STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235336	A. Building B. Wing	06/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Traverse City	2585 S Lafranier Rd Traverse City, MI 49686

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40330 This citation relates to Intake #MI00145188. Based on observation, interview, and record review, the facility failed to ensure dignified care was provided for one Resident (R1) of seven residents reviewed for dignity. This deficient practice resulted in an undignified care interaction for R1. Findings include: Review of the FRI (Facility Reported Incident) received by the State Agency (S.A.) revealed on 6/11/24 at approximately 8:30 p.m., R1 was observed by Registered Nurse (RN) B in the doorway assisting a resident to return to the secured memory care unit. At that time, R1 was attempting to exit the unit through the same door. Another nurse, RN A, told R1 she needed to stay on the unit and she had her hands over her ears. RN B reportedly observed RN A use a door-knocking gesture on R1's forearm to get her attention so she would not leave the unit. R1 did not sustain an injury per the skin assessment after the incident. The report showed an interview after the incident with RN A revealed they moved their hand towards R1's face and made a non-verbal gesture to reduce the volume of her voice, and in doing so, made light contact with R1's right arm with their left hand, which was reportedly non-intentional. No psychosocial decline was found when R1 was interviewed after the incident. The investigation further revealed when R1's family member was interviewed, they revealed R1 had a prior undisclosed history of trauma, which may have contributed to R1's reaction to RN A while she was trying to exit the secured memory unit door. Review of the Minimum Data Set (MDS) assessment revealed R1 was admitted to the facility on [DATE], with diagnoses including kidney disease, urinary tract infection, and dementia. The assessment revealed R1 required maximal assistance with toileting and toileting transfers. The Brief Interview for Mental Status (BIMS) assessment revealed a score of 3/15, which showed R1 had severe cognitive impairment. An interview on 6/25/24 at 2:45 p.m. revealed R1 could answer a few basic yes/no questions. R1 reported she was happy and receiving good care and had no recall of any resident or staff incident. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/25/24 at 4:15 p.m., RN A and RN C were asked about the incident on 6/11/24. RN C confirmed no abuse was substantiated, and RN A described the incident occurred on 6/11/24 at the doorway to the memory unit. RN A explained when the unit door was opened by RN B, R1 attempted to leave the unit unsupervised at the unit doors, while RN B opened the door for another resident to reenter the unit. RN A revealed they stood in front of the secured memory unit door to block R1 from leaving the unit, as she was unsafe to leave the unit unsupervised. R1 clarified the incident occurred around 8:30 p.m. RN A described R1 began yelling at the top of her lungs and in an attempt to try to quiet her I put my hand up towards her mouth .that was a dumb move on my part .I put my hand up to her mouth about 3 inches away. RN A demonstrated to Surveyor while R1 was flapping her arms back and forth with elbows bent they made a shhhhhh sign, with one finger pointed up and moved towards R1's mouth. In doing so, RN A described how his arm accidentally struck the inside of R1's forearm, but there was no intent to do so. RN C was asked if there was a video of the incident, which RN C denied, and clarified they understood R1 struck RN A's arm as her arms were flapping and moving when RN A made the gesture towards R1. RN A reported it was a gesture meant to quiet and calm the resident. When asked if they could have done anything differently, RN A' reported he was acting more like a parent with a child than a resident. RN A clarified if this occurred again they would have just allowed the yelling, however they were concerned about R1 waking up the residents on the unit who were sleeping. During further interview, both RN A and RN C agreed the behavioral interaction and RN A's response was undignified. During an interview with the Nursing Home Administrator (NHA) on 6/25/24 at approximately 5:00 p.m., the NHA was made aware and understood concerns related to the undignified care interaction. A telephone call was attempted to R1's responsible party on 6/26/24 at 9:56 a.m., with no response by the end of the survey time period. Review of RN B's witness statement, dated 6/11/24, revealed RN B described R1 was trying to exit the secured memory unit when they were at the door and R1 let out a loud scream, which was startling. RN B described RN A's reaction was to let out a frustrated noise, and R1 placed her hands over both sides of her ears due to the noise. RN B reported they next observed RN A knock twice on R1's forearm approximately two inches from her wrist, telling her to be quiet. RN B clarified it was not a punch or a slap, and not a hard strike. RN B explained RN A initially put his hands toward the resident to place his hand towards her mouth to shush R1, but R1 did not stop yelling. RN B reported they completed a skin assessment and there were no new skin concerns noted. RN B deemed RN A was trying to tell R1 to be quiet. During an interview on 6/26/24 at approximately 6:00 p.m., RN B confirmed their description in their witness statement was how the incident occurred. Review of the policy, Promoting/Maintaining Resident Dignity, revised 10/26/23, revealed, It is the practice of the facility to protect and promote resident rights and treat each resident with respect and dignity as well as care for each resident in a manner and in an environment that maintains or enhances resident's quality of life by recognizing each resident's individuality . During the onsite survey, past noncompliance was cited after the facility implemented actions to correct the noncompliance which included: (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A police report was filed, Social Services provided R1 supportive visits, A PTSD diagnosis was added to R1's care plan, The facility initiated an action plan and an had an ad hoc QAPI meeting, Residents on R1's hall including R1 had skin and pain assessments completed (with no concerns found), An all staff education regarding abuse prevention, dementia care, dignified care, behavioral management, and signs of (employee) burnout was completed. Residents were interviewed regarding the potential for abuse; none was found. One to one education was provided by the NHA to RN A, who completed the education on abuse prevention, dementia care, dignified care, behavioral management, and signs of employee burnout as well as additional education on Relias educational training. R1 was referred to a behavioral care provider to evaluate and treat newly diagnosed history of trauma and identify triggers. R1's Care Plan was updated and revised to reflect history of behaviors (which was verified). The facility demonstrated corrective monitoring by completing observations of RN A providing resident care, with no concerns found. The investigation revealed no willfulness was determined or intent to make physical contact of R1 by RN A. The facility determined no functional decline or psychosocial outcome for R1, and no new bruising or skin concerns. The facility was able to demonstrate monitoring of the corrective action and maintained compliance by completing weekly audits of abuse including observations of RN A providing care. The QAPI meeting was initiated to ensure concerns were addressed and sustained compliance with their Plan of Correction.