

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235473	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/24/2024
NAME OF PROVIDER OR SUPPLIER Medilodge of Shoreline		STREET ADDRESS, CITY, STATE, ZIP CODE 14900 Shore Line Dr Sterling Heights, MI 48313	

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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44750</p> <p>This citation pertains to Intake MI00143567.</p> <p>Based on observation, interview, and record review, the facility failed to get residents out of bed per their preference for two residents (R803 and R806) out of two reviewed for resident rights. Findings include:</p> <p>R803</p> <p>On 4/23/2024 at 9:30 AM, R803 was observed laying in bed. R803 was interviewed regarding their care in the facility. R803 stated that they enjoy being at the facility, however they (facilitly staff) do not get them up like they should R803 stated they prefer to get up before breakfast and be up for all meals. R803 stated they do not like eating their meals in the bed. R803 stated that they also don't like to miss bingo.</p> <p>On 4/24/2024 at 10:15 AM, R803 was observed still in bed. R803 stated they asked to get up before breakfast, but no one got them up. R803 stated they hope they are up by lunch.</p> <p>On 4/24/2024 at 11:51AM, R803 was observed eating lunch in their bed. R803 stated they were informed they would be getting up after lunch.</p> <p>On 4/24/2024 at 12:06 PM, an interview was conducted with Certified Nursing Assistant (CNA) D. CNA D stated that R803 is supposed to get up on midnights so that R803 would be up for breakfast. CNA D stated they were unable to get R803 up before lunch because of something going on in the facility. CNA D stated they informed R803 they would get them up after lunch.</p> <p>A review of the medical record revealed R803 was admitted into the facility on [DATE] with the following diagnoses, Muscle Wasting and Atrophy and Diabetes. A review of the Minimum Data Set assessment revealed a Brief Interview for Mental status score of 15/15 indicating an intact cognition. R803 also required assistance with bed mobility and transfers.</p> <p>R806</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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 4/24/2024 at 9:45 AM, R806 was heard crying in their room. R806 stated they have been trying to get out of the bed and attend activities for the last two days. R806 stated that no one will get them up and they keep being told they are short staffed. R806 stated they get depressed sitting in the room and laying in bed all day. R806 stated the Activities Director came and stated that they would make sure they got up today and attended activities.</p> <p>A review of the medical record revealed that R806 admitted into the facility on [DATE] with the following diagnoses, Edema and Major Depressive Disorder. A review of the Minimum Data Set assessment revealed a Brief Interview for Mental status score of 15/15 indicating an intact cognition. R806 also required assistance with bed mobility and transfers.</p> <p>On 4/24/2024 at 11:27 AM, an interview was conducted with the Nursing Home Administrator (NHA). The NHA stated that it is resident preference when they get up. The NHA stated some people like to get up early, and some like to get up late. It all depends on what the resident prefers, and they accommodate.</p> <p>A review of a facility policy titled, Activities of Daily Living noted the following, .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.</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44750</p> <p>This citation pertains to Intakes MI00143495 and MI00143567.</p> <p>Based on observation, interview, and record review, the facility failed to float heels per physician orders for two residents (R802 and R803) out of two reviewed for skin conditions. Findings include:</p> <p>R802</p> <p>On 4/23/2024 at 9:28 AM, R802 was observed laying in bed. R802 heels were noted to be resting on the mattress. No pillow was observed under their legs to float their heels.</p> <p>On 4/23/2024 at 11:23 AM, R802's heels were observed resting on the mattress.</p> <p>On 4/24/2024 at 9:45 AM, 10:10 AM, and 12:08 PM, R802's heels were observed resting on the mattress.</p> <p>A review of the medical record revealed that R802 admitted into the facility on [DATE] with the following diagnoses, Diabetes and Dysphagia. A review of the Minimum Data Set assessment revealed a Brief Interview for Mental status score of 15/15 indicating an intact cognition. R802 also required assistance with bed mobility and transfers.</p> <p>Further review of the physician orders revealed the following, Start: 10/23/2023. Status: Active .Cleanse bilateral heels with Normal Saline, pat dry, apply skin prep. Keep heels floated.</p> <p>Further review of the Care Plan revealed the following intervention, Date Initiated: Assist to elevate heels off the mattress with pillows as tolerated.</p> <p>R803</p> <p>On 4/24/2024 at 9:07 AM, 9:49 AM, 10:15 AM, and 11:51 AM, R803's heels were observed resting on the mattress.</p> <p>On 4/24/2024 at 11:51 AM, R803 was interviewed regarding their heels being floated. R803 stated that they asked the staff last night to put their legs on a pillow and float their heels, but they did not do it.</p> <p>A review of the medical record revealed that R803 admitted into the facility on [DATE] with the following diagnoses, Muscle Wasting and Atrophy and Diabetes. A review of the Minimum Data Set assessment revealed a Brief Interview for Mental status score of 15/15 indicating an intact cognition. R803 also required assistance with bed mobility and transfers.</p> <p>Further review of the physician orders revealed the following order, Start Date: 5/12/2023. Status: Active . Cleanse bilateral heels with NS (Normal Saline), pat dry, apply skin prep, float heels when in bed.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 4/24/2024 at 12:12 PM, an interview was conducted with Unit Manager (UM) C. UM C stated that if there is an order for their heels to be floated then they should be floated.</p>		

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<p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Make sure that a working call system is available in each resident's bathroom and bathing area.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44750</p> <p>This citation pertains to Intake MI00142973.</p> <p>Based on observation, interview, and record review, the facility failed to answer a call light and provide needs in a timely manner for one resident (R805) out of three reviewed for call lights. Findings Include:</p> <p>On 4/23/2024 at 1:50 PM, R805's call light was observed activated. At 2:09 PM, R805 call light was observed still activated. Multiple people were noted in the hallway and walking past the light. R805 was interviewed regarding what assistance they were waiting for Certified Nursing Assistant (CNA) B. R805 stated that they were waiting to be changed and that they had been waiting for an hour and a half.</p> <p>On 4/23/2024 at 2:10 PM, CNA B was observed going into the room with R805 and turning off their call light. CNA B stated that R805 was a two person assist and they had to go find someone to help.</p> <p>On 4/23/2024 at 2:20 PM, CNA B was observed going into R805's room with another staff member and stated they were about to perform care.</p> <p>A review of the medical record revealed that R805 admitted into the facility on [DATE] with the following medical diagnoses, Muscle Weakness and Major Depressive Disorder. R805 also required assistance with bed mobility and transfers.</p> <p>On 4/24/2024 at 12:12 PM, an interview was conducted with Unit Manager (UM) C. UM C stated that they checked on R805 when their light was on and went to find the CNA to assist them. UM C stated that they inform the staff to leave the light on until the need has been met.</p> <p>A review of a facility policy titled, Call Lights: Accessibility and Timely Response noted the following. Any staff member who sees or hears an activated call light is responsible for responding. If the staff member cannot provide what the resident desires, the appropriate personnel should be notified.</p>		