STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235296	A. Building B. Wing	05/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Southfield	26715 Greenfield Rd Southfield, MI 48076

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34208 This citation pertains to intake #MI00144187. Based on observation, interview, and record review, the facility failed to ensure treatment in a dignified manner for two residents (R#'s 506 and 510) of three residents reviewed for dignity, resulting in verbalized feelings of anger, embarrassment and disgust. Findings include: On 5/14/24 at 8:30 AM, upon entry to the facility a schedule of events for Nursing Home Week was observed taped to the reception desk. It was noted an activity scheduled for 5/13/24 was Wheelchair Races. On 5/14/24 at 10:40 AM, an interview was conducted with R506 in their room. They related an incident that occurred on 5/13/24. They went on to say the staff had a facility sponsored Wheelchair Race in the hallway where they pretended to be disabled to celebrate Nursing Home Week. R506 said they overheard, yelling, hooting, hollering, cheering and a general ruckus in the hallway. R506 stated, They picked disabilities and had to race in the wheelchair as if they had that disability. R506 further went on to say they overheard staff saying, I want to change my disability. R506 expressed her deep concern saying she was disgusted with the activity citing it as rude, insensitive, and in poor taste. They said they felt staff were making fun of people with disabilities or anyone who requires a wheelchair for mobility. They were asked if they expressed their concerns about the event to any staff members and said they told Nurse 'D', Business Office Manager 'H' and the Assistant Administrator. On 5/14/24 at 11:09 AM, an interview was conducted with Nurse 'D'. They were asked about the Wheelchair Races and said staff participated in them. They acknowledged R506 telling them about their concern and said R506 requested to file a complaint. Nurse 'D' further went on to say it was shift change and they let R506 know the oncoming nurse, Nurse 'G' would assist them with filing a complaint. On 5/14/24 at 11:30 AM, an interview was conducted with Office Manager 'H' regarding their knowledge of the Wheelchair Race and R506's complaints. They said they did not see any of the event as they were busy but acknowledged R506 made them aware of the concerns. Office Manager 'H' said R506 told them they thought the event was demeaning and staff were laughing about disabilities. They were asked if they knew who scheduled/coordinated the event and said they believed it was Admissions Director 'I'. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/14/24 at 11:42 AM, an interview was conducted with Admissions Director 'I' regarding the wheelchair races. They were asked to describe the event and said it was one of the scheduled activities for Nursing Home Week. They further explained staff randomly picked disabilities and had to race in the wheelchair pretending they had that disability. They were asked how they decided what disabilities staff were to pretend and said there was a list. When asked what types of disabilities were on the list and how they decided what would be on the list, they said, things like paralysis and amputations. Admissions Director 'I' did not give a clear answer how the list of disabilities was formulated. They were asked if any of the disabilities used during the event affected any of the residents currently in the facility and they confidently said none of them were actual disabilities experienced by residents. They were asked if they thought this activity could have been viewed as offensive or insensitive and said, Not at all, stating, Nobody was forced to watch. They went on to say they used the event as a learning tool and sensitivity training to help staff better understand disabilities. Finally they were asked who approved the event and said the Administrator and Assistant Administrator approved it. On 5/14/24 at 12:02 PM, R510 was observed in their motorized wheelchair in the hallway. R510 was observed to have a left below the knee amputation and a right above the knee amputation. A request for a private interview with R510 was made and they agreed. They were asked about the Wheelchair Race event on 5/13/24. They said they heard an overhead page by Admissions Director 'I' announcing a staff only wheelchair race. They said they witnessed some of the event but they were disgusted. They further went on to say staff pretended to have a disability and had to use a wheelchair for mobility. They said they voiced their anger to the Admissions Director 'I'. They further went on to say it was offensive to anyone who requires a wheelchair for mobility and in poor taste. They said they wanted a public apology and a written apology for anyone who required the use of a wheelchair. They were asked if staff responded to their concern and said they were given the explanation of the event being a sensitivity training exercise. On 5/15/24 at 11:50 AM, an interview with the facility's Administrator was conducted about the Wheelchair Race event. They said they approved the event, allowing staff only participation where they were assigned disabilities for them to better understand how residents in wheelchairs navigate. They were asked if they had been made aware of any residents taking offense to the event and acknowledged R506 and R510 did have complaints about it. They were asked what they did to address the concerns and said the Unit Managers handled it. Lastly, the Administrator was asked if they thought the event was appropriate and they confidently said, Absolutely. They said they never thought it would be inappropriate and they had, been doing them for [AGE] years in previous facilities. A request for a policy on dignity was made, however; the policy provided was titled, Resident Rights and did not directly address the resident's right to be treated in a dignified manner, but did read, 10. All residents will be treated equally regardless of age, race, ethnicity, religion, culture, language, physical or mental disability, socioeconomic stats, sex, sexual orientation, or gender identity or expression

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F 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to manage his or her financial affairs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48680 This Citation is based on intake MI00143989. Based on interview and record review, the facility failed to (1) obtain authorization to manage personal funds, (2) properly manage a trust account, and (3) follow the policy provided by facility on personal funds and trust accounts for one resident(R500) reviewed for misappropriation of funds resulting in resident alleging stolen money. Findings include: On 4/16/24 the State agency received a Facility reported incident (FRI) for R500 alleging that 50 dollars was stolen from their wallet during the nighttime hours. The facility conducted an onsite investigation and concluded that there was no evidence to substantiate the missing money. On 5/14/24 the facility was asked to provide their FRI report and investigation. The investigation revealed that R500 was missing 50 dollars that the facility stated, couldn't confirm R500 had (the money); a police report was made. The resident's guardian was notified and it was considered not substantiated. On 5/14/24 at around 1:00 PM, R500 was observed in their room lying down in bed. R500 was interviewed and asked about the incident regarding the stolen money, R500 stated that they had 50 dollars and they put the money in their wallet and put it underneath their pillow like they did every night before bed and when they woke up the next morning, the money was not there, but the wallet was. R500 stated, they reported the money missing to the facility and they asked if the wallet placed in the nightstand and R500 replied, I never put my money in the drawers. R500 asked what the facility did about the missing money and R500 replied, Nothing, am I going to get it back? A record review revealed that R500 was admitted to the facility on [DATE] with the medical diagnosis of insomnia, muscle weakness and asthma with a brief interview for mental status score of 15. A further review of the record revealed that, R500 receives money from their durable power of attorney (DPOA) and the facility holds the money, gives a receipt and distributes it to resident when needed or requested. On 5/14/24 at 1:15 PM, the facility was asked to provide a copy of R500's trust account information and balances. The facility explained that R500's DPOA refused a resident trust account. The facility was then asked to provide a copy of the resident's admission packet with the refusal of a trust account. A record review revealed that the contract that was signed by the DPOA did not indicate a refusal of a trust account. (continued on next page)

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F 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/14/24 at 1:30 PM, R500's DPOA was contacted and interviewed. The DPOA was asked if they were aware of the incident that occurred with R500 in regards to stolen money. The DPOA stated, Yes, the facility called me and told me that the money was missing and stated that [R500] must have bought food or something and forgot they made a purchase spending the money. The DPOA was then asked how often did she give R500 money and who collects the money. The DPOA replied, I give [R500] money every week. I come to the facility on ce or twice a week. I give the facility the money to put it into their account so the resident can have money because I found out that [R500] likes to eat at the restaurant that's located next door and [R500] has people go out and get them something from the restaurant (take out) so I make sure that [R500] has money in their account. The DPOA continued and explained that they give money to the receptionist or the lady that is in the back of the receptionist office and then they give her a receipt for the money that she deposits. The DPOA was asked did she receive a monthly or quarterly statement of the balance for R500's account and the DPOA stated that they only get a receipt at the time of deposit. On 5/15/24 at 11:00 AM, the Assistant Administrator (AA) was interviewed and asked what the conclusion of the investigation for R500's missing money was. AA replied, I could not substantiate after the investigation; no staff members could recall [R500] with money. Also, we called the DPOA who also verified that the resident buys food and goes to the vending machine all the time and could have spent the money. So, the conclusion was that [R500] did not have the money because they spend their money at the store or vending machines. AA was then asked does R500's DPOA give them money? AA responded, Yes. AA was asked how much money did R500 have and AA replied, I am not certain but she did receive money from the DPOA. AA was then asked if R500 did not have a trust account why was the facility taking the resident's money, distributing it to the resident, holding it for the resident and how did they know R500's money was not stolen (if there is an unofficial account being held for R500). AA responded, We will look into that. No additional information was provided by the exit of survey.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34208 This citation pertains to intake #MI00144015. Based on observation, interview, and record review, the facility failed to properly care for percutaneous endoscopic gastrostomy (PEG) tubes (feeding tubes) for one resident (R#505), of two residents reviewed for PEG tubes. Findings include: On 5/14/24 at 10:18 AM, Certified Nurse Aide (CNA) 'B' was observed in R505's room preparing to provide care. At that time, they were asked to reveal R505's PEG tube site. An observation of the site revealed a dressing, but no abdominal binder in place. On 5/14/24 at 1:15 PM, a review of R505's clinical record was conducted and revealed following census information: 3/10/24-discharged from facility and admitted to the hospital for a PEG tube replacement. R505 readmitted to the facility on [DATE]. 4/1/24-discharged from facility and admitted to the hospital for respiratory distress. Records indicated R505's PEG tube was dislodged upon admission to the hospital. R505 readmitted to the facility on [DATE]. 4/16/24-discharged from the facility and admitted to the hospital. There were no nursing notes or assessments in the record that indicated the reasoning for their transfer to the emergency room . A review of R505's facesheet from the hospital dated 4/16/24 was reviewed and read, .Visit Reason: SEPSIS .Admitting Diagnosis: Gastrostomy malfunction . R505 readmitted to the facility on [DATE]. Continued review of the clinical record revealed R505 had no current orders for PEG tube site monitoring and care. The record revealed they had orders in the past for monitoring and care, but the order had been discontinued on 4/17/24, and never re-ordered. Further review of the orders did not reveal any orders for an abdominal binder. A review of R505's progress notes revealed the following: A note dated 3/18/24 from the Nurse Practitioner that read, .Assessment Plan: .Resident readmitted <sic> into facility after peg tube became dislodged .Resident is wearing abdominal binder . A note dated 3/21/24 that read, .specific interventions to prevent unnecessary return to hospital: Wear abdominal binder q (every) shift to reduce risks of dislodgement . R505's care plans were reviewed and revealed the following interventions: .Treatment to tube site per order(s) . initiated 11/22/23, and .Wear abdominal binder q shift to reduce risks of dislodgement . initiated 11/22/23, and revised 5/10/24. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/14/24 at 10:55 AM, an interview was conducted with the facility's Director of Nursing (DON) regarding PEG tubes. They were asked if there should be orders for PEG tube site care and evidence of presence of the abdominal binder for R505 and said there should be. A review of a facility provided policy titled, Feeding Tubes revised 6/2022 was conducted and read, .Feeding tubes will be maintained in accordance with current clinical standards of practice, with interventions to prevent complications to the extent possible .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 34208 This citation pertains to intake #MI00144187. Based on observation, interview, and record review, the facility failed to appropriately implement enhanced barrier precautions (EBP, infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities) and wear the required personal protective equipment (PPE) for resident's on EBP for two residents, (R#'s 505 and 509) of three residents reviewed for enhanced barrier precautions, resulting in the potential for the transmission of multidrug-resistant organisms. Findings include: R505 On 5/14/24 at 10:10 AM, R505's room door was noted to have a sign that indicated they were on EBP. The directions on the sign indicated any providers or staff performing high-contact resident care activities (dressing, bathing/showering, transferring, changing linens, providing hygiene, changing briefs, or assisting with toilet use) were to be wearing a gown and gloves. At that time, R505 was observed in their bed asleep. A tube feeding pump and pole were observed at the bedside. On 5/14/24 at 10:18 AM, Certified Nurses Aide (CNA) 'B' was observed in R505's room preparing to assist them with activities of daily living (ADL's). CNA 'B' had towels, clean clothing, and an adult incontinence brief at the bedside. They were observed to be wearing gloves, but no gown in the room. On 5/14/24 at 10:26 AM, CNA 'B' exited the room with two trash bags, one with soiled linens and one with refuse/waste. R505 was observed to be changed out of their gown and into clothing. CNA 'B' was not observed to exit the room and don the isolation gown prior to providing the ADL care to R505. On 5/14/24 at 10:32 AM, CNA 'B' and CNA 'C' were observed to enter R505's room with a mechanical lift, and close the door. They were not observed to don an isolation gown upon entry to the room. At approximately 10:41 AM, CNA 'B' and CNA 'C' exited the room and R505 was observed to be in their geri-chair. CNA 'B' or 'C' were not observed to exit the room and don the isolation gown prior to transferring R505. A review of R 505's clinical record was conducted and revealed an order dated 5/14/24 that indicated they were to be on EBP. R509 On 5/14/24 at 10:28 AM and 5/15/24 at 9:10 AM, R509 was observed in their room. During the observation it was noted R509 had a urinary catheter drainage bag with urine observed in the tube. There was no signage on the door or isolation equipment to indicate R509 was on EBP. A review of R509's clinical record was conducted and did not reveal an order for EBP. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/14/24 at 10:55 AM, an interview was conducted with the facility's Director of Nursing (DON). They said when providing direct care for residents with devices such as feeding tubes, catheters, IV access, or wounds, staff were expected to wear isolation gowns and gloves. On 5/14/24 at approximately 1:30 PM, the DON acknowledged R509 did not have an order for EBP. A review of a facility provided policy titled Enhanced Barrier Precautions (EBP), revised 3/2024 was conducted and read, Policy: It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms .2. Initialization of Enhanced Barrier Precautions- a. Nursing staff may place resident with certain conditions or devices on enhanced barrier precautions .i. Wounds .ii. Indwelling medical devices .