STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235416	A. Building B. Wing	08/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Sterling	500 School Rd Sterling, MI 48659

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 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37668 This Citation Pertains to Intake Numbers MI00141220 and MI00141312. Based on interview and record review, the facility failed to honor a resident's right to return to the facility following the hospitalization of one resident (Resident #702) of three residents reviewed for transfer and discharge, resulting in Resident #702 being transferred to the hospital for evaluation and treatment related to mental health, and not being allowed to return to the facility without an alternative placement arrangement, necessitating them to stay in the Emergency Department for six days. Findings include: Resident #702: Review of intake documentation revealed concerns that Resident #702 was taken to the hospital Emergency Department (ED) on [DATE] for a mental health evaluation due to aggressive behaviors. Per the intake, Resident #702 was not allowed to return to the facility after having been evaluated at the hospital and determined not to require inpatient mental health treatment. Per information included on the intake documentation, Resident #702 was collaboratively managed by the area Community Mental Health while at the facility and had been taken to five different Emergency departments since [DATE] for mental health evaluations due to behaviors and hospitalized on ce. Record review revealed Resident #702 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included schizoaffective disorder, bipolar disorder, anemia, conversion disorder with seizures (mental health condition that causes real, uncontrollable physical symptoms), Traumatic Brain Injury (TBI), and depression. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the Resident was cognitively intact and required limited-to-extensive assistance with dressing, personal hygiene, and toileting. The MDS further detailed the Resident displayed verbal behaviors directed toward others ,d+[DATE] days with no other behavioral symptoms. Resident #702 was discharged to the ED on [DATE] and did not return to the facility. Review of Resident #702's Electronic Medical Record (EMR) revealed the following documentation related to their final discharge from the facility: (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- [DATE] at 1:25 PM: SBAR Communication Form and progress note . The change in condition, symptoms, or signs I am calling about is/are: Resident has physical aggression toward staff x 4 staff. Resident also has a hx (history) of physical aggression toward residents x 2. This started on: [DATE]. Since this started has it gotten: Worse . Things that make the condition or symptom worse are: Triggers unknown, severe issues with impulse control . Things that make the condition or symptom better are: N/A . Treatment for last episode (if applicable): Resident has been sent to ER as well as in patient in [NAME] . Primary Diagnoses: Schizoaffective disorder, bipolar . pertinent history: Depression, Bipolar disorder . Mental Status Changes . New or worsening behavioral symptoms . Resident being physically aggressive toward staff and residents . Nursing Notes: On [DATE] resident was observed attempting to go into another residents room, when 2 staff members had to redirect him back to his room. On [DATE] the NHA and DON went down to the resident's room to discuss why he was attempting to go into another residents room when this resident grabbed the NHA by the neck and hair and threw her onto the bed. The DON and another staff member assisted to get this resident off of the NHA. NHA was observed with hair pulled out and red marks around face/neck and arm. Approximately 10 minutes later, this resident also came out into the hallway and grabbed the CNA who was doing one-on-one by the neck, also leaving red marks on his neck. Police notified. Clinical certifications completed . Scanned documentation in the EMR included Bed Holds for prior transfer/discharges but not the transfer/discharge on [DATE]. On [DATE] at 10:00 AM, an interview was completed with the DON and the facility Administrator. When queried regarding Resident #702's discharge from the facility on [DATE], the DON and Administrator verbalized that Resident #702 had an altercation with the Former Administrator causing injury. When asked, the DON revealed that the Police were called, facility physicians completed certifications for mental health, and the Resident was transferred to the ED. When queried what occurred after Resident #702 was transferred to the ED, the DON replied, They (ED Provider) said (Resident #702) could come back and did not qualify for inpatient mental health. The DON stated, We did not take (Resident #702) back. When queried why they did not take Resident #702 back, the DON revealed the Resident had two previous resident-to-resident altercations and they were concerned about safety. The DON verbalized the facility's corporate lawyers got involved and revealed an involuntary discharge was completed. When queried when the involuntary discharge document was given to the Resident, the DON stated, (CNA B) delivered to the hospital. When queried regarding the Resident's plan of care at the facility and interventions following the resident-to-resident altercations, the DON and Administrator revealed the Resident #702 had a one to one staff member and was seen by the county Community Mental Health (CMH). The DON and Administrator revealed CMH was working with the Resident find an Assisted Living Facility for the Resident to move to but had not found placement at the time of the incident involving the Former Administrator. The DON provided facility investigation documentation related to the incident involving Resident #702 on [DATE]. The provided documentation included: - Witness statements related to the incident involving Resident #702 and the Administrator - Typed Letter, signed by the DON detailing, Date of Notice: [DATE] . Hand Delivered. (Resident #702) Hospital Name (Note: Incorrect Hospital Identified) . Re: Immediate Involuntary Discharge . from (Facility) . This letter is to inform You that you will be immediately discharged on [DATE] . The specific reasons for your discharge are: Safety of other individuals in the facility is endangered due to clinical or behavioral status . (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- State of Michigan Probate Court, County of Gogebic (not county of facility) . Clinical Certificate . My determination is that the person has mental illness . recommend hospitalization on ly . Signed by facility Physician D on [DATE] at 3:01 PM. Note: The Clinical Certificate Form was not the most recent version of the form provided by the State of Michigan. - State of Michigan Probate Court, County of Gogebic (not county of facility) . Clinical Certificate . My determination is that the person has mental illness . recommend hospitalization on ly . Signed by facility Physician E on [DATE] at 3:01 PM. Note: The Clinical Certificate Form was not the most recent version of the form provided by the State of Michigan. - State of Michigan Probate Court (Blank) County . Petition of Mental Health Treatment . I request: the individual be examined at the hospital . I request . hospitalization on ly . Signed by the DON on [DATE]. - Lined piece of paper with the following written: [DATE] . ED Nurse . (Resident #702) belongings were dropped off by (Facility Name). Signed and dated [DATE] by hospital staff. - Pictures of the Former Administrator showing redness/bruising on face and arm. - Printed phone logs with unknown numbers. - Personal Protection Order (PPO) Application documentation for the Former Administrator against Resident #702 dated [DATE]. The documentation indicated the Former Administrator's statement of their reason for requesting the (PPO). The order was signed by the Judge on [DATE] but the facility premises was excluded from the order. A note on the on the order indicated the PPO was never served to Resident #702. A Police Incident number and business card was included in the documentation, but a Police Report was not provided. A copy of the Police Report was requested from the DON. An interview was completed with CNA B on [DATE]. When asked, CNA B confirmed they recalled Resident #702. When queried regarding the Resident, CNA B revealed they had been involved in a resident-to-resident altercations but then hit (Former Administrator) and was sent to the hospital. CNA B was asked if they were involved when Resident #702 was sent to the hospital and revealed they dropped off the discharge notification to the Resident at the hospital. When queried if Resident #702 signed the form, CNA B stated, No, the legal team had me deliver it. CNA B continued, I went to see (Resident #702) in the hospital and gave it to them. When asked if they said or explained anything when they gave Resident #702 the form, CNA B verbalized they told Resident #702, They wanted me to give this to you and left. CNA B added, Said I am sure you know what it is for. When queried if Resident #702 read and/or understood the form, CNA B revealed they did not know and were only instructed to deliver it. CNA B was asked when they went to the hospital to deliver the notice, CNA B revealed they did not recall. (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #702's Hospital Documentation revealed the Resident remained in the ED from [DATE] to [DATE]. Documentation included the following: ED Provider Notes: - [DATE] at 5:15 PM: Patient was sent over from (facility) due to violent behavior . hitting people and assaulting staff. When I asked the patient why . doing this says 'I do not know' . unwilling to talk to me further at this time - [DATE] at 11:43 PM: Patient . admits . was upset with the nursing staff at his facility due to the voice . understands that it is wrong for the hands another individual. I did discuss this as well with CMH . patient is not a candidate for mental health hospitalization . ED Notes: - [DATE] at 11:45 PM: Spoke with (nurse) from (facility) who stated . cannot accept this patient back to (Facility). This RN requested to speak to the nursing administrator and is awaiting a call back . - [DATE] at 8:29 PM: Per (Hospital Social Worker), the pet and cert (Mental Health petition and certification) sent by (Facility) is invalid due to being on an expired form . - [DATE] at 11:12 PM: This RN spoke with (Former Administrator) who states . cannot allow this patient to return to (Facility) due to violence that (Resident #702) has inflicted on herself and staff . states . placed a personal protective order on this patient and . has placed a formal complaints to the (County Police) to have this patient charged for assault and that this ED and BH (Behavioral Health) units have better ways to manage this patient. This RN explained to that the patient does not qualify for MH (Mental Health) unit placement per (CMH and Mental Health Provider) . (Former Administrator) stated will not speak with this RN on this matter anymore and that will be in contact with this ED manager in the morning regarding this patient's status at her facility and that the patient should go to jail. This RN offered to allow (Former Administrator) to speak with nursing supervision that was currently on and refused stating 'We will handle this all in the morning'. - [DATE] at 3:14 AM: (Police Dispatch) to infer on whether pt is to be released into Police custody due to reported charges being pressed against pt by (facility) staff. After talking with Deputy, (Resident #702) does not currently have any charges/investigations against them at this time . pt is not to be taken into police custody and the residence concern would be strictly between our ED and the (Facility). Pt will remain in ED . - [DATE] at 5:02 PM: Spoke with telehub (mental health) in regards to patient . doesn't meet criteria for mental health admission . if (Resident #702) is still here on Monday they will call a community meeting. Waiting to see when pt (patient) will be placed in AFC (Adult [NAME] Care) home . (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was completed with the DON on [DATE] at 2:00 PM. When queried why Resident #702 was not allowed to return to the facility from the emergency room after being medically cleared for discharge and not provided an opportunity to appeal the involuntary discharge, the DON revealed it was related to safety concerns and the discharge form was authored and provided to the facility to deliver to Resident #702 by Corporate. An interview was completed with the Former Administrator on [DATE] at 3:08 PM. When queried if they recalled Resident #702, the Former Administrator confirmed they did. The Former Administrator was asked what occurred on [DATE] and stated, I was terrified. I went in to talk to them about going into other resident rooms and (Resident #702) became aggressive. The Former Administrator was asked to explain how Resident #702 became aggressive and what was said. The Former Administrator stated, It was so fast. I can't believe (Resident #702) moved that fast. The Former Administrator revealed the Resident was a 1:1 sitter at the time because of two prior resident-to-resident altercations which had occurred including one in which Resident #702 had hit another resident on their ear. When queried if they were alone in room, the Former Administrator indicated no one was directly in the room but responded quickly when they yelled out. The Former Administrator revealed the Resident pulled their hair and they had multiple areas of bruising on their face and arm. A follow-up interview was conducted with the Former Administrator on [DATE] at 5:12 PM. When queried regarding the PPO, the Administrator replied, It was never served (to Resident #702) because the Police said they couldn't find them. With further inquiry, the Former Administrator revealed they did not know how the Police were unable to locate the Resident and were unsure if the PPO was effective as it had not been served. The Former Administrator verbalized the PPO authorized by the court did not include the facility building/premises which was what they had requested and been most concerned about. When asked, the Former Administrator confirmed criminal charges were not pressed against Resident #702. When queried regarding Resident #702's discharge plan, the Former Administrator verbalized CMH was working with the Resident and the facility to find a different placement and had taken the Resident to visit different Assisted Living Facilities. An interview was conducted with CMH Staff B on [DATE] at 10:14 AM. When queried regarding Resident #702's stay and discharge from the facility, Staff B stated, (Resident #702) and I were going out and looking at AFC's but apparently we weren't moving quick enough. When asked what they meant, Staff B stated, (Former Administrator) was not happy and wanted (Resident #702) moved. (The Former Administrator) let everyone know they were not happy (Resident #702) was there and let it show. CMH Staff B was asked how the Former Administrator let it show that they were unhappy Resident #702 was there, Staff B stated, (The Former Administrator) called me all the time and wanted us to move faster but it takes time to get things going. CMH Staff B elaborated they were working to get Resident #702 set up with the waiver program. CMH Staff B stated, (The Former Administrator) would call me all the time and tell me over and over how much it cost (the facility) to have (Resident #702) on a 1:1 sitter. They did not want (Resident #702) there. (continued on next page)

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