

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235371	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/02/2024
NAME OF PROVIDER OR SUPPLIER Medilodge of Yale		STREET ADDRESS, CITY, STATE, ZIP CODE 90 Jean St Yale, MI 48097	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44750</p> <p>This citation pertains to intake MI00143016 and MI00143086.</p> <p>Based on interview and record review, the facility failed to promptly identify and intervene for an acute change in condition for one resident (R700) out of one reviewed for change in condition, resulting in R700 experiencing pain and hospitalization . Findings Include:</p> <p>On [DATE] at 1:38 PM, an interview was conducted with Caregiver (CG) D. CG D stated that they were with R700 the entire night. CG D stated that R700 had been complaining of pain since 10:00PM. R700 stated that they had to keep going in the hallway to find someone. CG D stated that they R700 had emesis (vomiting) and was moving around because they could not find a comfortable position. CG D stated that they asked R700 what their pain level was and that they told them that it was an ,d+[DATE], sometimes a ,d+[DATE] depending on their position. CG D stated that the nurse said they had to call the on-call physician for orders but gave them a Tylenol around 5:00 AM in the meantime. CG D stated that R700 kept asking to go to the hospital. CG D stated that the nurse came in and stated the physician stated R700 could go to the hospital or have a stat (immediate) abdominal x-ray and R700 stated they wanted to go to the hospital. CG D stated they called R700's spouse around 5:30 AM, to let them know that R700 was going to the hospital. CG D stated shortly after the nurse came back in and stated they were putting the transfer on hold because the Director of Nursing (DON) wanted to come in and assess R700 first. CG D stated the next shift nurse came in and saw the emesis and how much pain R700 was in and called 911. CG D stated that the DON did not come into the facility until around 8:00 AM right before the ambulance came. CG D stated that R700 died while in the emergency room . CG D stated that they wish they knew they could call 911 themselves because they would have called.</p> <p>A review of the medical record revealed that R700 admitted into the facility on [DATE] with the following medical diagnoses, Congestive Heart Failure and Gastro-Esophageal Reflux Disease. A review of the Minimum Data Set assessment revealed a Brief Interview for Mental Status assessment score of ,d+[DATE] indicating an intact cognition. R700 also required assistance with bed mobility and transfers.</p> <p>Further review of the progress notes revealed the following,</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Date: [DATE] at 5:30 AM .On call physician notified of resident's c/o (compliant of) discomfort, PRN (as needed) Tylenol given and not effective at this time. Resident was given option of a stat x-ray or to be sent to the hospital per on call [Physician Group]. Resident chose to be sent to the hospital. Paperwork for transfer was printed and signed. DON notified of transfer and ordered floor staff to hold off sending to ER and inform resident [DON] would be in shortly to evaluate and talk to [R700]. Staff informed resident DON would be arriving to discuss situation between 8:00 AM -8:30 AM, resident was emotional .</p> <p>Date:[DATE] at 7:30 AM .Resident's vital signs abnormal when checked in AM. This could be due to resident having an episode of emesis and possible dehydration due to that, as well as anxiety that resident stated [they] have.</p> <p>Date: [DATE] at 7:35 AM .Spoke to DON regarding residents and care givers concerns, complaints of ABD (Abdominal) pain r/t (related to) HX (History) of hernia. ABD 2 view x-ray was ordered and increased v/s (vital sign) monitoring to every 4 hours.</p> <p>Date:[DATE] at 4:23 PM .Spouse and caregiver arrived in facility to pickup resident's belongings. Resident passed (expired) upon arriving to (name of local hospital) this morning. Spouse stated unsure of what occurred, and autopsy has been ordered .</p> <p>Further review of R700's last recorded vital signs at 5:32 AM on [DATE] noted the following, Blood Pressure-, d+[DATE], Respirations-30, and Oxygen level-88% on room air.</p> <p>A review of the Medication Administration Record (MAR) revealed that R700 received 4 MG (Milligrams) of Zofran (Antiemetic) at 11:51 PM and 650 MG of Tylenol at 4:53 AM.</p> <p>On [DATE] at 10:54 AM, an interview was conducted with Certified Nursing Assistant (CNA) B. CNA B stated that they saw R700 the day they went to the hospital. CNA B stated that R700 was complaining about being in a lot of pain and they were given report at 6:00 AM that R700 was going to the hospital. CNA B stated that R700 ended up going to the hospital around 8:30AM-9:00AM.</p> <p>On [DATE] at 11:13 AM, an interview was conducted with Registered Nurse (RN) A. RN A stated that they never assessed the resident themselves. RN A stated that they just ordered an Abdominal x-ray and put the order in for increased vital signs.</p> <p>On [DATE] at 11:20 AM, an interview was conducted with RN C. RN C stated that they came in a little after 6:00 AM and was told by the two-night shift nurses that they obtained an order from the physician and R700 was going to the hospital but was later informed that they were told to hold the transfer by the DON. RN C stated they did not actually see R700 until around 7:40 AM and noted that R700 was anxious and kept saying they wanted to go to the hospital and wondering why they were not sending them out. RN C stated that they called 911 immediately and sent them out to the hospital.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On [DATE] at 12:19 PM, an interview was conducted with the DON. The DON stated they were called by staff and informed them they were sending R700 to the hospital. The DON stated they chose to put the transfer on hold until they assessed based on the facilities return to hospital protocols. The DON stated they did not call the on-call physician and let them know they were not sending R700 to the hospital. The DON was queried as to why the abdominal x-ray was not entered until 7:35 AM, if R700 was not going to the hospital. The DON stated they did not know. The DON was queried about if they saw R700's last recorded vital signs. The DON stated they were not told R700's vital signs over the phone during the initial call from staff. The DON stated R700 was sent out due to family insistence, however when they assessed them, they did not appear to be in any distress. The DON stated that they were not sure what caused R700's death.</p> <p>A review of a facility policy titled, Transfer and Discharge (including AMA) noted the following, . 9. Anticipated Transfers or Discharges - initiated by the resident. a. Obtain physicians' orders for transfer or discharge and instructions or precautions for ongoing care.</p>		