

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235226	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/27/2026
NAME OF PROVIDER OR SUPPLIER Medilodge of Grand Blanc		STREET ADDRESS, CITY, STATE, ZIP CODE 11941 Belsay Road Grand Blanc, MI 48439	
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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interviews, and record review, the facility failed to ensure that clean linens were consistently available to meet residents' needs. This resulted in delayed incontinence care and bathing for one resident (Resident #103) of four residents reviewed for quality of care. Findings include: Resident #103 (R103):A record review of the face sheet and Minimum Data Set (MDS) assessment indicated R103 was admitted to the facility on [DATE] with diagnoses: diabetes mellitus (DM), failure to thrive, muscle weakness, protein calorie malnutrition, bipolar II (mental health disorder of mood cycling between high and low) and difficulty in walking. The MDS assessment dated [DATE] indicated the resident was cognitively intact with a Brief Interview for Mental Status (BIMS) score of 15/15 and was dependent on care for toileting and shower/bathing.On 05/27/2026 at 12:10PM, Nurse A was asked to open the linen closet on west 100 hall, the observation of the linen closet revealed the following contents: 5 blankets; 0 fitted/ 8 flat/ 0 draw sheets; 0 pillowcases; 2 wash cloths, 4 towels; 9 clothing protectors; 0 gowns were present. Nurse A was asked how many residents were on that hall and she responded 36. Nurse A was asked if 2 wash cloths and 4 towels were enough to provide care for the 36 residents on the hall at any given time and she said that the staff had used them and if they needed more, they could borrow from another hall until the laundry delivered more. Nurse A was able to identify what time a laundry deliver occurred and indicated every shift.On 05/27/2026 at 12:12PM, Unit Manager (UM) B was asked to open the linen closet on east 100 hall, the observation of the linen closet revealed the following contents: 0 blankets; 2 fitted/ 12 flat/ 12 draw sheets; 2 pillowcases; 5 wash cloths, 12 towels; and 12 clothing protectors; 2 gowns were present. UM B was asked how many residents were on the hall and he stated 16. UM B was asked if this was enough to support the needs of the 16 residents on the hall, he said this is the linen closet for the hall, but the main laundry supply was in the basement. UM B was asked to escort the SA to the laundry in the basement.On 05/27/2026 at 12:15PM, observed of the laundry folding room there were 2-3 yellow bins of clean linens waiting to be folded and laundry staff C was folding sheets and had a table partially full of folded laundry. Laundry staff C was asked how often linens were delivered to the closets on the halls and she stated, every two hours. Laundry staff C was asked if that was even throughout the night and weekends, she stated yes. Laundry staff C was asked what the were the laundry department hours and she said 6 am to 1 pm, she was quired and confirmed no deliveries were made between the hours of 1am to 6 am throughout the night, as the department was not operational those hours. At 12:18 PM our interview was cut short when the laundry manager D arrived. On 05/27/2026 at 12:18PM, during an interview with laundry manager D, she was asked if they had any complaints from staff about not having enough linen supplies and she said that she had and that the night laundry worker had not been able to keep up with the demands. Laundry manager D said it's a hard building and you can't stop; it's an ongoing cycle and went on to say that they had trialed a new schedule for the laundry services and that it lasted less than a month because it was not working out with supply and demand. Laundry manager D was asked if she had any specific complaints , she said yes that a Nurse had called her on 05/17/2026 at 3:30AM (referenced the calendar) in a panic and said the whole building was out of linens and there were none in the closets, the laundry room and they was no (continued on next page)		

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	laundry worker available on site. laundry manager D said she lived an hour away and she got ready and went in early, stated she arrived at 5:45AM. Laundry manager D said she had a back stock room of new linens that she kept in a locked room, she was asked who had access and she said maintenance and herself. laundry manager D, was asked why the limited access and she said because the staff would take them instead of washing the used ones. Observation of the stockroom with supply of new blankets, sheets, towels, pillowcases and wash clothes. Laundry manager D was asked to supply the order histories and inventory logs. On 05/27/2026 at 12:41PM, Certified nurse aide (CNA) F was asked to open the linen closet on west 500 hall, the observation of the linen closet revealed the following contents: 0 blankets; 12 fitted / 12 flat sheets; 5 wash cloths, 5 towels; 24+clothing protectors; and 12 gowns. CNA F was asked how many residents were on the hall and he stated 16, she said that there was about 7-8 residents that are on check and change. CNA F was asked what check and change meant and she said it meant to check and change the residents brief when needed, every two hours. CNA F was asked if they ever ran out of laundry supplies and she said that during the week the supply was better but, on the weekend, it was not uncommon for them to run out of wash cloths. CNA F was asked what they did if they ran out of wash cloths, she said they used towels or other linens that are available. CNA F was asked how often laundry was delivered to the hall and she said they come once a shift but not on weekends, and that she did not think the laundry staff worked on weekends. CNA F was asked to open the linen closet on west 400 hall, an observation of the linen closet revealed the following contents: 0 blankets; 12 fitted / 12 flat sheets; 4 wash cloths, 7 towels; 24+clothing protectors; and 12 gowns. On 05/27/2026 at 12:47PM, SA was approached by R102 in the hallway and R102 shared that the scant linen supply in the closets was not uncommon and said that staff will use towels and bibs if they run out of wash cloths. R102 had no specific incident recalled when queried. On 05/27/2026 at 12:49PM, CNA G was asked to open the linen closet on front and back 600 hall, the observation of the linen closets combined revealed the following contents: 4 comforters; 10 blankets; 6 fitted/22 flat sheets; 15 wash cloths, 20 towels; 24+clothing protectors; 12 pillowcases. CNA G was asked if they ever ran out of linen supplies and she stated Actually, yes and They are supposed to deliver laundry once a shift, but they do it whenever they get around to it followed by We run out of washcloths a lot. CNA G was asked what happened when they ran out of wash cloths, she said they used what ever linen there was until the next laundry was delivered. On 05/27/2026 at 1:13PM-2:30PM, During a follow up interview with laundry manager D, she was asked about the phone call from the nurse on 05/17/2026 and asked to verify what was said. Laundry manager D said she had the text voicemail. According to a record review of the voice/text message from Nurse I left on 05/17/2026 at 03:55AM, .the last I knew you were the head of the linen services, and I just needed to make sure somebody else is coming in tonight for because this entire building has almost like no linens again already and went on to explain ?at the start of the shift 7PM, half the building had little to no washcloths, towels and fitted sheets and on (her hall) there was none. At 9 PM there was still no delivery of linens and so she when down to the laundry room where the laundry person told her they had just arrived, it was by then 2 hours with no linens. The laundry worker told her the shift before had hardly left anything clean, but she would fold what was available and bring it to her, she then brought up a small stack. She said the rest of the building was also out of linens again, so she went back down again to ask for more and the staff was gone.' The message ended with So, we need wash cloths and towels so that we can wash people, give us a call back at the building when you get this message let us know if someone else is coming in thank you. Laundry manager D said she was unable to return the phone call, and she got ready and went in early, she arrived at 5:45AM and the first shift laundry worker arrived at 6 AM. She said we got busy folding and delivered to the floors in about 30 minutes. Laundry manager D said she had heard that CNA's had cut up towels to use in place of wash cloths to clean residents and said I believe it because she observed there were cut up towels in the returned laundry. Laundry manager D was further queried about the schedule change in laundry services and she said that the last week in (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	April they had changed the hours but changed back to the old schedule after the incident on 05/17/2026. Old and current hours: 7 days a week, first shift 6AM to 2PM (1 staff, facility laundry), Second shift 12 Noon to 8PM (1 staff, resident personal laundry), third shift 7PM to 3AM (1 staff, facility laundry). Laundry manager D said the only change was made to third shift and that was from 5PM to 1AM, she said that lasted about 3-4 weeks. Laundry manager D said that the 100, 200 and 300 halls had linens delivered twice a shift, because they use more linens, and 400, 500 and 600 halls had linens delivered once a shift. According to a record review of the monthly linen inventory: In March wash clothes: 1365 in circulation and 1120 new in storage for a total of 2485 in facility In April wash clothes: 658 in circulation and 84 new in storage for a total of 742 in facility Which revealed a difference of 1742 wash clothes unaccounted for between March and April facility wide. May's inventory was not completed at time of survey advised it was to be done at end of month according to laundry manager D. Laundry manager D had no explanation for the large quantity difference and said she continued to order to meet the PAR. When asked what that meant she said it was number of items in use needed per resident and was based on census. Laundry manager D said she was unsure of who was in charge of setting the number per resident needed. PAR on wash clothes was set at 10 per resident. On 05/27/2027 At 2:36PM, during an interview NHA was asked who set the PAR for the facility and she said, at first, it was the contract company however we had an issue last year with laundry and decided to up the PAR on linens / wash clothes. NHA said we had a huge issue before with staff who flushed or thrown them away. NHA said that it had gotten better but could not verify that they don't do that still. NHA was asked about the 1700+ wash cloth inventory from March to April that was unaccounted for according to the inventory sheets, she had no explanation. On 05/27/2027 At 3:13PM, during a telephone interview with CNA H said for a few weeks the staff has had to go searching up and down halls and look for enough linens to complete care for residents, specifically washcloths and sheets to change bedding. CNA H said that on her shift 5/16 to 5/17 that she had a resident refuse (identified as R103) to get a shower because there were no washcloths available and only had a towel. CNA H said she had checked on all the halls and could not find any wash clothes and that she told her nurse. CNA H said the nurse went to the basement to get some laundry from the laundry staff so we could do resident showers and incontinence care, but no one was there. CNA H was asked if there was any additional linens in a back up that they could access and she said there was not, if there was none in any hall closets and no one was available in laundry. On 05/27/2027 At 3:24PM, an observation of R103 resting in bed and was agreeable to interview, she was asked if they ever ran out of items to provide her care and she said that last week on Saturday (05/16/2026) that she wanted to get her shower but they did not have any wash cloths or towels and she said she did not want to use a sheet. R103 said that she was upset and stated, I felt dirty, and was stinking in my underarms. R103 said that she had to wait over two hours in a dirty brief because of the same reason, no linens. R103 said she was upset that they did not offer to make up the shower and that she had to wait until her next shower day for a shower which was days later on Wednesday (05/20/2026). R103 stated it's not my fault they didn't have the linens and said the guy in laundry wasn't doing his job, and there are times when linens were low but that was not right. A record review of R103's treatment administration record (TAR) for May 2026 revealed: Showers - Wednesday and Saturday 2nd shift. Every night shift Wed, Sat ensure shower is provided and documented in POC (plan of care) and noted that on Saturday May 16th resident refused a bath/shower. Nurse to ensure CNA's offer resident to change clothes, wash face and hands. Nurse to document ADL care was completed in (electronic medical record) enter a progress note for any refusals and include reason why resident refused. According to a record review of R103's progress notes dated for May 17th, 2026, at 5:55AM revealed: note text: Showers . Washcloth unavailable and resident was offered assistance with showering using clean towels of which she refused. Message left for linen manager and nurse on call manager. On 05/27/2027 At 3:48PM, during a telephone interview with Nurse I she was asked the night of the phone call to laundry manager D, and she said they were out of linens on her hall and just (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	about everywhere else was low, she said that it happened on a regular basis over the past few weeks. Nurse I said she had been getting complaints from the CNA's about not having enough linens. Nurse I said they had an in-service with the CNAs about check and changes not getting done on nights and said that they don't have the linens to use for incontinence care. Nurse I said that on her shift which is 7PM to 7AM she does not see the laundry get delivered until about 10 PM. Nurse I said that the second shift laundry only delivered personal clothes to residents and no linens to the closets. Nurse I said there is a big gap between deliveries and that is part of the problem. Nurse I confirmed that R103 refused her shower because there was not any washcloths available on her 5/16/2026 shift. On 05/27/2027 At 4:02PM, during a phone call interview with CNA L she verified she worked the night shift on 5/16/2026 and said that running out of linens was a regular issue and we have to try and hunt them down to complete our resident's care. CNA L said it is hard for the residents to understand when staff cannot complete their care until we have the linens. On 05/27/2027 At 4:24PM, during a telephone interview with laundry staff E, he was asked about his routine. Laundry staff E said he worked 5PM to 1AM shift and that he was responsible for washing, drying folding and delivering linens. Laundry staff E said there are 8 closets to deliver to. Laundry staff E said he delivered to 100 hall at start of shift, then a couple hours later to the 200-300 halls, then a couple hours to the 400-500 and then a couple hours later to the 600 hall. Laundry staff E stated I try to then make it up to the 100 hall again because they use a lot of laundry. Laundry staff E said somedays there were not a lot of wash cloths and others it was fine. Laundry staff E said staff will come down and ask for more, but he could only give them what he had, and he did not have access to any back stock to give out. On 05/27/2027 At 4:40PM, during a follow up interview with laundry manager D she was asked if the second shift laundry staff that was in charge of personal laundry delivered linens as well, and she said they were supposed to be checking linens and stocking as needed. She agreed that the floors would run out of linens if they had a 5-hour span that was replenished. On 05/27/2026 at 4:46PM, during a follow up phone call with laundry staff C verified she worked on 5/16/2026 the 5PM to 1AM shift and admitted that she was 2 hours late and arrived at 9PM. Laundry staff C said she did not work over to cover. Laundry staff C said that she arrived and delivered what was available, that she had a nurse come down and ask for linens and she took up a small stack after she got them folded. Laundry staff C said she completed what she could and delivered to the closets and said it was her first week and she could have missed some. Laundry staff I said she left at 1AM. On 05/27/2027 At 5:28PM, During a follow up interview with NHA she was if she had any complaints or grievances filed related to linens or care, she said no official grievances but she was aware that staff called the laundry manager on 05/17/2026 and said they were out of linens, the laundry manager came in and got the linens to the floor right away. The NHA was asked if 2 wash cloths was adequate to provide care for 36 residents, and she said no it was not. The NHA was asked if 5 washcloths was adequate to provide care for 16 residents and she agreed it was not. Reviewed the other observations made and NHA agreed residents deserved to have quality care provided at all times and that included available supplies for the staff to do so. According to a record review of R103's care plan: Focus: Resident has an ADL self-care performance deficit related to Malnutrition, Failure to thrive, anxiety, depression, generalized weakness, pain, shortness of breath (SOB) with intervention: BATHING: 1 person assist for bed bath. 1-person extensive assist for bathing while in shower chair; TOILETING: 1-person extensive assist resident prefers to use bedpan in bed. and Focus: Resident is at risk for impaired skin integrity related to needs assistance with Activities of Daily Living, with intervention: Provide incontinence care as needed; Yellow dot program: encourage/assist resident with turning/repositioning every 2 hours and as needed. And Focus: Resident is frequently incontinent of bowel and bladder. With intervention: Check at regular intervals and change as needed. According to a record review of R103's physician orders revealed: Showers - Wednesday and Saturday 2nd shift and Nurse to ensure CNA's offer resident to change clothes, wash face & hands, clip nails, shave or trim facial hair (if applicable), apply deodorant, brush hair, offer oral care & teeth to be brushed. Nurse to (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	document ADL care was complete in PCC. Enter a progress note for any refusals & include reason why resident refused.According to a record review of (laundry contract company) schedules: Laundry delivery: 6 AM Deliver any clean linens left from previous shift; 10:30Am Deliver Clean Linens to ALL Closets; 12:30PM Deliver Clean Linens to ALL Closets; 2PM deliver to hallways; 4PM deliver to hallways; 7PM Deliver Clean Linens to ALL Closets;1 AM Deliver Clean Linens to ALL Closets.According to a record review of the facilities policy titled incontinence: Policy: Based on the resident's comprehensive assessment, all residents that are incontinent will receive appropriate treatment and services with .guidelines; 4. Residents that are incontinent of bladder or bowel will receive appropriate treatment to prevent infections and to restore continence to the extent possible.According to a record review of the facilities policy titled activities of daily living: Policy: the facility takes measures to minimize the loss of resident's functional abilities including activities of daily living. 1. Bathe, dress, groom; 3. Toilet. With .guidelines: 3. President who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.According to a record review of the facilities policy titled Promoting/Maintaining resident dignity: Policy: It is the practice of this facility to protect and promote resident rights and treat each resident with respect and dignity as well as care for each resident in a manner and in an environment, that maintains or enhances resident's quality of life by recognizing each resident's individuality with Guidelines: 6. Respond to requests for assistance in a timely manner; 9. Groom and dress residents according to resident preference.According to a record review of the facilities policy titled Safe and Homelike environment:Policy: In accordance with residents' rights, the facility will provide a safe, clean, comfortable and homelike environment. and defines Sanitary includes, but is not limited to, preventing the spread of disease-causing organisms by keeping resident care equipment clean and properly stored. Resident care equipment includes, but is not limited to, equipment used in the completion of the activities of daily living. With Guidelines: 4. The facility will provide and maintain bed and bath linens that are clean and in good condition.		