| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 235300 | A. Building<br>B. Wing | 10/17/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Medilodge of Taylor | 23600 Northline Rd<br>Taylor, MI 48180 |

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| F 0561<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34901<br><br>Based on observation, interview, and record review the facility failed to ensure one resident (R76) was updated in a timely manner regarding preference to move to another home, resulting in resident experiencing frustration.<br><br>Findings include:<br><br>On 10/15/24 at 12:12 PM, R76 was observed awake and lying in his bed. When queried about his stay in the facility, R76 said he wanted to speak to the social worker. R76 stated, I want to move to (Facility XX). I haven't spoken with anyone about this in two months.<br><br>A review of the clinical record for R76 revealed an admission into the facility on [DATE] with diagnoses of metabolic encephalopathy, chronic obstructive pulmonary disease, and type 2 diabetes mellitus. R76 was his own responsible party. A Minimum Data Set assessment dated [DATE] documented intact cognition.<br><br>A Social Service progress note dated 8/22/24 documented the following: MSW (Masters of Social Work) notified by SS asst. (Social Service Assistant) that patient is wanting referral sent to (Facility XX). Referral was sent, as requested, to admissions dept and writer additionally notified RDO (Regional Director of Operations). Writer requested for team to be updated when/if they are able to accept to confirm again with patient at that time on wishes to transfer.<br><br>(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 0561<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 10/16/24 at 2:14 PM, MSW B said when a resident expresses a desire to move to another facility, we first determine if they are their own responsible party and then ask where they want to move to. Once the appropriate documents have been sent to the admission department of the desired location, we give them time to review it clinically. We then reach out to obtain an update regarding the resident's move request. MSW B stated, I usually wait two days to reach out and will go back to the resident regarding what happened when we reached out. MSW B added that they try for week to get information and will let the resident know if they are not getting a response. When queried about R76's request to move, MSW B acknowledged that R76 wanted to move to (Facility XX). MSW B said because the admission person for (Facility XX) was on vacation during the time the request was made, that the Admission Director and RDO were also notified. MSW B said she waited for them to respond. MSW B could not recall if she got back with the resident and was unable to provide documentation that R76 had been updated. MSW B stated, I should have followed up with them (Facility XX) and got back with the resident. I needed to see the referral through, provide and update to the resident, and (determined) if there was another facility choice.<br><br>On 10/17/24 at 12:29 PM, Assistant Director of Nursing (ADON) A said when the social worker did not hear back from the facility, she should have called to see if they received the referral and notified the resident of that status.<br><br>On 10/18/24 at 4:40 PM during the exit conference, the Nursing Home Administrator and Director of Nursing were asked if there was any additional documentation or information that the facility would like to provide prior to the end of the survey, and they reported there was not. |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide care and assistance to perform activities of daily living for any resident who is unable.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38230<br><br>Based on observation, interview, and record review the facility failed to provide adequate nail care, facial hair grooming, and hair washing for two (R18 and R118) of seven residents reviewed for activities of daily living for dependent residents resulting in unmet hygiene needs, loss of dignity, and emotional distress.<br><br>Findings include:<br><br>R18:<br><br>On 10/15/24 at 11:25 a.m. R18 was observed in bed watching television. R18 was also observed with matted braided hair that was greasy and full of dandruff. R18 facial hair was overgrown and unkept. R18 had impaired speech, however when asked the last time his facial hair was trimmed and hair was washed, the resident replied, good question (indicating it has not been done). R18 became tearful when asked if the staff offered to wash hair and trim facial hair. R18 responded, No! No! No! R18 was asked do you want your hair washed and facial hair trimmed. Tearfully R18 said, Yes! Yes! Yes! Please, please, please.<br><br>On 10/15/24 at 11:59 a.m. CNA O was interviewed and confirmed regularly being the resident's nurse aid. CNA O said R18 often refuses care, and it has been documented.<br><br>On 10/15/24 at 12:01 p.m. LPN I was interviewed and said R18 will cooperate with care with regularly scheduled staff. The resident will refuse care with newer staff. When the resident (all residents) refuse care, the aides are to report the refusal to the nurse or unit manager.<br><br>On 10/15/24 at 12:25 p.m. Director of Nursing (DON) A and Unit Manager (UM) N were in R18's room and said the resident received a shower yesterday. They were asked is shaving and hair washing included if needed on shower days. DON A said shaving and hair washing should be done on shower days. DON A did not know why the care have not been rendered. UM N said R18 refuses but was uncertain if he refused getting shaved or hair washed. DON A and UM N agreed the resident's hair needed to washed and facial hair trimmed.<br><br>On 10/16/24 at 1:11 p.m. review of the clinical record documented R18 was admitted into the facility on [DATE] with diagnoses that included diabetes mellitus with neuropathy, dementia, encephalopathy, and traumatic brain injury. According to the quarterly minimum data set assessment (MDS) dated [DATE], R18 had moderate impaired cognition and dependent on staff for grooming and bathing.<br><br>Review of the Activities of Daily Living care plan dated 9/22/23 documented: Resident has an ADL self-care performance deficit related to dementia and traumatic brain injury. Interventions: Bathing: 2-person assistance, prefers a shower over a bed bath; Personal Hygiene: 2-person assistance. Honor resident's choices and preferences whenever possible.<br><br>Review of the task list revealed no refusals were documented for R18.<br><br>(continued on next page) |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of the facility's policy titled Activities of Daily Living (ADLs) dated 12/28/23 documented: The facility takes measures to minimize the loss of resident's functional abilities, including activities of daily living (ADLs). Activities of Daily Living include the ability to: 1. Bathe, dress, and groom . 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 .<br><br>41423<br><br>R81<br><br>On 10/15/24 at 09:46 AM, Resident 81 was observed open in bed with their eyes opened. R81 had an unkept appearance and their hair was disheveled with a greasy appearance. R81's hair had thick dandruff and was matted at the top of their head.<br><br>On 10/15/24 at 01:18 PM and on 10/16/24 at 09:17 AM, R81 was observed in bed on their back. R81 had an unkept appearance and their hair was disheveled with a greasy appearance. R81's hair had thick dandruff and was matted at the top of their head. The Resident's hands and legs were visible. The Resident's fingers on their left hand were curled towards palm. Their right leg was tucked underneath their left leg. R81's left leg appeared contracted.<br><br>On 10/16/24 at 01:05 PM, R81 was observed in bed, positioned on their back with their eyes closed. R81 continued to have an unkept appearance and their hair was disheveled with an oily appearance. R81's hair had thick dandruff and was matted at the top of their head.<br><br>On 10/17/24 at 09:01 AM, Certified Nurse Aide (CNA) M was interviewed and asked if they provided care to R81. CNA M said that they were not familiar with R81. CNA M was asked about the facility's policy if a resident refused care. CNA M said, If a resident refused a bath or shower I tell a nurse.<br><br>A review of R81's electronic medical records indicated an initial admission was on 09/01/2020 and most resent admission on 05/30/2024 with diagnoses of Cerebral Infarct (lack of adequate blood supply to brain), Toxic Encephalopathy, Dysphagia, Type II Diabetes, Hypertension, and Seizures. A review of the R81's Minimum Data Set (MDS) dated [DATE] indicated a score of 15 (resident's cognition was intact). R81 was dependent with all Activities of Daily Living (ADLs).<br><br>A review of R81's care plan noted the following, Resident has an ADL self care performance deficit related to [Stroke], Muscle Weakness . Date initiated 08/22/2023, Revision on 10/16/2024 .Encourage participant in daily care and provide positive reinforcement for activities attempted and/or partially achieved .Dated 8/23/2023 .Observed for pain during ADL tasks and report to Nurse if observed. Dated 8/23/2024 .Oral mouth swab [R81] q 4 hours [every four hours] .Dated 06/06/2024 .Actively involve the resident/family in the resident's plan of care .Dated 09/01/2023.<br><br>A review of R81's electronic medical records progress notes resident's refusal to bathe on 7/31/2024. No other resident refusal and/or notification of legal guardian from 06/01/2024-10/11/2024.<br><br>On 10/17/24 at 10:25 AM, the Director of Nursing (DON) was asked about her expectations for bathing and the DON stated that R81 always refused bathing. |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe and appropriate respiratory care for a resident when needed.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41423<br><br>Based on observation, interview and record review, the facility failed to ensure continuous tracheostomy humidification for one (R125) of three residents reviewed for respiratory therapy, resulting in the potential for thickened secretions, dehydration of airway secretions, and the potential for lung infection.<br><br>Findings include:<br><br>On 10/16/24 at 08:39 AM, R125 was observed in bed on their back, with eyes opened. R125 was lying on their back with their left arm pulled up to their chest and right hand culled tight towards their palm. The humidifier canister that holds water for humidification was completely empty (without water to generate humidification).<br><br>On 10/17/24 at 08:40 AM, R125 was observed in bed on their back, with eyes closed. R125 was lying on their back with their left arm pulled up to their chest and right hand culled tight towards their palm. The humidifier canister that holds water for humidification was completely empty (without water to generate humidification).<br><br>On 10/17/24 at 10:15 AM, R125 was observed in bed on their back, with eyes closed. R125 was lying on their back with their left arm pulled up to their chest and right hand culled tight towards their palm. The humidifier canister that holds water for humidification was completely empty (without water to generate humidification).<br><br>A review of R125's electronic medical record revealed an admission to the facility on [DATE] with diagnoses which included a Traumatic Subdural Hemorrhage (07/03/2024 secondary to a motor vehicle accident), Traumatic Brain Injury, Lung Injury, Fracture of Lumbar Vertebra, and Fracture of Right Eye.<br><br>Review of the Minimum Data Set (MDS) assessment revealed R125 was severely cognitively impaired and dependent with all Activities of Daily Living (ADLs). A review of R125's care plan noted: Resident has an impaired pulmonary/respiratory status related to tracheostomy date Initiated 09/17/2024.<br><br>On 10/17/24 at 10:39 Director of Nursing (DON) was interviewed and asked if water was needed for tracheostomy treatment of R125. The DON stated, It should not be empty .it should always have water.<br><br>A review of the facility's policy Tracheostomy Care reviewed/revised 10/26/23, noted the following: The facility will ensure that residents who need respiratory care, including tracheostomy care and tracheal suctioning, is provided such care consistent with professional standards of practice, the comprehensive person care plan and resident goals and preferences. |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>34901<br><br>Based on observation, interview, and record review, the facility failed to properly date-label food in the kitchen and ensure the drain from the coffee machine was properly air gapped.<br><br>Findings include:<br><br>On 10/15/24 at 8:50 AM, during the initial tour of the kitchen with Dietary Manager (DM) D and Registered Dietitian (RD) C the following was observed:<br><br>Three loaves of white bread, two loaves of wheat bread, and one bag of white hotdog buns were opened and undated on the bread rack. RD C stated food items should specify delivery, opened, and discard dates.<br><br>Inside the reach in cooler, an opened five-pound bag of shredded cheese was dated 10/8/24. DM D and RD C were unable to identify if the date signified the delivery, opened, or discard date. Additionally, an opened five-pound tub of sour cream did not specify an expiration date.<br><br>The drain line from the coffee machine did not have the required minimum one-inch air gap (an unobstructed vertical space between the end of the drain line and the flood rim of the floor drain).<br><br>On 10/17/24 at 12:40 PM, the Nursing Home Administrator (NHA) said the items in the kitchen should be labeled when received, opened, and use-by. Kitchen staff should have notified maintenance to adjust the coffee machine drainpipe.<br><br>On 10/18/24 at 4:40 PM during the exit conference, the NHA and Director of Nursing were asked if there was any additional documentation or information that the facility would like to provide prior to the end of the survey and they reported there was not.<br><br>According to the following sections of the 2013 FDA Food Code:<br><br>3-101.11, entitled, Safe, Unadulterated, and Honestly Presented, was reviewed and revealed, Food shall be safe, unadulterated, and, as specified under S 3-601.12, honestly presented.<br><br>5-202.13: An air gap between the water supply inlet and the flood level rim of the plumbing fixture, equipment, or nonfood equipment shall be at least twice the diameter of the water supply inlet and may not be less than 1 inch. |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38208<br><br>This citation pertains to intake MI00146662.<br><br>Based on interview and record review the facility failed to maintain complete and accurate medical records for one resident (R130) out of three residents reviewed for wound care.<br><br>Findings Include:<br><br>Record review of R130's electronic medical record (EMR) revealed admission into the facility on [DATE] with a pertinent diagnosis of acquired absence of left leg below knee. According to the Minimum Data Set (MDS) dated [DATE], R130 had intact cognition and required assistance with Activities of Daily Living (ADLs).<br><br>Record review of Physician Orders documented, LBKA (left below the knee amputation) cleanse with wound cleanser pat dry and apply dry dressing every day for surgical incision. Start Date-02/15/2024 0700.<br><br>Record review of Treatment Administration Record (TAR) revealed that a dressing was applied on 2/15/24. On 2/16/24, Licensed Practical Nurse (LPN) L documented that R130 refused to have dressing changed. On 2/17/24 LPN I documented that dressing change was administered. On 2/18/24, LPN J documented that dressing change was administered. On 2/19/24, LPN K, documented that dressing change was administered.<br><br>Record review of Performance Improvement Form dated 2/20/24, documented LPN I, was given a verbal counseling and it further documented the following: On 2/17/24 you signed out that you provided wound care to R130, but today it was noted the daily dressing was last changed on 2/15/24. Documentation was not completed appropriately.<br><br>Interview on 10/18/24 at 1:30 PM, LPN I, reported signing out the treatment was completed on TAR, but did not administer the treatment.<br><br>Record review of Performance Improvement Form dated 2/20/24, documented that LPN J, was given a verbal counseling and it further documented the following: On 2/18/24 you signed out that you provided wound care to R130, but today it was noted the daily dressing was last changed on 2/15/24. Documentation was not completed appropriately.<br><br>Record review of Performance Improvement Form dated 2/20/24, documented that LPN K, was given a verbal counseling and it further documented the following: On 2/19/24 you signed out that you provided wound care to R130, but today it was noted the daily dressing was last changed on 2/15/24. Documentation was not completed appropriately.<br><br>Interview on 10/17/24 at 2:00 PM, LPN K, reported signing out the treatment was completed on TAR, but did not administer the treatment.<br><br>(continued on next page) |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | An interview on 10/18/24 at 2:30 PM with Director of Nursing (DON), reported being made aware after a State Agency investigator on 2/20/24 had observed R130's treatment to LBKA had not been administered since 2/15/24. DON further reported that nursing should not document a treatment was completed if it had not been administered, It is a standard of practice. |