STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235263	A. Building B. Wing	12/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Sterling Heights	14151 East 15 Mile Road Sterling Heights, MI 48312

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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. This citation pertains to Intake 2680407 Based on observation, interview, and record review, the facility failed to provide restorative therapy services (therapy to prevent or maintain range of motion - ROM) for one resident (R701) of two residents reviewed for ROM.Findings include:On 12/18/25 at 10:00 AM, R701 was observed lying in bed with their feet lying flat on the mattress. When queried, R701 confirmed they had not received consistent restorative therapy this week. A review of R701's medical record revealed they were admitted into the facility on 6/27/25 with diagnoses that included Spinal Stenosis, Multiple Sclerosis and Fibromyalgia. Further review of the medical record revealed the resident was alert and oriented x 4 (person, place, time, & situation) and required extensive assistance with bed mobility and transfers.A review of the physician orders dated 11/17/25 documented the following, Skilled restorative nursing three times a week for 12 weeks as tolerated. A review of the clinical record tasks revealed a 14 day look back for the following task: skilled restorative nursing: range of motion active to BUE (Bilateral Upper Extremity) and BLE (Bilateral Lower Extremity) three times a week for 12 weeks. 15-20 repetitions, three sets to include shoulder flexion/extension, elbow and wrist flexion/extension. flexion hip extension, abduction/adduction, knee and ankle flexion/ extension. The task record revealed the following dates were charted that restorative therapy was provided were on 12/6/25, 12/9/25, and 12/15/25 over a 14-day period (3 of 6 opportunities were provided). On 12/18/2025 at 5:00 PM, an interview was conducted with Certified Nursing Assistant (CNA) A who confirmed R701 received restorative therapy with them on 12/10/25, 12/11/25, and 12/12/25 and failed to document when once the task is complete. On 12/18/2025 at 2:30 PM, an interview was conducted with the Assistant Director of Nursing (ADON). The ADON was queried to why the restorative dates were not accurately documented as being completed and treatment not given as ordered. The ADON stated the restorative program was being reviewed for effectiveness. A review of a facility policy titled, Restorative Nursing Programs revealed the following: The goal(s) of Restorative Nursing includes improving and/or maintaining independence in activities of daily living and mobility. A restorative nursing program, when appropriate is based on the comprehensive assessment and resident .Restorative documentation requirements include documentation of implementation should be completed on the restorative delivery record or EMR (Electronic Medical Record) as applicable.

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