STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235600	A. Building B. Wing	02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Montrose Inc	9317 W Vienna Rd Montrose, MI 48457

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 37668

This Citation Pertains to Intake Number MI00150467.

Based on observation, interview and record review, the facility failed to ensure the provision and documentation of Activities of Daily Living (ADL) and hygiene care for five residents (701, 702, 703, 704, and 705) of five residents reviewed.

Findings include:

Review of intake documentation dated as received [DATE] revealed concerns of inadequate staffing and that residents are not getting the proper care they need . showers are not being done, and residents are not getting the proper grooming .

Resident #701:

Record review revealed Resident #701 was originally admitted to the facility on [DATE] and readmitted with [DATE] with diagnoses which included cerebral infarction (stroke) with resulting attention and concentration deficit, chronic respiratory failure, tracheostomy (surgically created opening in the front of the neck to the trachea to allow for breathing), gastrostomy (surgically created opening in the abdomen to the stomach to allow for introduction of nutrition), and pressure ulcer. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the Resident was severely cognitively impaired and was dependent upon staff to complete ADL's.

On [DATE] at 12:55 PM, Resident #701 was observed in their room. The Resident was in bed, positioned on their back in bed. The Resident had an unkept appearance. Resident #701 was confused and unable to provide meaningful responses when asked questions.

Review of Resident #701's Electronic Medical Record (EMR) revealed a care plan entitled, (Resident #701) has an ADL self-care performance deficit . (Initiated: [DATE]; Revised: [DATE]). The care plan included the interventions:

- Bathing: Dependent (Initiated: [DATE])

- Dressing: Dependent (Initiated: [DATE])

- Personal Hygiene: Dependent (Initiated: [DATE])

(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: 235600	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/27/2025
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F 0677

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

- Toileting: 1 person assist (Initiated: [DATE])

- Toileting: Dependent 2 person assist at bed level (Initiated: [DATE]; Revised: [DATE])

- Transfers: Dependent with 2 person assist AND use of mechanical lift (hoyer) and (lg Green) (Initiated: [DATE])

- (Resident #701) prefers showers: Wednesday and Saturday, Evening shift Ensure nails are clean/trimmed as needed Likes short mustache (Initiated: [DATE]; Revised: [DATE])

Review of Resident #701's Documentation Survey Report for February 2025 revealed the Resident received one bed bath on [DATE] and no showers. The Report also revealed no oral care was completed during the day shift on [DATE], [DATE], [DATE], [DATE], and [DATE]. Oral care was completed one time during the evening shift on [DATE].

Review of Resident #701's progress note documentation in the EMR revealed no documentation of ADL care refusal.

Resident #702:

On [DATE] at 1:05 PM, Resident #702 was observed in their room in bed. The Resident was positioned on their back in bed with their eyes closed. Resident #702 was receiving tube feeding via infusion pump with the head of the bed elevated at 20 degrees. The Resident had a tracheostomy and was receiving supplemental oxygen via a tracheostomy mask. Resident #702 was wearing a hospital gown and had a disheveled and unmaintained appearance.

Record review revealed Resident #702 was admitted to the facility on [DATE] with diagnoses which included cerebral infarction with resulting dysphagia (difficulty swallowing), gastrostomy, tracheostomy, heart disease, and kidney disease. Review of the MDS assessment dated [DATE] revealed the resident was cognitively intact and required total assistance for bathing, toileting, and personal hygiene.

Review of Resident #702's care plans revealed a care plan entitled, (Resident #702) has an ADL self-care performance deficit related to decreased functional mobility and physical limitations . (Initiated: [DATE]; Revised: [DATE]). The care plan included the interventions:

- Bathing: 2 person assist (Initiated: [DATE])

- Bed Mobility: 2 person assist (Initiated: [DATE])

- Toileting: 2 person assist (Initiated: [DATE])

- Transfers: Dependent with 2 person assist and use of mechanical lift (HOYER) and (SLING) (Initiated: [DATE]; Revised: [DATE])

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No. 0938-0391

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident #702's Documentation Survey Report for February 2025 revealed the task, Bathing Monday and Thursday PM shift. Per the documentation, Resident #702 received one bed bath on [DATE] and no showers. The report also revealed no oral care was completed during the day shift on [DATE], [DATE], [DATE], [DATE], and [DATE]. No oral care was completed during the evening shift. Resident #703: Record review revealed Resident #703 was admitted to the facility on [DATE] with diagnoses which included cerebral infarction with left sided hemiparalysis and hemiplegia (one sided paralysis), tracheostomy, gastrostomy, cognitive communication deficit, heart failure and acute respiratory failure. Resident #703 was transferred to the hospital from the facility on [DATE] and did not return to the facility. Review of the MDS assessment dated [DATE] revealed the Resident was rarely/never understood and was dependent upon staff for all ADL completion. An interview was completed with Family Member Witness R on [DATE] at 6:25 PM. When queried regarding Resident #703's care in the facility, Witness R verbalized multiple areas of discontentment including ADL care. When queried regarding bathing and ADL care, Witness R indicated Resident #703 was not provided sufficient bathing and hygiene care because they are to understaffed to do it. When asked what they meant, Witness R verbalized they believed the nursing staff care but are unable to ensure care is provided to all the residents because there is not enough staff. Review of Resident #703's Documentation Survey Report for February 2025 revealed the Resident received one bed bath during their stay at the facility on [DATE] at 3:52 PM. Resident #704: On [DATE] at 1:10 PM, an observation of Resident #704 in their room was completed. The Resident was in bed, positioned on their back. The Resident's hair had an unclean and unkempt appearance. Resident #704 was receiving tube feeding via infusion and also had a tracheostomy with supplemental oxygen via a tracheostomy mask in place. Resident #704 did not respond verbally when spoke to. had a disheveled and unmaintained appearance. Record review revealed Resident #704 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included seizures, gastrostomy, kidney disease, and diabetes mellitus. Review of the MDS assessment dated [DATE] revealed the Resident was severely cognitively impaired and was dependent upon staff to complete ADL's. Review of Resident #704's Documentation Survey Report for February 2025 revealed the Resident received a bed bath on [DATE]. The report also revealed no documentation of oral care during the day shift on [DATE], [DATE], [DATE], [DATE], [DATE], and [DATE]. Oral care was documented as being provided two times on the night shift on [DATE] and [DATE]. Resident #705: (continued on next page)

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review revealed Resident #705 was admitted to the facility on [DATE] with diagnoses which included cerebral infarction with resulting dysphagia (difficulty swallowing) and left sided hemiparalysis and hemiplegia, tracheostomy, and gastrostomy. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the Resident was severely cognitively impaired and was dependent upon staff for completion of all Activities of Daily Living (ADL's). Resident #705 died in the facility on [DATE]. Review of Resident #705's Documentation Survey Report for February 2025 revealed the Resident received one bed bath on [DATE]. The report also revealed oral care was completed two times on [DATE] and [DATE] during the day shift. An interview was completed with the Director of Nursing (DON) on [DATE] at 3:45 PM. When queried if ADL care should be documented including bathing and oral care as completed and/or refused, the DON confirmed it should. Resident #701's Documentation Survey Report for February 2025 was reviewed with the DON at this time. When queried regarding the lack of documentation of ADL care completion, the DON confirmed but did not provide further explanation. The lack of ADL care documentation on Resident #702, 703, 704, and 705's Documentation Survey Report was discussed with the DON at this time. When queried, the DON indicated they believed staff were not documented care they provide. When queried if there were other places where staff would document ADL completion, the DON responded there was not. Review of policy/procedure entitled, Activities of Daily Living (ADL) (Reviewed [DATE]) revealed, Policy: The facility takes measures to minimize the loss of residents functional abilities, including activities of daily living (ADL's) . 3. 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 .

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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 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** 37668 This Citation Pertains to Intake Number MI00150264. Based on interview and record review, the facility failed to ensure timely nursing assessment, response, and documentation for a change in condition for one resident (#705) three residents reviewed. Findings include: Resident #705: Review of intake documentation revealed concerns related to lack of appropriate care and Resident #705's subsequent death. Record review revealed Resident #705 was originally admitted to the facility on [DATE] with diagnoses which included cerebral infarction (stroke) with resulting left sided hemiplegia and hemiparalysis (one sided paralysis), dysphagia (difficulty swallowing), and dysarthria (difficulty speaking), and gastrostomy (surgically created opening in the abdomen to allow for a feeding tube to be placed). Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the Resident was severely cognitively impaired and was dependent upon staff for completion of all Activities of Daily Living (ADL's). Record review revealed Resident #705 was a full code and died in the facility on [DATE]. Resident #705's Electronic Medical Record (EMR) revealed one Nurses' Note dated [DATE] at 5:08 AM. The note was authored by the Director of Nursing (DON) and detailed, Nurse and CNA (Certified Nursing Assistant) in resident's room between 4:15 and 4:30 am to provide care with resident. Resident was observed by charge nurse to be sitting up in bed watching TV resident sounded a little congested, so (nurse) went to get a suction container to assist with relief. Upon returning to room resident was observed with decreased response and code was called at 5:08 am . A timeline of events following the code being called was included in the note. The timeline specified: - 5:08 AM: Unresponsive, Code blue called, 911 called, Crash cart to room and CPR initiated. - 5:09 AM: Ambu bag applied with 15L(liters)/min (minute) of oxygen - 5:12 AM: Analyzed for pulse and CPR to continue - 5:13 AM: Suction of airway as tube feed was being forced up with chest compressions - 5:14 AM: Analyzed for pulse and CPR continued - 5:23 AM: EMT/Paramedic/sheriff . Fire and police in room. Suctioning of airway (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 5:25 AM: Connected to EMT Monitor and observed Asystole (no cardiac function) CPR was continued by Emergency Medical Services (EMS) staff at the facility without success. The EMS staff contacted the Hospital Emergency Physician and time of death was called at 5:58 AM. The note did not specify if and when Resident #705's family was contacted. There were no assessments present in Resident #705's EMR pertaining to the change in condition and/or death in the facility. Review of Resident #705's Medication Administration Record (MAR) and Treatment Administration Record (TAR) for February 2025 revealed Registered Nurse (RN) A completed documentation of eye drop administration at 1:00 AM and taking down the Resident's tube feeding solution at 5:00 AM on [DATE]. Review of Resident #705's Documentation Survey Report for February 2025 revealed no documentation of ADL care completion during on [DATE] after 1:59 PM and no documentation on [DATE]. A review of the [DATE] facility staffing sheet confirmed RN A was assigned to work on Resident #705's unit from 6:00 PM on [DATE] to 6:00 AM on [DATE]. Review of facility provided investigation documentation pertaining to Resident #705's death in the facility revealed the following: - Typed timeline and note included in Nurses' Progress Note - Typed statement from RN A (not signed or dated): Nurse and CNA in residents room between 4:15 and 4:30 AM to provide care with resident. Resident was observed by charge nurse to be sitting up in bed watching TV resident sounded a little congested so (RN A) went to get a suction container to assist with relief. Upon returning to room, resident was observed with decreased response and code was called at 5:08 AM. - Typed statement from CNA B (not signed or dated): At approx. 4:15 AM, the nurse and I went into (Resident #705's) room to provide care. The lodger was breathing a little heavier than usual. It did start to subside. We continued and completed care on lodger then I exited the room. The lodgers breathing seemed to be returning to normal. I continued to provide care for other individuals then heard the Code Blue overhead and returned to (Resident #705's room). The nurses were performing CPR at that time. - Incident and Accident (I and A) Report, dated [DATE]: Code Blue . Person Preparing Report: (DON) . There was no additional information contained in the I and A report. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 12:55 PM, an interview was conducted with RN A. When asked if they were Resident #705's assigned nurse when they passed away on [DATE], RN A confirmed they were. RN A was asked what happened and stated, (Resident #705) was fine. Their (significant other) came in and seen them and they were fine. (Resident #705) was fine. (The Resident) wanted (their significant other) to stay but they told me (the Resident) always wanted them to stay. RN A continued to talk, in a very scattered manner, about the Resident's visit with their significant other. RN A was asked if Resident #705's significant other stayed at the facility and replied, No. When queried regarding the events prior to the Resident's passing, RN A replied, We were in there and (Resident #705) was fine. RN A was asked who and where they were referring to and specified Resident #705's room. RN A stated, The CNA and then went back and (Resident #705) sounded mucousy. RN A was asked when Resident #705 sounded mucousy and replied, Between 4:15 AM and 4:30 AM. Everything was fine before. RN A was asked to clarify if they were saying the Resident was fine and then when they went back in the room, Resident #703 sounded mucousy between 4:15 and 4:30 AM. RN A confirmed and added it was, Approximately between 4:15 AM and 4:30 AM. RN A then stated, It was when I went back in there to turn off their tube feeding. (Resident #705) sounded jittery and waspy in their voice. When queried what time they went back in to shut off the Resident's tube feeding, RN A stated, Around 4:45 (AM). When asked what they meant when they said the Resident sounded jittery and waspy, RN A responded, Mucous sounding and their hands were shaking. RN A was asked what happened after that and stated, I ran to the desk and got the other nurse. We got the crash cart. I did the PA and called the code overhead. (Resident #705's) eyes were still open and color was bad. The ADON (Assistant Director of Nursing) paged it again louder. When asked if they assessed the Resident when they sounded jittery and waspy in their voice, RN A replied, What do you mean? When queried what the Resident's coloring was and if they checked their vital signs, RN A replied, their SPO2 (non-invasive blood oxygen level monitoring - normal is greater than 92%) said low. When asked what low meant, RN A repeated it was Low. When asked to clarify what the SPO2 percentage was, RN A state the SPO2 monitor displayed the letters LO and not a percentage. When asked if they were using their personal SPO2 monitoring device or the facility vital sign monitoring machine, RN A replied that they were using the facility machine. When queried regarding the Resident's coloring, RN A stated, (Resident #705) was blue. When queried if the Resident had oxygen in place, RN A replied, No, didn't wear oxygen. RN A then stated, When I went back in (Unit Manager Licensed Practical Nurse [LPN] G) was already doing CPR (Cardiopulmonary Resuscitation). I don't know if they already done one cycle. Our DON was down there. They were in the building. RN A was asked if they did CPR and stated, No. I went up and tried to get their paperwork ready. When queried when they went to get suction, RN A replied, I mean there was nothing there. When asked if they attempted to suction the Resident, RN A repeated there was nothing to suction. RN A then stated, I went up and tried to get paperwork ready. (Resident #705) was mucus sounding and hands were shaking. There was nothing in their mouth or anything. When asked if they applied oxygen to Resident #705 when the SPO2 reading was low, RN A replied, No. When asked why they did not apply oxygen, a response was not provided. RN A was informed of the facility provided timeline of events detailing they went to get suction after providing care with the CNA. When asked if and when they went to get suction and the reason, RN A did not answer. When asked where suction machine/equipment is located, RN A indicated it is on the crash cart. RN A was then queried regarding the timeframe between identification of the change in Resident #705's respiratory status and when the code was called at 05:08 AM and what actions and interventions they implemented, RN A did not provide any additional information. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was completed with Licensed Practical Nurse (LPN) C on [DATE] at 1:10 PM. When queried if they were working on [DATE] when Resident #705 died , LPN C confirmed they were. LPN C revealed they were working on the same unit but were assigned to a different hall. When asked what happened, LPN C revealed RN A was assigned to Resident #705's hall. LPN C stated, (RN A) screamed (Resident #705's) blue and gurgling so I go in there (Resident #705's room) and grab the crash cart. LPN C was asked if they went in Resident #705's room to see what was happening or if they immediately got the crash cart and stated, When I heard (RN A) screaming, I went and looked at (Resident #705) first and then went and grabbed the crash cart. When queried if the Resident was blue, LPN C stated, (Resident #705's) eyes were real big and (the Resident) was more like dark red purple like chocking on something. LPN C indicated they went to get the crash cart after seeing the Resident. With further inquiry, LPN C revealed the suction machine was located on the crash cart. When queried if the Resident was breathing and had a pulse when they first entered the room, LPN C revealed they did not assess the Resident's cardiac status as they were focused on their airway. LPN C verbalized Unit Manager LPN G entered the Resident's room and was assisting while they were plugging in the suction machine. LPN C stated, We were doing sternal rubs (firm rub - painful stimulus- on the sternum to determine responsiveness and level of consciousness) while getting the suction machine ready. LPN C was asked if Resident #705 had stopped breathing and/or lost consciousness and replied, We were trying to keep them with us. LPN C then stated, As soon as I got the suction machine plugged in, (Resident #705) stopped breathing. LPN C stated, At that time, (LPN G) took control of respirations. When asked if the Resident was choking and/or if there was something in their mouth, LPN C stated, I did not look in their mouth, but I could hear secretions of tube feed in the back of the mouth. LPN C then stated, As soon as laid flat all stomach contents came up from tube feed. LPN C was asked if RN A was in Resident #705's room and stated, No, (RN A) was kind of flustered. The DON and ADON walked in and told (RN A) to go print paperwork (for EMS and transfer). LPN C continued, I know (RN A) did call 911. When queried what RN A was doing when they went to get the crash cart, LPN C stated, (RN A) was half in the hall in the doorway of Resident #705's room. LPN C was asked to clarify if they were saying that RN A left the Resident unattended when they went to get the crash cart and confirmed RN A did not stay at the Resident's bedside. When queried regarding RN A, LPN C revealed they were very scattered. When asked if they were familiar with Resident #705, LPN C indicated they were and stated, (Resident #705) was doing really good and indicated their medical condition had been improving. When asked if there was anything else they recalled about the Resident and/or what occurred, LPN C stated, There was mottling (discolored, blotchy/marbled appearance on the skin due to the heart pumping ineffectively and decreased blood pressure which is often first seen in the feet and travels upward. Commonly seen in the final days or hours of life) and discoloration in (Resident #705's) legs and that is not instant. When queried if a vital sign machine, SPO2 monitoring device, and/or suction machine were present in Resident #705's room when they first went in after hearing RN A yelling, LPN C stated, No. When queried if Resident #705 had oxygen in place when they entered the room, LPN C replied, No. LPN C was asked when oxygen administration was initiated and replied, (LPN G) did with the ambu bag (hand-held medical device used to push air into the lungs of patients who are not breathing or are struggling to breathe adequately). When queried who initiated compressions, LPN C replied, Me. LPN C revealed the DON and ADON showed up after they started compressions. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with the DON on [DATE] at 2:00 PM. When queried regarding RN A, the DON revealed they had been a nurse for over [AGE] years, had worked at the facility in the past, and recently returned. When queried regarding Resident #705's death in the facility, the DON revealed they were in the facility and responded when the Code Blue was called. When asked why they were in facility, the DON indicated they were covering staffing along with other members of nursing management. When asked what occurred when Resident #705 passed, the DON referred to the timeline in the EMR progress note and the I and A provided. The interview completed with RN A was reviewed with the DON at this time. After review of RN A's statements, the DON stated, That is not what (RN A) told me. When queried regarding RN A's focus upon the Resident's family member during the completed interview and scattered thoughts, the DON confirmed RN A's responses were scattered. When queried regarding the timeframe between when RN A and CNA B provided care and RN A returned to the room and when the code was called at 05:08 AM, the DON was unable to provide an explanation. When queried regarding the lack of implementation of interventions and actions in that timeframe, the DON verbalized confirmation of concern. When asked why RN A did not document anything in Resident #705's EMR pertaining to the change in condition, RN A did not provide further explanation. When queried if the facility had video footage of the hallway available to review to determine when staff were in the room, the DON stated they would need to get it from the Administrator. An interview was completed with the facility Administrator and DON on [DATE]. When queried regarding video footage of Resident #705's hallway on [DATE], the Administrator verbalized the footage was not available as it is only saved in the system for 48 hours. When queried if the footage had been reviewed as part of the facility investigation, the DON revealed they did not review the footage. The Administrator and DON then stated they contacted RN A. The Administrator stated, (RN A) told me something completely different than what they told you or their original statement regarding Resident #705's death when they asked what happened. Both the Administrator and DON verbalized RN A's conversation and responses were varying and scattered. The DON was then asked if they noticed any abnormalities pertaining to Resident #705's skin when they were in the room and stated, There was mottling in their legs. When asked if mottling occurs immediately, the DON indicated it does not. When asked why a head-to-toe nursing assessment was not completed and documented by RN A when the Resident first displayed a change in condition and respiratory status, RN A confirmed an assessment should have been completed but did not provide further explanation. When queried regarding the timeframe between when Resident #705's change in condition and respiratory status was first noted and the delay in assessment, interventions and actions, both the DON and Administrator verbalization confirmation of concerns. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was completed with CNA B on [DATE] at 9:42 AM. When queried if they were working with Resident #705 on [DATE] when they passed, CNA B confirmed they were. CNA B was asked what happened and stated, I went in there (Resident #705's room) and then went and got the nurse (RN A) because (Resident #705) wasn't breathing right. When queried what happened next, CNA B replied, Me and the nurse went (in Resident #705's room) and did care. When asked what care was provided, CNA B revealed they could not remember if RN A put a patch on Resident #705 or if they just pulled the Resident up in bed. CNA B then stated, (Resident #705) wasn't breathing so good but (RN A) said they were fine. CNA B then stated, I gathered my linens and stuff and could still hear (Resident #705) breathing funny but (RN A) left out of there. CNA B then stated, I told the nurse, so I left the Resident's room. With further inquiry regarding how the Resident was breathing funny, CNA B indicated Resident #705 was breathing fast and noisily. When queried if vital signs were obtained at this time, CNA B responded they had not. CNA B reiterated they informed RN A about the change in the Resident's condition and RN A told them the Resident was fine. When queried what happened after both RN A and they left the Resident's room, CNA B stated, About 25 minutes later, (RN A) ran out of (Resident #705's) room yelling. CNA B revealed a Code Blue was called at that time and multiple facility staff responded. Review of facility provided policy/procedure entitled, Death of Resident (Reviewed/Revised [DATE]) revealed, Policy: Appropriate documentation shall be made in the clinical record concerning the death of a resident . 8. The person removing the deceased resident from the facility must sign the release for the body, and the release must be filed in the resident's medical record.

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NAME OF PROVIDER OR SUPPLIER: Medilodge of Montrose Inc		STREET ADDRESS, CITY, STATE, ZIP CODE: 9317 W Vienna Rd, Montrose, MI 48457	

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37668 This Citation Pertains to Intake Number MI00150264. Based on observation interview and record review the facility failed to ensure an operational call light system in the short-term units of the facility (100, 200, 300, and 400 hallways). Findings include: Review of intake documentation detailed a concern that Call lights have been broken for a month and Care is not properly given due to the call lights being broken. The intake further detailed the pager call light notification is delayed and/or non-functional. During an observation of the central area of the short-term units of the facility (100, 200, 300, and 400 hallways) and nurses' station on [DATE] at 1:00 PM revealed no central call light monitoring screen/monitoring system. There were no visual light indicators outside of the rooms in the hallways. On [DATE] at 1:13 PM, an interview was completed with Registered Nurse (RN) I. When queried regarding the call light system, RN I revealed the facility used a pager system and there were no lights and/or indicators in the hallway showing when a call light was on. RN I then revealed the central call light monitoring screen was broken and stated, It's (call light system) been down for a month or two. When queried how they knew when a Resident needed assistance if they were unable to view call lights on the screen, RN I revealed they only know when they go into a room. With further inquiry regarding the pager system, RN I indicated Certified Nursing Assistants (CNA's) have pagers. When asked if they had a pager, RN I replied, No, I have a walkie. When asked if the walkie-talkie was connected to the call light system, RN I replied that it was not. RN I stated, Nurses and managers have walkie. When queried how long nurses and managers have had walkie talkies, RN I replied, Got yesterday. When queried if the Certified Nursing Assistants (CNA's) also had walkie talkies, RN I responded that they did not. When asked how CNA staff got a hold of them in an emergency situation, RN I stated, No code button so (nurses) don't know unless they start yelling or come find them. An interview was completed with Certified Nursing Assistant (CNA) J on [DATE] at 1:24 PM. When queried, CNA J verbalized they were working on the 300 tracheostomy (surgically created opening in the front of the neck to the trachea with placement of a tube to facilitate breathing) hall of the short-term unit of the facility. When asked to see their pager, CNA J stated, I don't have one. When asked why they did not have a pager, CNA J revealed there were no pagers available. CNA J was asked how they know when a resident needs assistance and replied, Just have to check. CNA J revealed the only way they knew if a resident had their call light on was if they went into the Resident's room. CNA J then stated, The people who have a pager can let me know if one of my resident's call lights are on but it can take 20 minutes for someone to tell me. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 1:30 PM, an interview was conducted with CNA K. CNA K was working on the 100 hallway of the short term unit of the facility. When asked to see their pager for the call light system, CNA K stated, Don't have one. When queried how they know if one of their assigned residents needed assistance, CNA K revealed they try to do more frequent rounds but do not if a call light is on unless they are in a resident's room. An interview was completed with CNA L on [DATE] at 1:35 PM. CNA L was working on the short-term unit. When asked if they had a call light pager, CNA L stated, No. On [DATE] at 1:37 PM, an interview was conducted with RN N. When queried how they knew when a resident had their call light on, RN N responded that they did not know unless they went into the room. RN N revealed they were able to see which resident had their call lights on previously by looking at the screen in the central area of the unit, but the screen stopped working appropriately one month before. RN N stated the Director of Nursing (DON) and Infection Control Nurse O informed staff that the screen was not able to be repaired and/or replaced. At 1:59 PM on [DATE], an interview was completed with CNA P. When asked to see their call light pager, CNA P stated, I don't have one. When queried how many residents they were assigned to care for, CNA P stated, 15. CNA P was asked how they know if a Resident needs assistance, CNA P responded they do not know unless they are in the room. An interview was conducted with CNA M on [DATE] at 2:07 PM. CNA M revealed they were the only CNA assigned to the 200-hall. When asked if they had a pager for the call light system, CNA M removed a pager from their pocket and verbalized they had the 200-hall call light pager. When queried how the pager worked, CNA M stated, Get 200 (hall) calls immediately, delay for other halls. When asked to clarify, CNA M explained that call lights from the other halls (100, 300, and 400) on the unit will show on the 200-hall pager after a time delay if the call light is not answered. When queried how long the delay is, CNA M indicated they were not sure. In order to determine the delay in call light pager notification from a different hall on the unit, a call light on the 400 hall of the facility was activated at 2:09 PM. After call light activation, CNA M revealed CNA staff working on the short-term unit of the facility are sometimes able to use the department head call light pagers but revealed the department head call light pagers do not immediately notify staff when a call light is activated. When asked how long the delay is between a resident activating their call light and notification on a department head pager, CNA M stated, 10 to 15 minutes. Ongoing observation of CNA M's call light pager revealed the call light activated on the 400-hall of the unit did not show on the 200-hall pager until 2:19 PM, 10 minutes after activating the light. On [DATE] at 6:00 PM, an interview was completed with CNA Q. When queried, CNA Q revealed they frequently work on the short-term unit of the facility. When queried regarding the call light system and pagers, CNA Q revealed there is only one pager for all the halls on the unit. CNA Q revealed residents who are able will message them on their personal phone when they need assistance because the call light system does not work. When queried how residents who are unable or do not have a cell phone are able to reach them, CNA Q indicated they make frequent rounds and do the best they can to frequently check on residents. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 8:45 PM, an interview was completed with CNA E. When queried regarding the facility call light system, CNA E stated, There is no central call system on the short-term units. CNA E was asked how they know if a Resident needs something and stated, We only know that the lights are going off when we go in the room. When queried if management/administration are aware, CNA E responded that the DON, Administrator, Unit Managers, and everyone were aware. CNA E then stated, We brought it to the Maintenance Directors attention, and they said its corporate and they cannot do anything. When asked how long the call light system had not been working in the short-term hallways of the facility, CNA E replied, It has been out for like a month. CNA E added, Even if you have a pager, they aren't accurate. When asked what they meant, CNA E replied, The pagers don't tell you how long a light has even been going off. CNA E was then asked how many pagers there are for the facility and revealed they did not know the specific number but verbalized there are not enough for each staff member to have one. When queried regarding observation of only one pager being available during the day shift on the 200 hallway, CNA E stated, That sounds about right. CNA E then stated, Sometimes we can use the um pager but there is a delay in when that even goes off. When asked what they meant by a delay, CNA E stated the unit manager pager does not go off until the light has been on for 15 minutes and no one has responded. With further inquiry, CNA E stated, They gave some people bells but that doesn't really work because you can't hear it if you are in a room or helping someone on other hall. When asked, CNA E explained there is Only have one CNA per hall and lots of (residents are) 2 assists. CNA E verbalized the facility Administration seemed to care more about money than the residents and stated, That place has gone from a place where I thought people cared and now it is a place where I wouldn't even put my dog. At 3:00 PM on [DATE], an interview was completed with the facility Administrator and Director of Nursing (DON). When queried regarding the pager call light system on the short-term unit of the facility, the Administrator and DON verbalized all CNA staff should have pagers for their halls which signal the staff when a call light is activated. When queried if licensed nurses should also have pagers, the Administrator indicated nurses have walkie talkies. With further inquiry, the Administrator and DON confirmed the walkie talkies are not connected to the call light system but are intended to allow staff to communicate with each other. When queried why CNA's do not have walkie talkies, the Administrator revealed the walkie talkies are new and that All staff will have walkies in the future. When asked about the screen in the central area of the unit, both the Administrator and DON confirmed the screen used to display the call lights for the unit but no longer functioned. When queried why only one CNA on the 200-hall of short-term unit of the facility has a call light pager, both the DON and Administrator verbalized all CNA's should have a pager. The Administrator and DON were then informed of staff statements that there were no pagers available. When queried regarding the facility procedure for obtaining a pager, the DON and Administrator revealed the pagers are kept in a drawer and staff sign out a pager when they start their shifts. Upon request, an observation of the pager drawer was completed with the Administrator and DON. There were no pagers for the short-term unit of the facility (100, 200, 300, and 400 halls) in the drawer. A pager sign out book was present and reviewed. Review of the log revealed the last date a pager was signed out was on [DATE] and the last date a pager was signed out for the short-term unit was on [DATE] and specified the 200-hall. An interview was conducted with the Administrator on [DATE] at 8:10 AM. When queried regarding the lack of call light pagers and inability of residents and staff to call for assistance, the Administrator verbalized understanding of safety concerns and revealed they were hoping to replace the call light pager system. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 8:27 AM, an interview was conducted with Maintenance Director H. When queried regarding the facility call light pager system, Maintenance Director H verbalized they were new to the role and not familiar with the pager system for call lights. When asked if they were aware of staff not having pagers available for use, Maintenance Director H revealed the Administrator had purchased replacement pagers, but they were unable to program them. With further inquiry, Maintenance Director H revealed they contacted the call light company and stated the company is sending a new docking station for pager programing because we can't program them (pagers) with the current docking station. Maintenance Director H indicated the company would provide training for pager programming. Maintenance Director H was asked when the new docking station would arrive and when training would be completed, Maintenance Director H replied, They will be out next week. Review of facility policy/procure entitled, Call Lights: Accessibility and Timely Response ([DATE]) revealed, Policy: The purpose of this policy is to assure the facility is adequately equipped with a call light at each residents' bedside, toilet, and bathing facility to allow residents to call for assistance. Call lights will directly relay to a staff member or centralized location to ensure appropriate response. Policy Explanation and Compliance Guidelines: 1. Staff are educated in the proper use of the resident call system, including how the system works and ensuring resident access to the call light . 5. Staff will report problems with a call light or the call system immediately to the supervisor and/or maintenance director and provides immediate or alternative solutions until the problem can be remedied . (Examples include replace call light, provide a bell or whistle, increase frequency of rounding, etc.) 6. Ensure the call system alerts staff members directly or goes to a centralized staff work area. 7. 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.