STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235293	A. Building B. Wing	09/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Farmington	34225 Grand River Ave Farmington, MI 48335

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake #2595964 and #2579668.Based on interview and record review, the facility failed to ensure wound treatments were provided for two residents (R905 and R906) of three residents reviewed for pressure uclers. Findings include: R906 On 9/3/25 at 8:00 AM, a review of R906's closed clinical record revealed they originally admitted to the facility on [DATE] with diagnoses that included: traumatic brain hemorrhage, skull fracture, and diffuse traumatic brain injury due to a pedestrian motor vehicle accident. R906 was non-verbal, and displayed severely impaired cognition. A review of R906's weekly skin assessments revealed an assessment dated [DATE] that documented a scar to their neck and a blister to their toe. It was noted the next weekly skin assessment was conducted on 6/6/25 and documented an “Other” skin impairment to their left lateral malleolus (ankle bone). The next skin assessment dated [DATE] only documented a right upper leg skin tear, and the assessment dated [DATE] indicated an “Other” skin impairment to the left ankle with a treatment in place. It was noted the next weekly skin assessment was conducted on 7/13/25, nearly a month later. A review of R906's “Skin and Wound” evaluations was conducted and revealed the following: An evaluation dated 6/5/24 that indicated R906 developed a facility acquired, unstageable pressure ulcer with, “slough and/or eschar” measuring 2.0 cm (centimeters) in length x 1.4 cm in width, no depth. An evaluation dated 6/13/25 that indicated the wound was worsening measuring 4.0 cm in length x 1.3 cm in width, no depth. An evaluation dated 7/18/25 that indicated the wound was again worsening measuring 7.6 cm in length x 1.6 cm in width, no depth. An evaluation dated 7/24/25 that indicated the wound had worsened measuring 8.0 cm in length x 2.8 cm in width with 0.1 cm of depth. A review of R906's treatment administration records was conducted and revealed five missing dressing changes in June 2025 and four missing dressing changes in July 2025. (continued on next page)

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

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Continued review of R906's clinical record was conducted, and it was noted the physician documented progress notes numerous times through June 2025 and July 2025, however; none of the progress notes referenced R906 having a facility acquired, unstageable pressure ulcer, a statement of whether the wound was avoidable or unavoidable, or the plan of treatment for the wound. R906's care plans were reviewed and revealed their first care plan for the wound to their left ankle was implemented on 7/29/25, despite the wound being discovered on 6/6/25. On 9/3/25 at 1:38 PM, an interview was conducted with the facility's Director of Nursing, they acknowledged the concern with R906's facility acquired pressure ulcer. R905 On 9/2/25 the medical record for R905 was reviewed and revealed the following: R905 was initially admitted to the facility on [DATE], discharged on 8/3/25 and had diagnoses including Dysphagia and Gastrostomy status. A review of R905's Nursing admission Evaluation dated 7/29/25 revealed the following: Section V. Skin. A. 1. Does the resident have any identified skin conditions/wounds? b. [No] . A review of R905's progress notes revealed the following: 8/1/2025-Nurses' Notes Writer and DON (Director of Nursing) assessed resident. Resident had MSAD (moisture associated skin damage) to coccyx, heals balanceable 8/3/2025-Nurses' Notes Resident has MASD skin tear on coccyx triad applied. redness on bilateral heels . pictures of coccyx were taken before discharge . A Wound Evaluation dated 8/3/25 revealed the following: #1-Skin Tear-Category 1. Linear .Body Location: Right Gluteus .Acquired: Present on Admission. Dimensions: Area 0.63 cm (centimeters squared). Length 1. 14 cm. Width 0.78 cm. Deepest point 0.1 cm Wound Bed epithelial [yes]. Periwound: Edges [non-attached]. Treatment: Dressing appearance [intact]. Cleansing solution [Generic wound cleanser]. Primary dressing [other]. Other, Specify: Triad. Further review of R905's wound picture on their 8/2/25 evaluation revealed the following: The picture showed an open area on the right gluteal fold that appeared to be in an area where friction and shear forces would be heightened. The picture also revealed cicatrix (scar of a healed wound) that mirrored the left gluteus. A review of R905's Physican orders did not reveal any treatment orders for the identified wound on their coccyx/right gluteus area. A review of R905's July and August 2025 TAR (treatment administration record) revealed no treatments to R905's coccyx/right gluteus wound were administered during their stay in the facility. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/3/25 at approximately 11:18 a.m., The DON was queried regarding the process for the identification of new skin impairments, and they indicated that when a skin impairment is identified, the Physican is notified, and new order tor treatment is put into the record for it and the careplan is updated. The DON was queired regarding R905's wound that was identified on 8/1/25 and the wound evaluation that was done on 8/3/25 that indicated the wound was present on admission and they reported that a Physician's order should have been implemented to treat it and that it should have been implemented upon admission to the facility.

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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** This citation pertains to intake #2579668Based on interview and record review, the facility failed to ensure enteral feeding orders were accurately transcribed upon admission and administered correctly for one resident (R905) of two residents reviewed for enteral feeding. Findings include:On 9/2/25 a complaint submitted to the State Agency was reviewed that alleged R905 was fed an incorrect amount of enteral formula. On 9/2/25 the medical record for R905 was reviewed and revealed the following: R905 was initially admitted to the facility on [DATE], discharged on 8/3/25 and had diagnoses including Dysphagia and Gastrostomy status. A review of R905's initial admission hospice Physician orders revealed the following: Evaluate need for supplemental tolerance of Glucerna 1.2 at 40ml/hr (milliliters per hour) for 16 hours.A review of R905's transcribed admission enteral orders revealed the following: Enteral Feed Order every morning and at bedtime every shift Glucerna @45ml/hr (milliliters per hour) x 16hrs via peg tube (percutaneous endoscopic gastrostomy tube) or until a total volume of 720ml. -Start Date- 07/30/2025 0700A progress note dated 7/31/2025 at 08:13 a.m., revealed the following: Received resident in bed with eyes open and resting with family at bedside. Resident feeding was currently running total volume infused when writer stop feeding was 1191 (milliliters), total volume to be infused was 720 ml. Resident abdominal area was hard and distended. Writer pulled 1000cc with residuals. Writer notified on call NP (Nurse Practitioner), who ordered to hold tube feeding and get STAT (immediately) x ray of abdomen. Writer notified DON (Director of Nursing) and on coming nurse of this change.On 9/3/25 at approximately 11:18 a.m., The Director of Nursing (DON) was queried regarding the enteral feeding order for R905 and the error of R905 being overfed on 7/31/25. The DON indicated they were aware of the error and that they had done an in-service with the Nursing staff on ensuring enteral orders are administered appropriately. On 9/3/25 at approximately 2:24 p.m., Nurse A was queried regarding R905 being over fed on 7/31/25. Nurse A reported that after they got shift report then went into R905's room to check their tube feeding (enteral) and observed R905 to have over what they were supposed to have. Nurse A indicated they had to stop the tube feeding pump and called the medical provider who ordered to hold the tube feeding. Nurse A reported that due to the overfeeding, R905's abdomen was distended. Nurse A indicated that the facility enteral pumps had to be set with a stop time otherwise the pump would keep running. Nurse A reported that they informed the Director of Nursing of the error. On 9/4/25 a facility document titled Feeding Tubes was reviewed and revealed the following: Policy: Feeding tubes will be used only as necessary to address malnutrition and dehydration, or when the resident's clinical condition deems this intervention medically necessary to maintain acceptable parameters of nutrition and hydration. Feeding tubes will be maintained in accordance with current clinical standards of practice, with interventions to prevent complications to the extent possible 7. Feeding tubes will be utilized according to physician orders . 11. Direction for staff regarding nutritional products and meeting the resident's nutritional needs will be provided to include: e. Ensuring that the administration of enteral nutrition is consistent with and follows the practitioner's orders

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. This citation pertains to intake #2580612Based on observation, interview, and record review the facility failed to assess and provide tracheostomy care per physician's orders for one resident (R906), of one resident reviewed for respiratory care, resulting in the potential for tracheostomy complications. Findings include: On 9/3/25 at 10:44 AM, an interview was conducted with R904's responsible party and they expressed concerns regarding R904's tracheostomy care.On 9/3/25 at 11:25 AM, R904 was observed in bed. R904 was in a vegetative state, non-verbal, did not track with their eyes and was observed to have a tracheostomy.On 9/3/25 at 11:55 AM a review of R904's physician's orders, medication administration records (MAR) and treatment administration records (TAR) was conducted and revealed missing documentation for assessment of the stoma site under the tracheostomy collar and tracheostomy care on the following dates/times:Day shift 6/9/25, 6/22/25 thru 6/26/25, 6/29/25 and night shift 6/4/25 and 6/6/25.Day shift 7/22/25 and 7/23/25, and night shift 7/10/25.Day shift 8/7/25 and night shift 8/21/25.On 9/3/25 at 1:38 PM, an interview was conducted with the facility's Director of Nursing. They indicated tracheostomy care had been transferred over from respiratory therapy staff to nursing staff and that could have been part of the reason the treatments were not done as nursing may have thought respiratory therapy provided the care.A review of a facility provided policy titled, Tracheostomy Care was conducted and read, .1. Respiratory therapy or trained and competent personnel will provide and document tracheostomy care to all residents with a tracheostomy twice within 24 hours.

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure physician oversight for wound care for two residents (R#'s 906 and 903) of three residents reviewed for physician services, resulting in incomplete, comprehensive care. Findings include: R906 On 9/3/25 at 8:00 AM, a review of R906's closed clinical record revealed they originally admitted to the facility on [DATE] with diagnoses that included: traumatic brain hemorrhage, skull fracture, and diffuse traumatic brain injury due to a pedestrian motor vehicle accident. R906 was non-verbal and displayed severely impaired cognition. A review of R906's weekly skin assessments revealed an assessment dated [DATE] that documented a scar to their neck and a blister to their toe. It was noted the next weekly skin assessment was conducted on 6/6/25 and documented an “other” skin impairment to their left lateral malleolus (ankle bone). A review of R906's “Skin and Wound” evaluations was conducted and revealed the following: An evaluation dated 6/5/24 that indicated R906 developed a facility acquired, unstageable pressure ulcer with, “slough and/or eschar” measuring 2.0 cm (centimeters) in length x 1.4 cm in width, no depth. An evaluation dated 6/13/25 that indicated the wound was worsening measuring 4.0 cm in length x 1.3 cm in width, no depth. An evaluation dated 7/18/25 that indicated the wound was again worsening measuring 7.6 cm in length x 1.6 cm in width, no depth. An evaluation dated 7/24/25 that indicated the wound had worsened measuring 8.0 cm in length x 2.8 cm in width with 0.1 cm of depth. Continued review of R906's clinical record was conducted and the following was revealed: Physician's notes on 6/19/25, 6/20/25, 6/25/25, and 7/7/25, 7/14/25, 7/18/25, 7/21/25, 7/22/25, 7/23/25, and 8/2/25 with no mention of the facility acquired pressure ulcer, no statement of whether it was avoidable or unavoidable, and no treatment plan for the wound. A Physician note dated 7/9/25 that read, “…Patient doesn't have any current wounds…” On 9/2/25 at 9:20 AM, R903 was observed in their room. Certified Nursing assistant (CNA) was observed assisting the resident with 1:1 eating. There were scrambled eggs and grits on the tray. The CNA stated that the resident was not eating much but they were about to get residents up and dressed to take him to the dining room. (continued on next page)

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/2/25 at 9:25 AM, the Director of Nursing (DON) was interviewed about R903's skin impairments and if there were any updates to the plan of care the DON replied that R903 was readmitted to the facility but would find out. On 9/2/25 at 9:40 AM, R903's skin was observed. A dark wound was present on the left heel and an open area that was a whiteish pink in color was observed located on the left buttocks. On 9/2/25 a record review was completed and showed that R903 was readmitted to the facility on [DATE] with a medical diagnosis of Alzheimer's disease and muscle weakness. A further review of the record revealed that R903 had a wound care assessment completed and a wound care consult order in. On 9/2/25 at 9:48AM, the wound care coordinator (WCC) was interviewed. WCC was asked who oversees the wounds at the facility, the WCC reported, they were recently hired into the role, but that primary care provider oversaw wound care until the facility hired a provider. The WCC was then asked who did the weekly wound rounds and provided further guidance if needed to the facility. The WCC reported that they completed weekly rounds with themselves and usually another staff member until the facility hired a provider, but it was no one over looking the wounds. The WCC was asked, had they personally rounded with the primary care providers at the facility for individuals with wounds, the WCC reported no. On 9/2/25 at 10:06 AM, an interview with the DON and Administrator were conducted, they were asked who oversaw the wounds at the facility. The DON reported that the primary care provider is supposed to oversee the care for wounds. The administrator and DON were asked when the last time they had a Wound Care provider, the DON reported that since late May or early June they had been without. The DON was then asked for the oversite, notes or any documentation from the medical provider for R903's wounds from the beginning of the admission to current. There was no additional documentation provided by the exit of the survey.