STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	474020	A. BUILDING _____ B. WING _____	5/1/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDILODGE OF HOWELL	1333 W GRAND RIVER HOWELL, MI 48843

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F0000 SS=	INITIAL COMMENTS Medilodge of Howell was surveyed for an Abbreviated survey on 5/1/25. Intakes: MI00151296, MI00151369, MI00151554, MI00152565, MI00152602. Census=167	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	F0609	Element 1: Resident R907□s allegation of abuse has been reported to the State of Michigan. Completed by the Abuse Coordinator on 5/1/2025. Resident R907 has been reviewed for any negative outcomes related to the alleged violation by Social Services / Designee. Care plan has been reviewed and updated as needed by Social Services. Completed by 5/8/2025. Resident R901 no longer resides in the facility. Element 2: All current residents in the facility have the potential to be affected. The facility Administrator / Designee has reviewed all grievance forms for the last 30 days for any reportable incidents. Any reportable incidents were reported. This was completed by the administrator on 5/6/2025. Root Cause Analysis: Facility failed to follow the abuse, neglect, and exploitation policy to report an allegation of abuse within 2 hours of notification.	5/19/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/23/2025

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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	evidenced by: This citation pertains to intake #MI00152565 Based on observation, interview and record review, the facility failed to report allegations of abuse/mistreatment to the State Agency (SA) involving two residents (R901 and R907) of three residents reviewed for abuse/neglect/mistreatment. Findings include: On 5/1/25 a complaint submitted to the State Agency was reviewed which alleged R901 touched R907 inappropriately in their room on the midnight shift between 4/25/25 and 4/26/25 and that R901 was seeking out other women in the facility for sexual activity. R901 On 5/1/25 at approximately 1:22 p.m., R901 was observed in their room, laying in their bed. R901 was queried regarding the night of 4/25/25 into the early morning of 4/26/25. R901 reported they were aware of the night and that he was drinking alcohol in their room with R907. R901 indicated he likes female companionship. R901 was queried if the staff had to come in after R907 was yelling help and he indicated they did but that they did not do anything do them. On 5/1/25 the medical record for R901 was reviewed and revealed the following: R901		Element 3: The Abuse, Neglect, and Exploitation policy was reviewed by the QAPI committee and deemed appropriate on 5/2/2025. The facility administrator was re-educated on the reporting guidelines of abuse by the Regional Director of Operations on 5/7/2025. The Director of Nursing / Designee has re-educated all current employees on the Abuse, Neglect, and Exploitation policy by 5/19/2025. Any current employee who is not re-educated by 5/19/2025 will be re-educated prior to their next scheduled shift. All allegations of abuse and grievance forms are to be reviewed daily, Monday through Friday, in morning meeting and are to be reported by the facility. Element 4: The Administrator will audit up to 5 grievance forms weekly to ensure there are no reportable incidents. Audits will be weekly x4 weeks then monthly thereafter until substantial compliance is achieved. The results of the audits will be reviewed by the QAPI committee for 3 months or until substantial compliance is met. The facility administrator is responsible for compliance.	

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	was initially admitted to the facility on 9/26/24 and had diagnoses including Chronic obstructive pulmonary disease, Heart disease, Major Depression, Alcohol Abuse, Cannabis abuse, other psychoactive substance abuse. A review of R901's progress notes revealed the following: 4/26/2025 at 01:40-"Writer heard commotion from residents room. Writer immediately entered room. Resident was observed in room with other resident [R901] was visibly intoxicated and multiple pints of liquor were observed in and next to bed. Items were confiscated..." 3/24/25 at 18:38-"..."Resident upset throughout entire day about accusations. Would not stop talking to staff and other residents about same issue. Attempted to get nurse to leave another resident's room to talk about it further. Resident swearing throughout the day to staff and other residents. Resident making comments to other resident who he has had multiple issues with. This evening, resident went to main dining room to physically and verbally confront residents who he perceived were causing him trouble. Staff intervened and resident swore at them multiple times and then proceeded to return to room. Resident passed another resident in wheelchair and attempted to swing at him and called him a racial slur but resident in wheelchair was able to move out of the way before contact was			

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	made...." 3/24/2025-"encounter-resident petitioned out. Attempted to make physical contact with another resident. Making verbal and physical threats to staff and residents." 3/22/2025 at 23:36-"resident threatening another resident calling him profanity's and telling him he would put him in the hospital when he was done with him." 2/25/2025 at 06:49-"resident went into another residents room yelling for him to wake up and then began yelling at another resident and antagonizing him cursing profanities." 1/30/20252 at 1:51-Event Date:10/02/2024 Resident had some agitation toward roommate. was telling roommate to shut up and stop talking...." 1/1/2025 at 13:15-"Resident has been out of control arguing with resident in his room. He is yelling for his resident to shut up and he wants staff to tell him to shut up. Resident is yelling down the hall way that we are all ganging up on him . Very difficult to have a reasonable conversation with resident, any conversation at this point is just escalating his behavior. Finally managed to get resident to leave area for a few minutes and return when he has calmed down..." R907			

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	On 5/1/27 at approximately 2:49 p.m., R907 was queried pertaining to the incident with R901. They reported they were in R901's room and drinking and smoking. R907 Stated that R901 wanted them to have one more beer but R907 had wanted to leave but that R901 would not let them and blocked the way out and pinched them. R907 was queried why they had yelled out help and R907 indicated because R901 wouldn't let them leave and they had to get staff to help. On 5/1/25 the medical record for R907 was reviewed and revealed the following: R907 was initially admitted to the facility on 5/21/24 and had diagnoses including Alcohol dependence with alcohol-induced persisting dementia. Further review of R907's medical record revealed R907's husband was their activated power of attorney (POA). R907's BIMS score (brief interview of mental status) was six indicating they had severely impaired cognition. On 5/1/25 at approximately 11:37 a.m., Certified Nursing Assistant "I" (CNA "I") was queried if they were one of the CNA's providing care for R901 on 4/25/25 into 4/26/25 and they reported they were. CNA "I" was queried regarding the incident between 901 and R907 and they reported they heard R907 yelling out for help and when they got to R901's room, they found R907 and R901 in R901's bed but there was a little space between them. CNA "I" stated that both			

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	residents were intoxicated and R901 had liquor in their bed. CNA "I" reported that R907 stated that R901 had inappropriately touched them in bed. They stated that they told the Nurse and that they did a "green sheet" and put it under management's door. CNA "I" was queried if they had informed the Administrator and they indicated they did not but that the Nurse was aware. CNA "I" reported that R901 is a "problem" and is always drinking and trying to talk to females in the building that have dementia. On 5/1/25 at approximately 2:55 p.m., Nurse "J" was queried regarding the incident between R901 and R907 on 4/25/25. Nurse "J" reported that CNA "I" had informed them what had transpired and they went down to the room and R907 informed them that R901 had inappropriately touched them. Nurse "J" indicated they had a skin assessment done on R907 because they were both intoxicated and that they had called the Administrator and told them everything that had happened. Nurse "J" reported that R901 needs a one to one staff member to supervise because they are always drinking and starting fights with other residents and staff. On 5/1/25 at approximately 3:19 p.m., during a conversation with the facility Administrator (abuse coordinator, the Administrator was queried regarding R901's use of profanity and threatening behaviors towards other residents and the incident in which R907's allegation that R901 had inappropriately			

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	touched them while alone in their room. The Administrator indicated that they had been away from the facility for a few days and had not been made aware of R907's allegation until they had a chance to review the staff's "green sheets" (quality assurance forms) that day. The Administrator indicated they would be reporting the allegation at that time, but hat the staff should have informed them of R907's allegation the night that the incident occurred so it would have been reported then. The Administrator indicated they were unaware of any other incidents in which R901 had allegations of reportable incidents. On 5/1/25 a "quality assurance" form dated 4/26/25 filled out by CNA "I" revealed the following allegations between R901 and R907: "Details: I was on [Name of unit] when I heard yelling from [R901's] room about 11:55 p.m., It was [R907]. She was screaming. [R901] was touching her and asking why he was in her room. She was actually in his room. They were both intoxicated. [R901] was trying to hide the empty bottles of alcohol with his body..." On 5/1/25 a facility document titled "Abuse, Neglect and Exploitation" was reviewed and revealed the following: "Policy-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			

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	property...Reporting/Response: A. The facility will have written procedures that include: 1. Reporting of alleged violations to the Administrator, state agency, adult protective services and to all other required agencies....within specified timeframe's as required by state and federal regulations: a. immediately, but not later that two hours after the allegation is made, if the events that cause the allegation involved abuse or result in serious bodily injury, or b. not later than 24 hours if the event that caused the allegation do not involve abuse and do not result in serious bodily injury..."			
F0684 SS= D	Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: This citation pertains to intake #MI00151369 Based on interview and record review, the facility failed to timely address a change of condition for one resident (R#904) of one resident reviewed for a change of condition, resulting in delayed treatment, and failed to ensure the necessary documentation was completed to obtain a medically necessary power tilt recline wheelchair for one Resident (R#905) of two reviewed for	F0684	Element 1: Resident R904 no longer resides in the facility. Resident R905 appeal paperwork and supporting documentation for resident□s specialized wheelchair request has been sent to the vendor by the Director of Rehab on 5/1/2025. Element 2: Director of Nursing / designee reviewed last 7 days of Progress Notes for changes in condition being documented appropriately and timely and with proper notification. Any concerns identified were immediately addressed. Completed on 5/9/2025. Facility has reviewed all current residents that have been evaluated for a specialized wheelchair in the last 60 days to ensure all documentation has been completed timely and if appropriate wheelchair has been provided and care planned.	5/19/2025

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	rehab services. Findings include: On 5/1/25 at 9:20 AM, a review of R904's closed clinical record was conducted and revealed they admitted to the facility on 6/10/24 and most recently discharged to the hospital on 3/23/25. A review of R904's progress notes was conducted and revealed the following: A "Pertinent Charting-Change of Condition" note dated 3/17/25 at 7:43 AM entered into the record by Nurse 'M' that read, " ...Change identified: Confusion ...general weakness, Increased urinary frequency, abdominal cramping ...Assessment: ...Needing 2 people assist with all transfers due to weakness ...Needed to use the bathroom about every hour during the night. c/o (complains of) of pain during urination ...Nursing intervention: Collected urine culture to check for UTI (urinary tract infection)..." A progress note from NP (Nurse Practitioner) NP 'H' entered into the record on 3/18/25 at 12 AM that read, " ...Per nursing pt (patient) has increased confusion for the past few days, most occurs in the evening and at night. UA (urinalysis) & c/s (culture & sensitivity, a test for appropriate antibiotic treatment) ordered, pending result...ASSESSMENTS AND PLANS ...Altered mental status, unspecified: Pt (patient) also c/o (complains of) burning with urination, abdominal pain, ordered ...ua & c/s to further evaluate ..." Three notes entered into the record by the Assistant Director of Nursing (ADON) on 3/18/25 indicated R904 was tired, weak, confused, drowsy, and experienced a change of condition. A progress note dated 3/18/25 at 8:22 AM that read, " ...Resident was confused and disoriented could not stand or make sense of what is around		Root Cause: Facility staff did not timely address a resident□s change in condition. Facility failed to submit additional necessary medical documentation timely to order a power wheelchair. Element 3: The Notification of Change policy and the Provision of Quality of Care policy was reviewed by the QAPI committee and deemed appropriate on 5/2/2025. The DON/Designee has re-educated all current nursing staff on Notification of Change policy by 5/14/2025. Any current nursing staff member not re-educated by 5/14/2025 will be re-educated prior to their next scheduled shift. The DON/Designee has re-educated the IDT team and the Rehab team on the Provision of Quality of Care policy by 5/19/2025. Any IDT team member or rehab staff member not re-educated prior to 5/19/2025, will be re-educated prior to their next working shift. The Medical Director has re-educated the Nurse Practitioner on Antibiotic monitoring and timeliness of follow up. Completed by 5/19/2025. Element 4: The DON/Designee will audit all changes in condition daily, Monday - Friday, to ensure appropriate interventions are placed timely. Audits will continue daily x4 weeks then weekly thereafter until substantial compliance is achieved and the audits are discontinued by the QAPI committee. The DON/Designee will audit all specialized	

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	her ..." A progress note from NP 'H' entered into the record on 3/21/25 at 12 AM that read, " ...Pt is seen today for lab result. Pt?s <sic> urine culture +for uti (positive for a urinary tract infection). Pt admitted to bladder spasm, suprapubic tenderness. Per <Laboratory Name> recommended Cipro (antibiotic) for 3 days ..." Continued review of R904's chart included a review of orders and labs and revealed R904 was symptomatic for a urinary tract infection (mental status change, pain/burning, frequency, abdominal/suprapubic pain) on 3/17/25, NP 'H' ordered a urinalysis and culture & sensitivity lab on 3/17/25, the urine was collected on 3/18/25, the lab picked up the specimen on 3/20/25, the lab reported the results to the facility on 3/20/25, and R904 was started on antibiotics on 3/21/25, four days after symptom onset. Continued review of R904's chart revealed a nursing progress note dated 3/23/25 that read, " ...has been confused for the last couple weeks ...has antibiotics ...advised to send out for evaluation", as well as a second nursing progress note entered into the record on 3/23/25 that read, " ...Event date 03/17/2025 Originally identified change: altered mental status mental status change continues residents vs (vital signs) are residents O2 (oxygen level) was 89%, hr (heart rate) 128, bp (blood pressure) 118/81 ...with the positive uti I wrote the on call provider with concerns of possible sepsis ..." It was revealed through an SBAR (Situation/Background/Assessment/Recommendation) assessment dated 3/23/24 R904 was transferred to the hospital for a change of condition including confusion, heart rate of 128 (Normal value 60-100), low oxygen level, and		wheelchair requests weekly to ensure appropriate documentation is completed and submitted timely. Audits will continue weekly x4 weeks then monthly thereafter until substantial compliance is achieved and the audits are discontinued by the QAPI committee. The Administrator is responsible to maintain compliance.	

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	weakness. On 5/1/25 at 2:50 PM, a telephone interview was conducted with NP 'H' regarding R904's urinary tract infection with signs and symptoms beginning 3/17/25. They were asked if they started any antibiotic treatment based on R904's reported signs and symptoms prior to the urinalysis and culture and sensitivity reports and they said they did not. They were asked to provide their clinical rationale and explained they didn't know for sure R904 had a UTI based on the symptoms and they, "have to wait until cultures come back." They were asked why they had to wait, and if they suspected a UTI could they start antibitotics and either discontinue or change them when the cultures came back. They said they could have started antibiotics if they, "really suspect" a UTI. They went on to say R904's vitals were stable and they didn't have a fever so they decided to wait. They further said, they didn't see any signs or symptoms of R904 going septic, despite R904 exhibiting signs and symptoms of sepsis (rapid heart rate, (pulse 128) difficulty breathing, (oxygen saturation 89%), and documented altered mental status) upon their discharge on 3/23/25. Finally, NP 'H' was asked if they were aware four days passed between symptom onset and the start of the antibiotics due to a delay in the labs and they said they were not aware of that. On 5/1/25 at 3:47 PM, an interview was conducted with the facility's Director of Nursing (DON) regarding R904. They indicated NP 'H' could have started R904 on antibiotics prior to the labs being reported and said the delay in the time of symptom onset and beginning of the antibiotics should not have occurred. They further went on to say they, (DON) and the Assistant Director of Nursing (ADON) saw R904 was declining and had numerous conversations with R904's medical providers throughout the week of 3/17/25 and			

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	3/23/25 regarding R904's condition. They said they received "push-back" from the providers regarding sending R904 out for evaluation and they could not get an order to send them out. When asked why, the DON said the providers wanted to wait until after a scheduled cardiology appointment on 3/21/25 to address her becoming more edematous and the possibility of R904 signing onto hospice. The DON further went on to say R904 should have been transferred out sooner and volunteered their knowledge R904 passed away at the hospital. A request for a policy for addressing a change of condition in timely manner was requested on 5/1/25 at 4:04 PM, and a policy titled, "Notfication of Changes" was provided, however; it did not address the concern of timely assessment, monitoring, and treatment for a change of condition. R905 This citation pertains to Intake #MI00151296. A complaint was received by the State Agency on 3/18/25, which stated R905's additional necessary medical documentation had not been submitted timely to order a power wheelchair, and the process had been initiated five months prior. The complainant reported the provider was canceling the request on 3/18/25, as they had not received the documentation from the facility after numerous requests. The complainant stated R905 could not maneuver a manual wheelchair because three of the fingers on their hands were paralyzed, and they were struggling with coordinating their care and obtaining necessary assistance. Review of R905's Minimum Data Set (MDS) assessment, dated 4/22/25, revealed R905 was admitted to the facility on 7/14/23, with			

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	diagnoses including quadriplegia (partial paralysis from the neck down), traumatic brain injury, seizures, anxiety, and depression. The assessment revealed R905 required set up (with adaptive equipment) with eating and was dependent for toileting and transfers. The Brief Interview for Mental Status (BIMS) assessment revealed a score of 15/15, which showed R905 was cognitively intact. The behavioral assessment showed no behaviors or resistance to care. The skin assessment showed R905 had a Stage 4 pressure ulcer (a deep open wound that extended beyond the skin into the tissues, tendons, and bone). On 5/01/25 at 9:25 a.m., Occupational Therapist (OT) "A" reported they had submitted the vendor requested documentation showing medical justification for R905 to receive a power tilt wheelchair from their insurance provider in November 2024, which they believed was denied. OT "A" explained they newly understood the vendor was sending over a documentation request to them to submit for reconsideration for the power chair on this date (5/01/25). OT "A" clarified R905 had a loaner power chair, but they were not aware how long R905 could keep the chair, and understood R905 needed their own power tilt wheelchair. OT "A" was asked why R905 needed a power tilt wheelchair. OT "A" responded R905 had weakness in both arms and could not push a manual wheelchair without marked fatigue and pain, and needed their own power wheelchair for community mobility, as they went outside the facility in their loaner power wheelchair for medical appointments. OT "A" confirmed R905 had quadriplegia at the cervical (neck) level, with a head injury and seizures. OT "A" clarified R905 could use a power wheelchair with a joystick controller safely and needed the tilt recline feature for pressure relief. OT "A" stated they would resubmit the paperwork on 5/01/25, during the survey. OT "A"			

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	was asked if R905's wheelchair medical necessity appeal paperwork had been submitted timely, and responded, "Yes." Review of R905's Occupational Therapy power wheelchair evaluation, dated 11/04/24, revealed, "The patient (R905) demonstrated the ability to operate a motorized wheelchair safely. Cognition is good due to a score of 28 of 30 on the Montreal Cognitive Assessment (MOCA). (R905) demonstrated adequate strength, active range of motion, gross motor coordination, and fine motor coordination in BUE (both upper extremities) to operate all the controls. Her vision with glasses is within functional limits ..." On 5/01/25 at 9:57 a.m., R905 was observed in their bed in their room. Their head of bed was elevated to approximately 45 degrees, and they were positioned on their back. R905 was wearing only a sheet over their chest, and blankets, which they reported was most comfortable for them, and agreed to an interview. R905 was observed pushing their call light by grasping the cord with their hand and pushing the small red button with their chin. R905 was observed with flexed distal (farthest) digits on their hands. A power wheelchair was observed outside R905's room, with a headrest, joystick control, tilted seat, swing away armrests, foot cradle, elevating footrests, and a pressure relieving gel cushion. On 5/01/25 at 10:00 a.m., R905 was asked about their power wheelchair. R905 reported the process of obtaining a power tilt in space wheelchair for them had begun in July 2025, by their outpatient therapy provider, where they continued therapy until November 2024, and then planned to see therapy in house (in the facility), as they had a therapy prescription from their rehab physician for continued therapy. R905 reported they had a cognitive test completed by			

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	OT "A" in November 2024 and had not seen an occupational therapist since that time. R905 stated they had been in a loaner power wheelchair since November 2024 and were concerned they would not have a power chair soon, as they did not know when the vendor would ask for the loaner power wheelchair to be returned. R905 explained they had believed the facility was completing the necessary paperwork to get them their own power wheelchair until they learned in March (2025) the facility therapy department had not followed through on the paperwork from the vendor. R905 continued they maneuvered their loaner wheelchair down to the therapy department in March (2025) and asked OT "A" why their wheelchair application had not been completed, and was told the paperwork had already been sent over to the vendor for the reapplication, with the necessary documents. R905 contacted the Vendor afterwards, Vendor "C", who again stated they had not received the additional documentation requested and had also asked OT "A" in person during March 2025 for follow-up. R905 explained they received another phone call from Vendor "C" from April (2025) yesterday on their voicemail, and learned Vendor "C" had still not received their wheelchair paperwork. R905 reported this made them feel upset and frustrated. R905 was speaking in an elevated voice tone, appearing distressed and became tearful, and said she was tired of "playing the middleman" between their providers and the facility. R905 reported they had told multiple staff their concerns and nothing changed. R905 stated they wanted assistance with care coordination, as this was too much for them and they felt overwhelmed. R905 clarified they used their loaner power wheelchair for community mobility and to access community transportation regularly, as there were no other options available to them, which was confirmed in the medical record. On 5/01/25 at 10:42 a.m., Registered Nurse (RN)			

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	"B" confirmed R905 used their loaner power wheelchair during the week for community mobility. On 5/01/25 at 11:48 a.m., R905 initiated calling Vendor "C" with Surveyor present. Vendor "C" explained R905's initial power wheelchair paperwork was completed by therapy staff on 9/04/25, which was denied. Vendor "C" reported this was typical with power wheelchair applications, and often facilities had to submit additional paperwork up to several times during the application process. Vendor "C" confirmed R905 needed their own customized medically necessary power wheelchair, which included a tilt recline feature, elevating legs, joystick propulsion, and pressure relieving cushion due to their pressure ulcer. Vendor "C" reported they requested in an email to the therapy department on 2/07/25 the facility submit additional paperwork due to a second wheelchair denial they received on 2/06/25 from the 11/04/2024 submission and specified what was needed from the occupational therapist in the email. Vendor "C" reported they sent a second email in February 2025, with no response to either email. Vendor "C" reported they left a voicemail on 2/26/25 with the facility therapy department with no response. Vendor "C" indicated they went to the facility on 3/10/25, and spoke directly to OT "A", who reported they would leave a message for the Interim Rehabilitation Director, Speech Language Pathologist, SLP "E", about the additional documentation requested. Vendor "C" reported on 3/18/25 they called R905 since they had not received the necessary documentation. They reported R905 attempted to facilitate the completion of the appeal documentation themselves. Vendor "C" stated they heard from the current Rehabilitation Director "today" (5/01/25), who reported they had received an email on 5/01/25 from them and would submit the required paperwork on 5/01/25. Vendor "C"			

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	reported the email they sent on 5/01/25 was to the same email address where they had sent earlier documentation requests to the facility. Vendor "C" confirmed the delay in documentation had been from 2/07/25 until 5/01/25 and understood why R905 was frustrated and concerned, since this was an extended period. Review of an email thread dated 5/01/25 by Vendor "C" received from R905 at 12:14 p.m., showed Vendor "C" had sent the facility therapy department two emails, dated 2/07/25 and 2/13/25. The emails specified additional documentation the insurance provider requested from therapy and the facility to obtain R905's power tilt recline wheelchair. On 5/01/25 at 2:18 p.m., the Rehabilitation Director, Certified Occupational Therapist Assistant (COTA) "D", reported they had been on a leave from February 3, 2025, until April 23, 2025, and confirmed the Interim Rehab Director, SLP "E" was covering the department during their absence. COTA "D" conveyed they had not made aware the additional power wheelchair documentation had not been submitted until today (5/01/25), when OT "A" and Vendor "C" made them aware. COTA "D" reported their emails dropped off over time, so they had no record of earlier emails received by the therapy department. COTA "D" shared with Surveyor an email received by Vendor "C" on 5/01/25, which specified additional documentation needed from the facility to reapply for R905's power wheelchair they had earlier requested, and a thread of the two February emails to the therapy department. COTA "D" shared there appeared to a larger gap in time where there was no follow up on the wheelchair when they were on leave, and stated they were not finding evidence of any paperwork submitted. COTA "D" showed Surveyor two paper packets which included letters of medical necessity completed by therapy			

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	staff during 9/2024 and 11/2024, and reported this was all they found. COTA "D" reported SLP "E" had a full-time caseload when they were working as the Interim Rehab Director, and this may have impacted the completion of R905's follow-up power wheelchair additional documentation request from their insurance provider. On 5/01/25 at approximately 2:40 p.m., SLP "E", with COTA "D" present, reported they took full responsibility for the additional documentation not being resubmitted for another appeal, per R905's and Vendor "C"'s request. SLP "E" clarified they unintentionally had not followed up, after receiving two emails from Vendor "C", which they recalled receiving, and believed one was in February 2025 and the second was possibly in March 2025. SLP "E" stated they had a full-time resident therapy caseload while in their role as Interim Rehab Director. Both reported they understood the concern related to the nearly 3-month gap in time related to the additional appeal documentation not being resubmitted. COTA "D" confirmed they were submitting the documentation on this date (5/01/25) to Vendor "C", since they had been made aware of the documentation omission. COTA "D" confirmed the recommended power wheelchair would benefit R905, and R905 had a loaner power wheelchair they were using in the interim from Vendor "C". On 5/01/25 at 3:10 p.m., Vendor "C" clarified in a phone interview they had made multiple attempts to obtain the medically necessary documentation from the facility therapy department to submit per request from R905's insurance provider, after the insurance provider requested additional documentation on February 6, 2025. Vendor "C" confirmed they had reached out to the facility initially on February 7, 2025. Vendor "C" reported they believed R905 was advocating for			

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	themselves without assistance from the facility and was understandably frustrated. Vendor "C" explained applying for a power wheelchair for a resident can be a lengthy process with several denials however it was possible R905's power tilt recline wheelchair would be approved with the additional documentation requested. Vendor "C" stated they wanted R905 to receive the power wheelchair, if possible, as they deemed it medically necessary for R905. Vendor "C" confirmed they had loaned R905 a pressure-relieving cushion and power wheelchair Review of R905's, "Evaluation and Medical Justification for Complex Seating Systems and Mobility Devices ...", dated 11/04/25, revealed R905 required the power tilt recline wheelchair due to a cervical spinal cord injury. The form further revealed, "The equipment is needed for independent mobility for lifelong use and will improve caregiver ability to manage pt (patient) care ..." The medical justification form revealed in summary, "(R905) has demonstrated the ability to operate a power wheelchair independently and safely on several occasions in the past month utilizing a borrowed power wheelchair, including on 11/02/24. (R905) has adequate vision, active range of motion, coordination, and strength to operate the power wheelchair and good cognition." Signed by OT "A". On 5/01/25 at 4:35 p.m., the Director of Nursing (DON) was asked about R905's power wheelchair additional documentation request not being completed by the facility from 2/07/25 until 5/01/25, during the survey. The DON reported they did not recall being made aware of the concern and understood R905's frustration. The DON stated if they had known about the concern, they would have followed up timely. A policy for Rehabilitation Services and/or			

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	Rehabilitation Services was requested from the facility administration on 5/01/25 at 3:30 p.m. via email. The policy was not received by survey exit.			
F0725 SS= E	Sufficient Nursing Staff §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: This citation pertains to intake #MI00152565. Based on interview and record review, the facility failed to ensure sufficient Nursing staff were available to meet resident medical and supervision needs for 15 residents (R901 and	F0725	Element 1: Resident R907 has been reviewed for any negative outcomes related to the alleged violation by Social Services / Designee. Care plan has been reviewed and updated as needed by Social Services. Completed by 5/8/2025. Resident R901 no longer resides in the facility. Nurse staffing patterns were reviewed by the Administrator to ensure that nurse staffing was sufficient to meet all current resident needs on 5/9/2025. Element 2: Nurse staffing was reviewed for the last 14 days to ensure that staffing was sufficient to meet all current residents needs. This was completed by the Administrator / Designee on 5/9/2025. Element 3: The Nursing Services and Sufficient Staff policy was reviewed by the QAPI committee and deemed appropriate on 5/2/2025. The facility Administrator and Director of Nursing were re-educated on the Nursing Services and Sufficient Staff policy by the Regional Director of Operations on 5/7/2025. Staffing will be reviewed daily, Monday through Friday, in morning stand up meeting. Any concerns will be addressed.	5/19/2025

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	R907) and 13 anonymous residents residing on "Mum" Unit 2, resulting in delayed medication administration and inadequate resident supervision. Findings include: On 5/1/25 a concern submitted to the State Agency was reviewed that alleged the facility was short on Nursing staff on 4/25/25 through 4/26/25 and were not able to provide adequate supervision. On 5/1/25 at approximately 11:37 a.m., Certified Nursing Assistant "I" (CNA "I") was queried if they were one of the CNA's providing care for R901 on 4/25/25 into 4/26/25 and they reported they were. CNA "I" was queried regarding the incident between R901 and R907 and they reported they heard R907 yelling out for help and when they got to R901's room, they found R907 and R901 in R901's bed but there was a little space between them. CNA "I" explained that both residents were intoxicated and R901 had liquor in there bed. CNA "I" reported that R907 stated that R901 had inappropriately touched them in bed. They stated that they told the Nurse and that they did a "green sheet" and put it under management's door. CNA "I" was queried if they had informed the Administrator and they indicated they did not but that the Nurse was aware. CNA "I" reported that R901 is a "problem" and is always drinking and trying to talk to females in the building that have dementia. CNA "I" was queried regarding the facility staffing levels that night and they reported that there		Weekend staffing will be reviewed on Friday in morning stand up meeting. Any concerns will be addressed. Element 4: The Administrator will conduct a daily staffing meeting, Monday Friday, to ensure that nurse staffing is sufficient to meet the residents needs. Staffing meetings will be held daily, Monday through Friday, x4 weeks, then weekly thereafter until substantial compliance is achieved. The results of the audits will be reviewed by the QAPI committee for 3 months or until substantial compliance is met. The facility administrator is responsible for compliance.	

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	were only four Nurses in the building and that most of the residents that had Nurse "J" had late medications. CNA "I" reported the CNA's were trying to help but there were too many residents with behaviors and risk of falling to supervise them all. CNA "I" was queried if they were aware of R901 and R907 being intoxicated in R901's room and they indicated they were not until R907 started yelling for help. CNA "I" further indicated there were not enough Nurses to help with supervising the residents and that R901 needed one to one supervision to ensure the safety of the other female residents. On 5/1/25 at approximately 2:55 p.m., Nurse "J" was queried regarding the incident between R901 and R907 on 4/25/25 into the early morning on 4/26/25. Nurse "J" reported that CNA "I" had informed them what had transpired and they went down to the room and R907 informed them that R901 had inappropriately touched them. Nurse "J" indicated they had a skin assessment done on R907 because they were both intoxicated and that they had called the Administrator and told them everything that had happened. Nurse "J" reported that R901 needs a one to one staff member to supervise because they are always drinking and starting fights with other residents and staff. Nurse "J" was queried regarding the staffing levels of the night of 4/25/25 and they reported the facility had four Nurses show up for the midnight shift. Nurse "J" indicated almost all of their residents that they were giving			

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	medications to that night had their medications administered past the scheduled times and some were multiple hours past. Nurse "J" reported they were residents with high fall risks and behaviors that needed supervision so they could not get all of their medications passed due to there other Nurses not showing up. On 5/1/25 a "quality assurance" form dated 4/26/25 filled out by CNA "I" revealed the following allegations between R901 and R907: "Details: I was on [Name of unit] when I heard yelling from [R901's] room about 11:55 p.m., It was [R907]. She was screaming. [R901] was touching her and asking why he was in her room. She was actually in his room. They were both intoxicated. [R901] was trying to hide the empty bottles of alcohol with his body..." On 5/1/25 a review of the facility staffing for 4/25/25 night shift revealed four total Nurses were assigned and the total required by the facility was six. Further review of the "calloffs" for the 4/25/25 into 4/26/25 midnight shift revealed two Nurses had called off. On 5/1/25 at approximately 4:11 p.m., the staffing levels for the 4/25/25-4/26/25 midnight shift were reviewed with Staffing Scheduler "N" (SS "N"). SS "N" reported that two Nurses had called off for that shift and were not replaced. SS "N" indicated that nobody was available to mandate to stay over and that Nurse managers are supposed			

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	to come in to cover the shortage but nobody did so the Nurses were short staffed that night. On 5/1/25 at approximately 4:32 p.m., during a conversation with the Director of Nursing (DON), the DON was queried regarding the staffing levels on 4/25/25 midnight shift and the allegation that Nurse "J" had administered many residents with late medications due to the staffing shortage. The DON reported they had reviewed Nurse "J's residents and indicated that thirteen residents on Unit 2 had their medication administered late that shift. On 5/1/25 a facility document titled "Nursing Services and Sufficient Staff" was reviewed and revealed the following: "Policy: It is the policy of this facility to provide sufficient staff with appropriate competencies and skill sets to assure resident safety and attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. The facility's census, acuity and diagnoses of the resident population will be considered based on the facility assessment."			
F0770 SS= D	Laboratory Services §483.50(a) Laboratory Services. §483.50(a)(1) The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. (i) If the facility provides its own laboratory services, the services must meet the applicable requirements for laboratories specified in part 493 of this chapter.	F0770	Element 1: Resident R904 no longer resides in the facility. Element 2: All current residents identified with labs and diagnostic tests ordered over the last 14 days were verified as completed. Any concerns were immediately addressed. Completed by	5/19/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	474020	A. BUILDING _____ B. WING _____	5/1/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDILODGE OF HOWELL	1333 W GRAND RIVER HOWELL, MI 48843

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	This REQUIREMENT is not met as evidenced by: This citation pertains to intake #MI00151369 Based on interview and record review, the facility failed to ensure timely laboratory services for one resident (R904) of one resident reviewed for laboratory services, resulting in a delay for the treatment of a urinary tract infection. Findings include: On 5/1/25 at 9:20 AM, a review of R904's closed clinical record revealed they admitted to the facility on 6/10/24 and discharged to the hospital on 3/23/25. R904's progress notes were reviewed and included the following: A note dated 3/17/25 that read, "...Change identified: Confusion...Increased urinary frequency, abdominal cramping...Needing 2 people assist with all transfers due to weakness... Needed to use the bathroom about every hour during the night. c/o (complains of) of pain during urination...Collected urine culture to check for UTI (urinary tract infection)..." A note dated 3/18/25 entered into the record by NP (Nurse Practitioner) 'H' that read, "Per nursing pt (patient) has increased confusion for the past few days, most occurs in the evening and at night. UA (urinalysis) & c/s (culture and sensitivity) ordered, pending result ...ASSESSMENTS AND PLANS ...Altered mental status, unspecified: Pt also c/o burning with urination, abdominal pain, ordered ...ua & c/s to further evaluate ..." A review of R904's orders indicated NP 'H' ordered a UA & C/S (urinalysis, culture & sensitivity) lab on 3/18/25. R904's lab result forms were reviewed and indicted the specimen		the Director of Nursing / designee on 5/7/2025. Root Cause: Facility failed to ensure timely follow up for lab services. Element 3: The Laboratory and Diagnostic Guidelines Policy was reviewed by the QAPI committee and deemed appropriate on 5/2/2025. The Director of Nursing / Designee has re-educated all current licensed nurses on the Laboratory and Diagnostic Guidelines Policy by 5/19/2025. Any current licensed nurse not re-educated by 5/19/2025 will be re-educated prior to their next scheduled shift. Nurse managers will review the order listing report daily, Monday through Friday, in morning clinical meeting to ensure labs and diagnostics are completed as ordered. Element 4: The Director of Nursing / Designee will audit the order listing report daily, Monday through Friday, to ensure labs are completed as ordered. Audits will continue for 5 days per week x4 weeks and then weekly thereafter until substantial compliance is achieved and the audits are discontinued by the QAPI committee. The Administrator is responsible to maintain compliance.	

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	was collected on 3/18/25 and not picked up by the lab for processing until 3/20/25. On 5/1/25 at 3:47 PM, an interview was conducted with the facility's Director of Nursing (DON) regarding laboratory services. They were asked about the lab schedule and said a courier picked up lab specimens daily Monday thru Fridays and if something needed picked up on a weekend they could call for a stat pick-up. They further indicated there should not have been the delay in between the specimen collection and delivery to the lab for testing. A review of a facility provided policy titled, "Laboratory and Diagnostic Guidelines" revised 10/2023 was conducted, however; the policy did not address the timeframe for lab collection, transportation to the lab for testing, and reporting the results.			