has already been immunized. Following assessment for any medical contraindications, the immunization may be administered in accordance with physician-approved standing orders. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Prior to offering the pneumococcal immunization, each resident or the resident's representative will receive education regarding the benefits and potential side effects of the immunization. a. The individual receiving the immunization, or the resident representative, will be provided with a copy of CDC's current vaccine information statement relative to that vaccine. b. If necessary, the vaccine information statement will be supplemented with visual presentations or oral explanations to assist vaccine recipients in understanding. 4. The resident/representative retains the right to refuse the immunization. A consent form shall be signed prior to the administration of the vaccine and filed in the individual's medical record. 5. The type of pneumococcal vaccine (PCV15, PCV20, or PPSV23/PPSV) offered will depend upon the recipient's age and susceptibility to pneumonia, in accordance with current CDC guidelines and recommendations. 6. Usually only one (1) pneumococcal polysaccharide vaccination (PPSV) is needed in a lifetime. However, based on an assessment and practitioner recommendation, additional vaccines may be provided. 7. A pneumococcal vaccination is recommended for all adults [AGE] years' and older and based on the following recommendations: a. For adults [AGE] years' or older who have not previously received any pneumococcal vaccine: Give 1 dose of PCV15 or PCV20. i. If PCV15 is used, this should be followed by a dose of PPSV23 at least one year later. The minimum interval is 8 weeks and can be considered in adults with an immunocompromising condition, cochlear implant, or cerebrospinal fluid leak ii. If PCV20 is used, a dose of PPSV23 in NOT indicated .

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F 0917 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure each resident has 1) at least one window to the outside in a room; 2) a room at or above ground level; 3) adequate bedding; 4) furniture that meets the resident's needs; or 5) adequate closet space. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30675 Based on observation, interview, and record review, the facility failed to ensure functional furniture (bed with working remote) was provided for one (R16) of 14 residents reviewed for the environment task, resulting in the potential loss of independence, dignity, and well-being due to poor positioning during meals. Findings include: On 7/29/24 at 10:10 AM, R16 was observed laying flat in bed. When asked about whether they had any concerns, R16 reported their bed didn't go up and down due to a broken bed remote control and This is my 24 hour position now. R16 further reported because they weren't able to put the head of the bed up and down, they had to try to eat while laying down. On 7/29/24 at 1:45 PM, 7/30/24 at 8:25 AM, and 7/31/24 at 8:20 AM, R16 was observed attempting to eating breakfast while laying flat in bed. R16 was asked if anyone had followed up with them and they reported they were told a new bed controller had to be ordered. When asked if they were offered the use of another bed until that occurred, they reported No. Review of the clinical record revealed R16 was admitted into the facility on [DATE] with diagnoses that included: pressure ulcer of unspecified site, unspecified stage, adult failure to thrive, major depressive disorder single episode moderate, generalized anxiety disorder, and lymphedema. According to the Minimum Data Set (MDS) assessment dated [DATE], R16 had intact cognition. Review of the care plans included an Activities of Daily Living (ADL) care plan initiated 9/26/23, revised on 7/24/24 that read: [Name of R16] has an ADL self-care performance deficit related to Weakness, Failure to Thrive .likes to eat her meals in her room. Interventions included: EATING: Independent - offer assistance with meal setup as needed. On 7/30/24 at 2:45 PM, an observation of R16's bed was conducted with the Maintenance Director (Staff 'B') from a sister facility since the facility was currently without a Maintenance Director. When asked about the lack of bed remote for the resident to move the bed up and down, Staff 'B' reported a new remote was ordered on 7/26/24 but they were unsure when that would come in. When asked if there was any consideration to swap the bed for a functioning one since there were open rooms, Staff 'B' reported they didn't think so. (continued on next page)

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F 0917 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/31/24 at 12:00 PM, the Director of Nursing (DON) reported they didn't have any specific policy for position during meals, but the residents should be positioned in a manner in which they can eat comfortably. The DON was informed of the concerns with R16 throughout the survey and poor positioning due to the broken bed control and the discussion with the maintenance director on 7/30/24. The DON reported they would follow-up.

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 07/31/2024

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 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22960 Based on observation, interview, and record review, the facility failed to maintain an effective pest control program, resulting in the presence of gnats and flies (R26 and R102) throughout the facility and resident complaints. This deficient practice had the potential to affect all residents in the facility. Findings include: On 7/29/24 between 8:45 AM-9:15 AM, during an initial observation of the kitchen with District Manager E, numerous gnats were observed in the following kitchen locations: The trash can near the handwashing sink had no liner inside, and when the lid was opened, numerous gnats flew out from inside the trash can. In addition, there were gnats observed near the steam table, and there was a heavy concentration observed near the 3 compartment sink. Underneath the 3 compartment sink, there was standing water, and a swarm of gnats was observed on the floor tiles. In the chemical/mop room, there was a mop bucket with wet sludge on the inside bottom surface, and standing water on the floor. There were numerous gnats observed flying about in the chemical/mop room. On 7/29/24 at 9:20 AM, when queried about the gnats, District Manager E confirmed that the gnats have been a problem, and stated that a pest control company had been in the kitchen approximately 3 weeks ago. Review of a pest control service report dated 5/24/24 noted: Spoke with Maintenance .the only concerns he had to report was the gnat activity in the kitchen .Heavy Nat(sic) activity was found upon inspection of the kitchen .Gnat activity is due mostly to poor sanitation in the kitchen including stagnant standing water and food debris. Review of a pest control service report dated 7/9/24 noted: Monthly service completed. I spoke to Maintenance Manager .he advised of complaints of gnats from the kitchen staff. Review of the facility's policy Pest Control Program dated 01/01/2022 noted: It is the policy of this facility to maintain an effective pest control program that eradicates and contains common household pests and rodents. 47283 R26 (continued on next page)

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	07/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Southfield	26715 Greenfield Rd Southfield, MI 48076

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 7/29/24 at approximately 10:55 AM an observation was completed. R26 was observed in their bed and they were receiving nutrition through their PEG (Percutaneous Endoscopic Gastrostomy/PEG is a tube surgically placed on the stomach to receive nutrition and hydration) tube. Based on the Minimum Data Set (MDS) assessment dated [DATE], R26 was dependent on staff for their mobility in bed and had impaired range of motion on both upper extremities. R26 had two roommates. The surveyor observed 3 house flies in the R26's area of the room. One fly was sitting on their bedside and 2 flies were sitting on R26's gown on their upper chest area. When this surveyor queried R26, they reported that it had been ongoing and they were upset. They reported that they were not able to move their arms to swat the flies and added I wish they would get an exterminator. R102 On 7/29/24 at approximately 11:05 AM an observation was completed. R102 was in laying on their bed. R102 was a roommate to R26. Based on the Minimum Data Set (MDS) assessment dated [DATE] R102 had a Brief Interview for Mental Status (BIMS) score of 15/15, indicative of intact cognition. The surveyor queried R102 about the flies in the room. R102 stated, They are nerve wrecking. R102 added that it had been ongoing for while and they were not sure where they were coming from. When queried if the facility staff were aware, they reported staff were able to see them when they came into the room and were aware of the situation. The surveyor also observed house flies in the hallway between rooms [ROOM NUMBERS].