STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235371	A. Building B. Wing	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Yale	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)
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** 46956 Based on observation, interview, and record review, the facility failed to honor resident's preference for incontinence products for one (R42) of five residents reviewed for resident rights. Findings include: Review of the facility record for R42 revealed an original admitted [DATE] and a most recent admitted [DATE] with diagnoses that included Cerebral Infarction with Left Hemiplegia, Congestive Heart Failure and Depression. The Brief Interview for Mental Status (BIMS) assessment dated [DATE] and scored 15/15 indicated no cognitive impairment. On 05/21/24 at 9:43 AM, R42 reported the facility would not allow them to use incontinence (blue) pads on the bed. R42 stated they preferred to use incontinence pads because of their severity of bladder incontinence and they purchased two of their own pads to use in addition to the facility-provided pads. R42 indicated late last year the facility staff took the pads away and will not allow the resident to use them saying, [the facility Administrator (NHA)] just told me that if they let me use them they have to let everyone use them. When asked if the facility offered them a choice to keep the pads or an alternative option to replace the pads R42 stated No, they just took them. Review of a facility Quality Assurance (Grievance/Concern) Form dated 12/12/23 revealed R42's concern description stating Resident purchased [their] own blue pads and they were removed with the rest (of the blue pads) in building. [They] state [they] need them. The Findings section of the form states Daughter ok with us keeping, doesn't want them. Further review of R42's facility record revealed the resident's daughter who signed the grievance form is not the resident's guardian and the resident is their own responsible party. On 05/23/24 at 12:14 PM, the facility Director of Nursing (DON) reported that R42's incontinence pads were removed because the facility's corporate ownership discontinued their use in their facilities due to evidence of increased skin breakdown and maceration (softening and breaking down of skin) related to their use. On 05/23/24 at 12:38 PM, the NHA reported the corporation did discontinue use of the incontinence pads. The NHA was asked to provide a policy or any documentation of the directive to institute the policy. The NHA reported they were not aware of any such documentation but they would investigate further. (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

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 05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Yale	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)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/23/24 at 12:50 PM, the NHA indicated their was no documentation of the directive to discontinue use of the incontinence pads and said It's a standard of practice and indicated the resident would wear an incontinence brief and be changed rather than using a pad. The NHA further stated [R42's] daughter works here (at the facility) and she signed off on it. Review of the facility policy Resident Rights dated 10/30/23 includes the Policy statement The facility will inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility will also provide the resident with prompt notice of changes in any State or Federal laws relating to resident rights or facility rules during the resident's stay in the facility. Receipt of any such information must be acknowledged in writing.

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 05/23/2024
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)
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** 49102 Based on observation, interview and record review, the facility failed to implement fall interventions per the plan of care for one resident (R38) out of six residents reviewed for care plan interventions. Findings include: On 05/21/24 at 2:30 PM, R38 was observed asleep lying in bed. There was no mat was on the floor by the bed. On 05/22/24 at 9:13 AM, R38 was observed lying in bed asleep. There was no mat on the floor by the bed. On 05/22/24 at 10:15 AM, R38 was observed lying in bed. There was no mat observed on the floor by the bed. A review of R38's medical record revealed that they were admitted into the facility on [DATE] with diagnoses of Huntington's Disease, Schizoaffective Disorder, Dementia, and Hypertension. A review of R38's Minimum Data Set (MDS) assessment dated [DATE] revealed, R38's Brief Interview for Mental Status assessment score was a 10 indicating moderate impaired cognition. Further review of R38's medical record revealed the following care plan: Focus: resident is at risk for falls / injury related to generalized weakness, needs assistance with Activities of Daily Living, opoid medication use, and psychoactive medication use. Interventions listed include mat to floor next to bed left side initiated 2/5/24. On 5/23/24 at 10:30 AM, the Director of Nursing (DON) was asked about the expectations for following the plan of care for resident at risk for falls. The DON stated, I expect the interventions to be used as needed for the necessary condition or reason needed for the resident. A review of the facility's policy titled Comprehensive Care Plan implemented 1/1/21 and revised 6/30/22 revealed the following, It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment.

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 05/23/2024
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)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40384 Based on observation, interview, and record review, the facility failed to document and monitor a change in condition timely, and follow the care plan for one resident (R50) of one resident reviewed for change of condition. Findings include: On 5/21/24 at 10:05 AM, R50 was observed lying in bed pleasantly confused and unable to be interviewed due to their cognition. A review of R50's medical record revealed they were admitted into the facility on [DATE] with diagnoses of Unspecified Dementia, Type II Diabetes, and Hypertension. Further review of the medical record revealed that the resident was significantly cognitively impaired, and required extensive assistance with Activities of Daily Living. Further review of the medical record revealed the following care plan: Focus: Resident has episodes of bladder/bowel incontinence related to dementia, depression, diabetes. Date Initiated: 09/20/2023 .Interventions: .Observe for signs/symptoms of UTI (urinary tract infection) and report to Physician/PA (physician assistant)/NP(nurse practitioner) pain, burning, blood-tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temp, urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, change in eating patterns.) Date Initiated: 09/20/2023 . Further review of the medical record revealed the following progress notes: 5/14/2024 12:01 (12:01pm) Nurses Note Text: Resident refusing to get out of bed today. Hospice aide reports cloudy/mucous in urine. 5/17/2024 18:28 (6:28pm) Nurses Note Text: Hospice called nurse this shift and ordered a UA C&S (urinalysis and culture and sensitivity). Hospice aid in earlier this shift and reported to hospice nurse that resident was more combative than usual, and urine was darker than normal. Order placed in computer. 5/20/2024 08:05 (8:05am) Nurses Note Text: Resident straight cathed (catheterized- a drain to remove urine from the bladder) for UA, immediate return of tan, foul smelling urine. A review of the physician orders noted the order for the UA was created on 5/17/24, but was not started until 5/19/24. It was further noted the UA was not collected until 5/20/24. On 5/22/24 at 1:04 PM, after a request, the Director of Nursing (DON) provided lab results for R50, and indicated the resident's urinalysis was collected and sent to the lab on 5/20/24, with results being received via fax on 5/22/24. A review of R50's urinalysis results dated 5/20/24 revealed that there were eight tests completed on R50's urine sample indicating abnormal results, per a legend noted at the bottom of the document. (continued on next page)

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 05/23/2024
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)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/22/24 at 2:09 PM, the DON was asked about the delay in R50 obtaining a UA, and the progress note indicating that on 5/14/24 the resident had cloudy/mucus in their urine. The DON explained that the resident's urine was not an indication of an infection, and her expectation of the facility staff would have been to monitor and push fluids. She further explained the resident's hospice nurse visited the resident on 5/16/24 and did not note any concerns with the resident. Regarding the timeliness of the lab and collections of results, she explained the order from the hospice company was received on a Friday, 5/17/24 after 6pm and the lab was not drawn until after the weekend, as the facility has access to the lab Monday through Friday. A review of R50's hospice progress note authored by the hospice nurse, and dated for 5/16/24 noted the following, .R50 is sitting up in the high fowler's position (laying on back with head of bed between 60-90 degrees), alert to self more withdrawn today. Does not want to converse with this writer which is new .Pt (patient) is having hallucinations . On 5/22/24 at 2:25 PM, the DON further explained the resident has a history of kidney stones, and a history of UTIs and the last time the resident was treated, they had to have 4-5 IVs (intravenous) placed because they kept ripping them out. On 5/23/24 at 10:29 AM, the DON and Corporate Employee A asked to speak to the surveyor and explained the resident's symptoms did not meet McGreer's criteria (criteria used to determine infections), and the symptoms the resident was displayed could have been from multiple things because the resident is incontinent and may have been an issue related to hydration as this has been an ongoing issue for the resident. The DON explained that she spoke to the nurse on R50's unit who hadn't noted any concerns related to the resident, and also questioned hospice management why an order for a UA was ordered when the resident did not display pain or suprapubic pain. On 5/23/24 at 11:00 AM, the Nursing Home Administrator (NHA) was asked about her expectations for nurses to monitor and assess changes in condition, and she explained it is her expectation that nurses are monitoring for changes of conditions. A review of the facility's Notification of Changes policy did not address monitoring a resident following a potential change in condition. A review of the facility's Comprehensive Care Plan policy did not address implementing care planned interventions.