

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 4/24/2025
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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 4/24/25. Intakes: MI00152290, MI00149734, MI00149776, MI00149930, MI00150606, MI00151103, MI00151220. Census=147	F0000		
F0677 SS= D	ADL Care Provided for Dependent Residents §483.24(a)(2) 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; This REQUIREMENT is not met as evidenced by: This citation pertains to intake# MI00151103. Based on interview and record review, the facility failed to ensure incontinence care was provided in a timely manner for one resident (R905) of two residents reviewed for Bowel and Bladder. Findings include: On 4/24/25 a complaint submitted to the State Agency was reviewed which alleged R905 was left soiled when a Certified Nursing Assistant (CNA) had refused to provide incontinence care on 2/25/25.	F0677		

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

TITLE

(X6) DATE

Electronically Signed

05/07/2025

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>On 4/24/25 the medical record for R905 was reviewed and revealed the following: : R905 was initially admitted to the facility on 8/26/22 and had diagnoses including Brain damage and Muscle weakness. A review of R905's MDS (minimum data set) with an ARD (assessment reference date) of 3/5/25 revealed R905 was dependent on staff for all of their activities of daily living. R905's cognition was documented as severely impaired.</p> <p>A review of R905's comprehensive careplan revealed the following: "Focus-[R905]/Resident incontinence related to Quadriplegia. Date Initiated: 02/14/2025....Interventions-Assist resident with toileting needs. Date Initiated: 02/14/2025..."</p> <p>On 4/24/25 at approximately 10:19 a.m., R905's legal guardian (LG) was queried if they had been made aware of R905 being left soiled by a CNA on 2/25/25 and they reported they had been and the afternoon Nurse that day had informed them about it. R905's LG indicated that the day shift CNA did not change R905 and had left them soiled and had been disciplined for the failure to provide the care. R905's LG reported they had walked into R905's room, they were still soiled from the day shift and two other CNA's from the afternoon shift had to come in and clean R905 up and complete the brief change. LG indicated they had let management know and had written the</p>			

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	<p>concern on a form.</p> <p>On 4/24/25 at approximately 11:15 a.m., Nurse "A" was queried regarding R905 being left soiled during the day shift on 2/25/25. Nurse "A" reported that they were the Nurse assigned to R905 that day and that they had asked CNA "C" to do a brief change and clean up R905. Nurse "A" indicated that when they went to check on R905 before they left for shift change, R905 was still soiled and CNA "C" had left the unit without informing them. Nurse "A" indicated they had left R905 soiled and their guardian had come in at the start of the afternoon shift (after 3:00 PM) and they were upset that R905 was still soiled and had not been changed. Nurse "A" reported that they had reported the incident to management and that they had disciplined CNA "C" for the failure to provide care.</p> <p>On 4/24/25 at approximately 12:06 p.m., during a conversation with the facility Administrator, the Administrator was queried regarding the incontinence care concern for R905 that had been submitted to them in a grievance form. The Administrator reported that Nurse Manager "B" (NM "B") had handled most of the investigation and CNA "C" was terminated for not providing the care to R905 that Nurse "A" had instructed them to provide.</p> <p>On 4/24/25 at approximately 12:25 p.m., NM "B" was queried regarding the allegation that CNA "C" did not provide care for R905 on</p>			

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	<p>2/25/25. NM "B" reported they were aware of the concern and reported that CNA "C" failed to provide incontinence care as instructed by Nurse "A" and as a result was terminated from the facility.</p> <p>On 4/24/25 a concern/quality assistance form filled out by R905's LG dated 2/25/25 was reviewed and revealed the following: "Assistance Needed [Care]...Details: On Tuesday, February 25, 2025, I arrived at the facility about 3:45 p.m. When I got to the unit, the Nurse for second shift pulled me to the side and said to me that before I go to my sisters room that she hasn't been cleaned up. The Nurse from first shift which was [Nurse "A"] was still there and working with cleaning her up as well as writing up the aide. She stated that the Nurse [Nurse "A"] told the aide to clean her up and the aide left out quickly without doing it....I went to her room and [Nurse "A"] and [CNA] was in there. My sister was soiled heavily everywhere. The stool was going up her stomach, was in her peg tube, on her gown, all under her lap and the pillow under her knees. It was awful.... [Nurse "A"] told me what happened....She said she's upset because she told the aide to clean her up and if she needed help she would have helped her. When [Nurse "A"] went into the room the next time she saw that she hadn't been cleaned up and the girl left....This is the second time that someone has left my sister soiled....People don't want to do their job, or don't want to help my sister that can't do for herself. I am</p>			

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	<p>requesting that the Unit Manager do rounds before the end of the morning shift to see if my sister has been changed. It's not fair to her and she or anybody doesn't deserve that kind of treatment.....Findings:...Charge Nurse provided info that day shift CNA was given directive to care for resident which was not provided...Plan/Actions: Discharge of CNA. Care was provided by other team members. Continue to provide check and changes in a timely manner...."</p> <p>A facility document titled "Performance Improvement Form" dated 2/26/25 for [CNA "C"] was reviewed and revealed the following: "Reason for Counseling/Corrective Action-Employee was given directive by the charge nurse to render care to a resident in room [R905's room] on 2/25/25. Employee was also instructed to let the Nurse know when the task was complete as the residents sister was coming for a visit. These instructions were given at approx. (approximately) 2:40 PM. Employee failed to follow the directive and failed to render care to a dependent resident, residents' sister came into the room and seen that her loved one was not cared for and was soiled....This is a violation of the employee handbook standards of conduct: Failure to render care to a resident and refusing a directive by a facility supervisor....Corrective Action Plan-Employee will be discharged. Failure to follow directive given by a facility supervisor, failure to render care to a resident and unsatisfactory probationary period...."</p>			

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	During the onsite survey, past noncompliance (PNC) was cited after the facility implemented actions to correct the noncompliance which included termination of CNA "C" and regular rounding by facility management for R905. The facility was able to demonstrate monitoring of the corrective action and maintained compliance since 2/26/25.				