

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 634480	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 3/13/2025
NAME OF PROVIDER OR SUPPLIER MEDILODGE OF SOUTHFIELD			STREET ADDRESS, CITY, STATE, ZIP CODE 26715 GREENFIELD RD SOUTHFIELD, MI 48076	
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F0000 SS=	INITIAL COMMENTS Medilodge of Southfield was surveyed for an Abbreviated survey on 3/13/25 Intake Number(s): MI00150901, MI00151135, MI00151140, MI00151161. Census = 146	F0000		
F0609 SS= D	Reporting of Alleged Violations §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c) (4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by:	F0609	Element 1 -R801 no longer resides in the facility. - Facility unable to identify an allegation of abuse for the "unidentified resident" Element 2 -On 3/12/2025, all residents who are able to report abuse were queried about feeling safe and free from abuse by staff. No additional concerns and/or allegations noted. -For residents who are unable to report abuse, skin assessments were completed by a licensed nurse for any signs or symptoms of abuse. -This was completed on 3/12/2025 Root Cause: Facility did not follow the Abuse, Neglect, and Exploitation Policy. Element 3 -The Abuse, Neglect, and Exploitation Policy was reviewed by QAPI Committee on 3/12/25 and deemed appropriate. - Staff were re-educated on the Abuse, Neglect and Exploitation policy by management staff with emphasis on types of abuse, reporting abuse, and also included staff testing after education, and an in-service card being handed out.	3/18/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

03/25/2025

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.

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	<p>This citation pertains to Intake Number(s): MI00150901, MI00151135, MI00151140, MI00151161.</p> <p>Based on interview and record review, the facility failed to report multiple allegations of sexual abuse by a staff member to the Abuse Coordinator and/or State Survey Agency in a timely manner for one (R801) of four residents reviewed for abuse, and one unidentified resident, resulting in a delay in investigation and R801 exhibiting signs of fear and distress when a male Certified Nursing Assistant (CNA) regularly assigned to the unit continued working after the allegations were made. Findings include:</p> <p>A review of a complaint submitted to the State Agency on 3/5/25 revealed allegations that a male staff (Certified Nursing Assistant - CNA 'E's first name only) touched R801's breast on two separate occasions. No additional details were given at that time.</p> <p>On 3/11/25 at 5:30 PM, the complainant was interviewed. The complainant reported R801 told them on two separate occasions that CNA 'E' touched her breasts. The complainant explained the first time, which was about 2-3 weeks ago, they just thought R801 was confused and did not report it to the Administrator/Abuse Coordinator. The second time, R801 mentioned CNA 'E' touching her breasts while in front of CNA 'E' and according to the complainant, CNA 'E's reaction was suspicious and R801 appeared more agitated when CNA 'E' was around. The complainant reported they notified the Administrator on 3/4/25, the same day R801 reported the allegation a second time. The</p>		<p>-This was completed by 3/17/2025 or prior to their next scheduled shift.</p> <p>Element 4 -Random weekly audits of staff will be conducted for 4 weeks, then monthly thereafter to ensure there are not any allegations of abuse coordinator until substantial compliance is obtained.</p> <p>- Results of the audits will be brought to the QAPI committee for monthly review and will only be discontinued with subsanital compliance and the approval of the facility's QAPI committee.</p> <p>-Administrator is responsible to maintain compliance.</p>	

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	<p>complainant explained they contacted the State Agency because the Administrator did not seem to take the report seriously and did not write anything down so they wanted to ensure it was investigated. The complainant explained R801 had dementia, but did not typically complain about things or people and was usually pleasant.</p> <p>A review of a complaint submitted to the State Agency on 3/11/25 revealed allegations that R801 was sexually abused by a male staff member at the facility. It was noted that the complainant was contacted by the facility's Administrator who informed them of allegations that R801's "breasts were played with, oral sex was performed on her and other sexual abuse".</p> <p>On 3/12/25 at 7:17 AM, the complainant was interviewed via the telephone. The complainant explained on 3/10/25, the facility's Administrator contacted them and said R801 was sexually abused by a male staff member who "played with her breasts and performed oral sex". The complainant reported R801 typically had a "sunny demeanor" but was selective about who she spoke to. The complainant was present in the facility when Physician 'I' performed an evaluation on R801 and explained R801 started crying and screamed, "Don't let them hurt me. Please don't let them hurt me." The complainant reported a change in R801's disposition for approximately 2 weeks noted by increased agitation with people and talking less. The complainant said they initially thought it was due to dementia, but was now concerned it was a trauma response after hearing about the allegations. According to the complainant, R801 reported multiple times that someone touched her</p>			

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	<p>genital area and referred to the area by using a slang word for vagina in Arabic.</p> <p>A review of a complaint submitted to the State Agency on 3/11/25 revealed allegations that an unknown male staff member was "caught sexually assaulting (R801) by another staff member...the male staff had his mouth on (R801's) genital area and there was some form of penetration".</p> <p>A review of a complaint submitted to the State Agency on 3/12/25 revealed allegations that "Within the past 24 hours, an employee had been touching multiple patients' breasts and vaginas. There is concern that (R801) may be one of the persons that was touched appropriately".</p> <p>An unannounced onsite investigation was conducted on 3/12/25 and 3/13/25.</p> <p>A review of R801's clinical record revealed R801 was admitted into the facility on 10/21/21 and discharged on 3/10/25 with diagnoses that included: dementia. A review of a Minimum Data Set (MDS) assessment dated 1/30/25 revealed R801 had clear speech, was sometimes understood and sometimes understood others, had severely impaired cognition, no behaviors, and required staff assistance for activities of daily living.</p> <p>A review of an "Encounter" progress note written by Physician 'I' on 3/11/25 revealed, "...Chief Complaint/Nature of Presenting Problem: concern for assault...I received a phone call yesterday from the facility administrator that (R801) had spoken to a staff member today indicating that she had been touched inappropriately by one of the</p>				

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	<p>staff members in the area of her breasts and genital area. She apparently became extremely upset when describing this...I received a call in the afternoon to come to the facility to examine (R801). Her daughter and her niece were present in the room during this exam. (R801) was very upset and agitated during the brief examination, more so than her usual level of anxiety and agitation...The exam was a visual exam and there was no palpation because (R801) appeared to be very upset and it was my impression that performing any palpation would further upset her..."</p> <p>A review of a "Social Services Progress Note" dated 3/10/25 at 11:35 AM revealed, "SW (Social Work) spoke to resident regarding a reported incident. Individual provided SW with information regarding the reported incident..."</p> <p>A review of a "NHA (Nursing Home Administrator) - Asst. (Assistant) NHA" progress note dated 3/10/25 revealed, "Admin informed of an alleged incident with the resident..."</p> <p>A review of a "Nurses' Notes" progress note dated 3/10/25 revealed, "New orders to transfer to hospital per family (for pelvic exam and rape kit). (Physician 'I') in to examine. No noted trauma to peri-area."</p> <p>On 3/12/25 at 11:37 AM, an interview was conducted via the telephone with the alleged perpetrator, CNA 'E'. CNA 'E' expressed they were "highly upset" because they were accused of touching a resident. CNA 'E' stated, "I didn't come here for that. These residents are sporadic and have a lot of behaviors and emotions. I am a fairly</p>				

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	<p>attractive male CNA so I know where these kinds of things (allegations) come from. It is upsetting how hard I work and how seriously I take my job to be accused of touching a resident". CNA 'E' continued and reported doing rounds and changed R801's brief. When queried about the date they were referring to, CNA 'E' did not offer a response and continued talking. CNA 'E' reported they changed R801's brief and after they completed the brief change R801 was "delusional and saying things out loud". CNA 'E' explained they did not think anything of it and ignored what R801 said. When queried about what R801 said, CNA 'E' said R801 "said something like 'You know what you did?' and I didn't do anything to this particular resident". CNA 'E' further explained that the next time R801 saw them in the activities room she yelled out, "I hate you!" in front of other staff and residents. CNA 'E' stated, "I can see how that would alarm someone". CNA 'E' further reported they typically "ignored" what residents said because they were on the dementia unit then stated, "I was shocked! I work too hard to do that. With all the young ones around, I'm not going to do that to a resident". CNA 'E' then began talking about other staff members who were suspended before. CNA 'E' stated, "I'm confident in my word".</p> <p>A review of the nursing staff assignment sheets from 2/15/25 through 3/10/25 revealed CNA 'E' was only assigned to R801 on 2/17/25 which was consistent with the documentation made in R801's clinical record.</p> <p>On 3/12/25 at 1:17 PM, an interview was conducted with Physician 'I' via the telephone. Physician 'I' reported they did a</p>			

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	<p>visual examination of R801 on 3/10/25 after there were allegations that R801 was touched inappropriately. Physician 'I' reported R801 was more tearful and agitated than normal.</p> <p>A review of an investigation started by the facility revealed the following:</p> <p>A "Statement of Witness" dated 3/10/25 documented in interview of R801 conducted by Social Services Director (SSD) 'B'. It was documented R801 "informed social work that a male touched her on her private area. Resident was asked where. Resident pointed down at her genitals. Resident then shouted, 'He was playing with it with his mouth". Resident then proceeded to cry. Social Worker proceeded to ask if she knew the male. Resident stated that she did not know the name of the individual. Social Worker asked resident if individual was giving care to her; resident answer (stated) no."</p> <p>A "Statement of Witness" dated 3/11/25 documented an interview with Activity Director (AD) 'A' conducted by the Administrator that noted, "On Friday, 3/6/25, (Activity Aide - AA 'D') informed me of incident on 2 North with a resident (R801) stating a staff member (CNA 'E') was touching her. I informed (AA 'D') to address the concern with the Abuse Coordinator (Administrator). (AA 'D') informed me Abuse Coordinator was in a meeting at the time and was unable to speak with her</p> <p>On 3/12/24 at 2:05 PM, an interview was conducted with AD 'A'. AD 'A' reported they began working in the facility in August 2024. When queried about the facility's protocol when any allegation of abuse was made, AD</p>			

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	<p>'A' reported all allegations were reported to the Administrator. When queried about whether any staff or residents every reported any allegations of abuse to them, AD 'A' reported one of their employees told them about an allegation and they were instructed to notify the Administrator. When queried about what was reported to them, AD 'A' said a resident was shouting out "He touched me. He touched me." AD 'A' explained the staff member who reported it to them was AA 'D' who attempted to notify the Administrator, but said the Administrator was in a meeting. AD 'A' reported they told AD 'D' to make sure the Administrator was notified and left for the day. AD 'A' reported they did not notify the Administrator because they told AA 'D' to, but AA 'D' only worked a couple days a week so they were not sure if it was every reported.</p> <p>On 3/12/25 at 2:15 PM, an interview was conducted with SSD 'B'. SSD 'B' reported on 3/10/25, they received a notice from the Administrator to follow up with R801 regarding allegations of abuse. SSD 'B' reported R801 was selective in who they talked to and SSD 'B' had good rapport with R801. SSD 'B' asked R801 what happened and R801 began crying. SSD 'B' explained they were careful not to ask leading questions and R801 reported a man touched her "down there" (and pointed to her genital area) "with his mouth" (and pointed to her mouth).</p> <p>On 3/12/25 at 2:55 PM, an interview was conducted with AA 'D' via the telephone. AA 'D' reported R801 alleged CNA 'E' touched her breasts on two separate occasions. When queried about whether they reported the allegations to anyone, AA 'D' reported she notified her manager (AD 'A') and the</p>			

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	<p>Administrator on 3/4/25 or 3/5/25. AA 'D' explained when they reported R801's allegations to AD 'A', a social worker (later identified as Social Service Assistant - SSA 'J') and another activities aide were in the room. AA 'D' explained SSA 'J' who was in the room said a female resident on the same unit as R801 said a CNA raped her. When queried about the interaction with the Administrator when the allegations made by R801 were reported, AA 'D' explained they went to the Administrator's office, knocked on the door and asked if they could talk to them for a minute. The Administrator was rude and said "No. We are in a meeting." AA 'D' reported they walked away from the door and they were going to find a piece of paper to write the concern on and slip it under the Administrator's door but instead of going home, they stayed in the building. AA 'D' explained they verbally told the Administrator about R801's allegation of sexual abuse (CNA 'E' touching her breasts) and they did not write anything down. After that AA 'D' went home. AA 'D' further reported AA 'K' had concerns about CNA 'E' and R801 that they heard about.</p> <p>On 3/12/25 at 4:05 PM, an interview was conducted with SSA 'J'. When queried about what she knew about allegations made by R801, SSA 'J' reported they were in the office with AD 'A' when an activities staff came in and said they wanted to report abuse allegations. SSA 'J' said the staff member said a male staff member touched R801 inappropriately. SSA 'J' denied any allegations expressed to them from residents. When queried about whether they notified the Administrator about the allegations reported by the activities staff, SSA 'J' reported they did not report to the</p>				

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	<p>Administrator because the activity staff reported it to their manager and "I was just in the room".</p> <p>On 3/12/25 at 4:23 PM, an interview was conducted with AA 'K'. When queried about any allegations made by R801, AA 'K' said they were sitting upstairs "a week or two ago" in the activity room with R801 and other residents. AA 'K' further reported when CNA 'E' would walk into the room, R801 would become agitated and started cussing at him and stated, "He's stupid! He's a dumbass! I hate him!" AA 'K' asked R801 what was wrong and R801 replied, "Do you really want to know? He comes to my room and rips my clothes off. He's a rapist!". When queried about whether AA 'K' reported R801's allegation of sexual abuse to anyone, AA 'K' said they did not and stated, "It was time for me to go, so I left." AA 'K' explained a coworker had similar concerns that they were going to report to the Administrator so AA 'K' assumed the Administrator was aware.</p> <p>On 3/13/25 at 10:36 AM, an interview was conducted with the Administrator who was the designated Abuse Coordinator for the facility. When queried about the facility's protocol if staff became aware of allegations of abuse, the Administrator reported staff were supposed to tell them immediately and their phone number was posted in the facility. They could call, text, come to the office, or put a statement under the door if it was closed. When queried about who was responsible to report reasonable suspicion of a crime to law enforcement and the State Agency, the Administrator reported they were responsible but anyone was allowed to make a report. When queried about when and how they became aware of the sexual abuse</p>				

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	<p>allegations made by R801, the Administrator reported on Monday (3/10/25) the unit manager notified them that they police were in the building. The police said they were there to interview R801 because they received report of allegations of abuse. The police said they received a call from Adult Protective Services (APS) that someone anonymously reported that a staff member named (CNA 'E's first name) touched R801's breasts. The Administrator reported they had a CNA by that name (CNA 'E'). According to the Administrator, the police reported they received the report the week prior to when they came to the facility. The Administrator further reported after the police showed up, SSD 'B' interviewed R801 who said a male put his mouth on her genitals. The Administrator explained at that time, they reported the allegations to the State Agency. When queried about why CNA 'E' was the only male suspended when there were two other male CNAs who worked on the unit where R801 resided, the Administrator reported because CNA 'E's name was what was reported to police. When queried about what was reported the week prior by activities staff, the Administrator stated, "Nothing". The Administrator explained AA 'D' came to their office door but they were in a meeting. According to the Administrator AA 'D' did not return or report any allegations of abuse to them. The Administrator said no staff member reported any sexual abuse allegations to them, but somebody reported to the police and APS.</p> <p>On 3/13/25 at 1:30 PM, a second interview was conducted with the Administrator. The Administrator reported that when AA 'D' reported sexual abuse allegations made by R801 to AD 'A', in the presence of SSA 'J', all</p>				

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	<p>staff that were aware of the allegations should have reported to the Administrator immediately.</p> <p>A review of a facility policy titled, "Abuse, Neglect and Exploitation" revised 1/10/24 revealed, in part, the following, "...The facility will make efforts to ensure all residents are protected from physical and psychosocial harm, as well as additional abuse, during and after the investigation...The facility will have written procedures that include...Reporting of alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (e.g. law enforcement when applicable) within specified timeframes as required...Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury...Promoting a culture of safety and open communication in the work environment prohibiting retaliation against any employee who reports a suspicion of a crime..."</p>				