STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235507	A. Building B. Wing	07/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Plymouth	395 W Ann Arbor Trail Plymouth, MI 48170

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** 34901 Based on observation, interview, and record review, the facility failed to provide dignified dining for two residents (R22 and R27) during dining observations, resulting in a staff member standing over the residents during meal assistance which did not resemble the comfortable characteristics of a home. Findings include: On 7/23/24 at 12:34 PM, Resident #27 (R27) was in her room, awake, and sitting in her geriatric chair. Certified Nurse Aide (CNA) G was standing next to R27 while offering the resident spoons of thickened apple juice. When R27 stated she had enough, CNA G stopped. On 7/23/24 at 12:39 PM, Resident #22 (R22) was in her room, awake, and sitting up in her bed. R22's lunch tray was positioned in front of her on an overbed table and had not been touched. Licensed Practical Nurse (LPN) H was observed in the room shared by R22 and R27 and said that sometimes R22 feeds herself, but other times staff feed her. LPN H was sitting next to the roommate of R22 and R27 while feeding the roommate her lunch. On 7/23/24 at 12:50 PM, CNA G was observed standing next to R22's bed while offering the resident bites of food. At the end of the meal, CNA G said R22 consumed the top of her roll, all her dessert and milk, and a small amount of the beef and rice. A review of the Admission Record for R22 documented an initial admitted [DATE] and readmitted [DATE]. R22's diagnoses included chronic obstructive pulmonary disease, diabetes mellitus-type 2, and unspecified dementia. A MDS dated [DATE] documented severe cognitive impairment. Physician orders documented R22 was to receive a regular diet, regular texture, regular fluids, thin consistency. R22's ADL care plan documented to provide supervision to one-person assist, varies on resident's mood/behavior, for eating. (continued on next page)

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	A review of the Admission Record for R27 documented an admitted [DATE] with diagnoses that included cerebral infarction, hemiplegia and hemiparesis, vascular dementia, and dysphagia. A Minimum Data Set (MDS) assessment dated [DATE] documented severe cognitive impairment. Physician orders documented R27 received bolus feedings of a liquid supplement via a gastrostomy feeding tube and a regular diet, pureed texture, and honey/moderately thick consistency fluids by mouth. A review of R27's nutrition and activity of daily living (ADL) care plans documented to provide assistance with meals as needed and one-person assist for eating. On 7/24/24 at 10:09 AM, Registered Dietitian (RD) B said that staff should be sitting on the same level of the resident when assisting them with feeding because it is respectful. Residents should be treated like family. On 7/25/24 at 3:00 PM, the Director of Nursing (DON) said staff should be at the same level of the resident when offering feeding assistance so you can see the resident's face and it is also an integrity issue. Staff should be sitting down not standing up while feeding residents. The facility policy titled, Resident Rights, dated 10/30/23, documented in part, The facility will ensure that all staff members are educated on the rights of residents and the responsibility of the facility to properly care for its residents. On 7/25/24 at 4:00 PM during the exit conference, the Nursing Home Administrator and DON did not offer additional documentation or information regarding this citation when asked.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39958 Based on interview and record review, the facility failed to immediately report a Resident-to-Resident incident for two residents (R3 and R40) of three residents reviewed for abuse, resulting in allegations of abuse that were not reported to the State Agency timely and the potential for feeling of not being protected or unsafe within the facility, and for abuse to continue without being reported. Findings include: R3 Review of an Admission Record revealed, R3 admitted to the facility on [DATE] and with pertinent diagnosis which included Schizophrenia and Bipolar Disorder. Review of a Minimum Data Set (MDS) assessment dated [DATE] revealed R3 had cognitive impairment with a Brief interview for Mental Status (BIMS) score of 6 out of 15. Review of a nurses note with a date of 4/28/24 at 10:27 p.m. revealed, . Resident did not appear to be upset. A resident was in his bed and had to be redirected out of (R3's) bed. While the resident was being redirected out of the area (R3) spontaneously hit him in the face . R40 Review of an Admission Record revealed, R40 admitted to the facility on [DATE] and discharged on [DATE] with pertinent diagnoses which Dementia and Alzheimer's Disease. Review of a MDS assessment dated [DATE] revealed R40 had cognitive impairment with a BIMS score of 6 out of 15. Review of a nurses note with a date of 4/28/24 at 9:32 p.m. revealed, . Resident has been wandering through out the unit and has to be redirected. Resident was observed in another resident's bed, resident was redirected by staff out of the bed and back into his wheelchair. When staff member turned around to attend to another resident, a resident spontaneously hit (R40) in the face. (R40) was taken out of the area and placed in his bedroom. The residents' nose was bleeding, and the writer placed an ice pack on the nose and stopped the bleeding. A head-to-toe assessment and a pain assessment was completed. Prn pain medication was given. The family the on call Physician, DON (Director of Nursing), and the Administrator were notified. Review of a nurses note with a date of 4/30/24 at 1:23 p.m. revealed, . resident noted picking at scabs on arms and face, bruise noted on right side of nose where glasses sit notified md ordered x-ray of the nose. encouraged family to bring long sleeve shirts lotion applied. safety maintained . In an interview on 7/24/24 at 11:16 a.m., the DON reported the resident-to-resident incident was not reported to the state agency. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 7/24/24 at 3:18 p.m., the Nursing Home Administrator (NHA) reported the incident should have been reported to the state agency within two hours if there is an injury. The NHA then confirmed the incident involving R3 and R40 should have been reported to the state agency. Review of the Abuse, Neglect and Exploitation policy revised 10/24/22 documented, It is the policy of this facility to provide protections for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation, and misappropriation of resident property . Reporting/Response A. The facility will have written procedures that include: 1. Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (e.g., law enforcement when applicable) within specific timeframes: a. Immediately, but not later than 2 hours after the allegations is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or b. Not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury .

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F 0658 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34901 Based on interview and record review, the facility failed to demonstrate professional standards of practice by not obtaining vitals per physician's orders for one resident (R39) out of one resident reviewed that died in the facility, resulting in an incomplete gauge of the resident's general health and well-being. Findings include: A review of the Admission Record for Resident #39 (R39) documented an initial admitted [DATE], readmitted [DATE], and death in the facility on [DATE]. R39's diagnoses included venous insufficiency, severe protein-calorie malnutrition, and hypertension. A Minimum Data Set assessment dated [DATE] documented intact cognition. Nursing note on [DATE] at 10:53 PM documented in part, Resident in bed, no audible apical heartbeat (pulse point on the chest), or no palpable pulse or no respirations. Verified by RN (Registered Nurse) on duty. Notified on call team .for notification of passing. Release of body form completed. On [DATE] at 2:15 PM, R39's clinical record was reviewed with the Director of Nursing (DON). Physician orders documented the following: 1. Vital signs every evening shift every Friday. Started on [DATE]. 2. Vital signs every night shift. Started on [DATE]. The DON said nursing should have contacted the physician to confirm the vital sign orders. The DON said that normally vitals include obtaining a resident's blood pressure, temperature, pulse, respiration, and oxygen level. R39's [DATE] Medication Administration Record (MAR), reviewed with the DON, revealed that nurses signed off that they completed vitals on R39 nightly. R39's clinical record provided the following documentation of vitals obtained during the month of [DATE]: Blood Pressure: [DATE] at 9:38 PM ,d+[DATE] [DATE] at 9:41 AM ,d+[DATE] [DATE] at 9:33 PM ,d+[DATE] [DATE] at 2:01 PM ,d+[DATE] [DATE] at 6:30 PM ,d+[DATE] Temperature: (continued on next page)

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F 0658 Level of Harm - Potential for minimal harm Residents Affected - Some	[DATE] at 9:38 PM 98.4 F (Fahrenheit) [DATE] at 9:41 AM 97.7 F [DATE] at 9:33 PM 98.6 F [DATE] at 2:01 PM 97.8 F [DATE] at 6:30 PM 98.2 F Pulse: [DATE] at 9:38 PM 72 bpm (beats per minute) [DATE] at 9:41 AM 63 bpm [DATE] at 9:33 PM 70 bpm [DATE] at 2:01 PM 69 bpm [DATE] at 6:30 PM 74 bpm Respiration: [DATE] at 9:38 PM 15 Breaths/min [DATE] at 9:41 AM 14 Breaths/min [DATE] at 9:33 PM 16 Breaths/min [DATE] at 2:01 PM 15 Breaths/min [DATE] at 6:30 PM 16 Breaths/min Oxygen level: [DATE] at 9:38 PM 98.0% Room Air [DATE] at 9:41 AM 92.0% Room Air [DATE] at 9:33 PM 98.0% Room Air [DATE] at 2:01 PM 95.0% Room Air [DATE] at 6:30 PM 96.0% Room Air The DON stated a resident's vital signs should be documented because that gives you an accurate picture of the resident's condition. (continued on next page)

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F 0658 Level of Harm - Potential for minimal harm Residents Affected - Some	On [DATE] at 4:00 PM during the exit conference, the Nursing Home Administrator and DON did not offer additional documentation or information regarding this citation when asked.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34901 Based on observation, interview and record review, the facility failed to implement effective skin care for one resident (R16) of two residents reviewed for skin care, resulting in dry, scaly skin and resident dissatisfaction. Findings include: On 7/23/24 at 10:02 AM, Resident #16 (R16) was observed awake and lying in bed. R16 stated, They are supposed to put salve on my legs and feet, but nothing is being done about it. R16 granted permission for the Surveyor to look at her feet. The bottoms of R16's feet were very dry, scaly, with peeling skin. The Admission Record for R16 documented an admitted [DATE] with diagnoses that included endometrium (uterus) cancer, chronic obstructive pulmonary disease, obesity, and congestive heart failure. A Minimum Data Set assessment dated [DATE] documented intact cognition. On 7/24/24 at 9:29 AM, Registered Nurse (RN) D reviewed R16's clinical record for orders related to foot care. There were none. RN D said R16 does not have the physical ability to apply lotion to her feet. R16 was dependent upon staff to do that for her. RN D admitted that she had not examined R16's feet lately. On 7/24/24 at 9:38 AM, after examining R16's feet, RN D stated, She really needs lotion for dry skin. I'm going to call the doctor for the order. RN D said the skin on the bottom of R16's feet was dry and scaly, and when you rub the bottom of R16's feet, skin would come off. RN D noted discoloration of dark brown spots on the top of both feet. RN D indicated that the condition of R16's feet did not recently happen. This should have been noted and brought to her attention. Nursing progress note of 7/24/24 at 9:58 AM documented in part: Resident both feet assess today, both feet are dry scaly skin on palm of the feet, dark brown skin noted on top of both feet, NP (nurse practitioner) on call notified of dry scaly peeling skin. stated I will put the order in now for (lac-hydrin) lotion. On 7/25/24 at 2:49 PM, the Director of Nursing said R16's skin should have been moisturized with lotion. R16's skin was extremely dry and should have been attended to on a regular basis. The facility policy titled, Activities of Daily Living (ADLs), dated 12/28/23, documented in part: 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. On 7/25/24 at 4:00 PM during the exit conference, the Nursing Home Administrator and DON did not offer additional documentation or information regarding this citation when asked.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34901 Based on observation, interview, and record review, the facility failed to change oxygen tubing in a timely manner for one resident (R16), out of one resident reviewed for oxygen therapy, resulting in the potential for cross contamination and respiratory infection. Findings include: On 7/23/24 at 11:20 AM, Resident #16 (R16) was awake and lying in her bed. R16 said staff do not change her tubing like they are supposed to. The tape on R16's oxygen tubing was dated 7/19/24. On 7/24/24 at 9:21 AM, the date on R16's oxygen tubing remained 7/19/24. The Admission Record for R16 documented an admitted [DATE] with diagnoses that included endometrium (uterus) cancer, chronic obstructive pulmonary disease, obesity, and congestive heart failure. A Minimum Data Set assessment date 6/27/24 documented intact cognition. Physician orders documented to date and change resident's oxygen tubing every three days. Order date: 12/29/23. On 7/25/24 at 2:36 PM, the Director of Nursing (DON) said R16's oxygen tubing should be changed every three days. The tubing dated 7/19/24 should have been changed to a clean one on 7/22/24. The DON said R16 drops her tubing on the floor and would need it changed more often than weekly. The DON indicated that physician orders supersede facility policies. A review of the policy titled, Oxygen Administration, dated 10/26/23, documented in part the following: change oxygen tubing and mask/cannula weekly and as needed if it becomes soiled or contaminated. On 7/25/24 at 4:00 PM during the exit conference, the Nursing Home Administrator and DON did not offer additional documentation or information regarding this citation when asked.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34901 Based on observation, interview, and record review, the facility failed to ensure resident food preference was honored for one resident R16) out of six residents reviewed for food preferences, resulting in resident meal dissatisfaction. Findings include: On 7/24/24 at 8:05 AM, the breakfast served to Resident #16 (R16) included a bowl of bran flake cereal, one boiled egg, one muffin, a glass of milk, and a glass of orange juice. R16 said to Certified Nurse Aide (CNA) G that she wanted another boiled egg. On 7/24/24 at 8:06 AM, R16 stated, This (breakfast) is not going to be enough to hold me until lunch. On 7/24/24 at 8:14 AM, CNA G informed R16 that the kitchen indicated they did not have any more boiled eggs. On 7/24/24 at 8:18 AM, Dietary Manager (DM) A stated, We gave out all the boiled eggs we cooked. When queried if there were more eggs in the kitchen, DM A stated, We have plenty of eggs. I can boil some more. On 7/24/24 at 10:09 AM, Registered Dietitian (RD) B said they use resident food preferences to adjust what the residents receive. RD B indicated it was important to honor resident food preferences because this was their home. They should get what they want, with what's available, and based upon their diet. We do our best to give them what they like. Regarding R16's request, RD B stated, They should have served her another egg. The Admission Record for R16 documented an admitted [DATE] with diagnoses that included endometrium (uterus) cancer, chronic obstructive pulmonary disease, obesity, and congestive heart failure. A Minimum Data Set assessment dated [DATE] documented intact cognition. A review of R16's breakfast meal ticket for 7/24/24 documented, Diet Order: Regular Diet. Notes: prefers boiled eggs. On 7/25/24 at 3:25 PM, the Nursing Home Administrator (NHA) stated it was unacceptable that R16 did not receive her request and added, They should have stopped to make her a boiled egg. If they (the residents) want two boiled eggs, they should have it. The facility policy titled, Resident Rights, dated 10/30/23, documented in part, The facility will ensure that all staff members are educated on the rights of residents and the responsibility of the facility to properly care for its residents. On 7/25/24 at 4:00 PM during the exit conference, the NHA and Director of Nursing did not offer additional documentation or information regarding this citation when asked.

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. 32000 Based on observation, interview, and record review, the facility failed to provide at least 80 square/feet per resident in eight of fifteen resident bedrooms (# 109, 110, 111, 112, 113, 114, 115 and 116) and at least 100 square feet in one of five single bedrooms (room # 102), resulting in the potential for inadequate space. Findings Include: Observations of resident rooms made on 7/23/24 at 1:49 PM during the environmental tour and review of the facility bed count information sheet with the Maintenance Director identified the following: Room # Square feet Beds 102 81 1 109 143 2 110 143 2 111 143 2 112 143 2 113 143 2 114 143 2 115 143 2 116 143 2 The health and safety of the residents was not affected by the room size. Interviews with the residents noted no complaints concerning the room size.