Residents "Get Chewed At"

The nursing home failed to: a. treat resident 29 and resident 45 with dignity and respect; b. resolve grievances in a timely manner; c. prevent abuse of five residents; d. implement their abuse policy for four residents; and e. report allegations of abuse for four residents.

During a confidential group meeting, eight residents said they are not treated with dignity. They reported staff frequently refuse to provide care or assistance. They make comments like, "Do it yourself." They expressed fear of retaliation and when they report, things get worse. They said care refused included using bed pans, getting towels for morning care, and getting clean briefs. When asked how it makes them feel, one resident said, "Retarded." Another said, "Upset." They were all very frustrated and upset.

During an interview, resident 45's spouse reported the nursing home is short staffed on weekends. He said that recently his spouse soiled herself in her bed because of an extended call light wait. The spouse reported two other occasions when she laid in wet bed awaiting a call light response. The spouse reported he complained to the Administrator who told him that maybe resident 45 should go to another nursing home.

Confidential resident reported, "I try to stay isolated because of disrespectful treatment by staff." She added she has witnessed other residents "get chewed" [*sic*] at when a concern was voiced. She said she knows not to say anything against staff because she will get spoken to. She reported she was afraid of staff retaliation and added, "I am nervous now that I said something" (to the surveyor). She declined to be identified to have her concerns addressed stating, "They will come at me."

The nursing home also failed to support resident choices for resident 15 and eight residents, resulting in residents being restricted from social interactions with other residents outside scheduled group activities.

During a confidential group meeting, residents said they were not allowed in the dining room from 9:00 PM to 7:30 AM. They said they did not want to discuss these concerns with the Administrator and the Director of Nursing because they feared retaliation. Resident 15 said, "The residents just want to use the main dining room as a place to just sit and relax." Resident 8 said they had nowhere to go outside their bedrooms during those hours other than the halls.

During the meeting, the residents said the nursing home did not resolve their grievances. They gave the example of a resident who would wander into their bedrooms and take their belongings. The resident yells and swears at the men and they are afraid of him. The residents said they didn't want to discuss these issues with management because management responds to concerns with retaliation against residents.

Name of Nursing Home	Medilodge of Midland / Provider ID: 235284
Address	4900 Hedgewood Dr. Midland, Michigan
Date investigation completed	March 12, 2020
Type of deficiency issued	F550 – Resident Rights; F561 – Self-determination F565 – Resident/Family Group and Response F600 – Freedom from Abuse, Neglect, and Exploitation F607 – Develop/Implement Abuse/Neglect, etc. Policies F609 – Reporting of Alleged Violations
Severity level	Minimal Harm or Potential for Actual Harm
Overall Quality Star Rating: 2; Staffing Rating: 4	

Investigation report: https://www.medicare.gov/care-compare/inspections/pdf/nursing-home/235284/health/standard?date=2020-03-12