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	11/12/2025

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

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 - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide appropriate treatment and care according to orders, resident's preferences and goals. (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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(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 - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to Complaint #2658300.Based on interview and record review the facility failed to ensure adequate monitoring, thorough assessment including notification to a medical provider, and accurate and thorough documentation for a resident having a change in condition for one (R501) of one resident reviewed for changes in condition, resulting in a resident experiencing respiratory distress for 30 to 45 minutes before receiving emergency care and being transferred to the hospital. Findings include:A review of a complaint submitted to the State Agency (SA) revealed it was alleged the facility nurse did not call 911 in a timely manner when R501 wasn't breathing right and something was wrong on 10/28/25.On 11/7/25 at 12:46 PM, an interview was conducted with the complainant. The complainant said on the day in question (10/28/25), R501's breathing was different than normal. The complainant explained R501 experienced labored breathing (difficulty breathing, requiring more effort than usual) at times because he was on a mechanical ventilator (an automated machine that moves air in and out of the lungs to breathe for the individual). The complainant said when that happened, R501 usually just needed secretions to be suctioned and then his breathing would stabilize. On 10/28/25, however, the complainant said R501's breathing was different. Around 8:30 PM, R501's family member got Registered Nurse (RN) ‘A' around 8:30 PM, she assessed the resident, took vitals, and went to get pain medications. She came back a couple minutes later, administered the medication, and said to let the medication work. About 30 minutes later, R501's lips were turning blue and his breathing did not get any better. R501's family member went to get a staff member and Respiratory Therapist (RT) ‘B' came into R501's room, unhooked the resident from the ventilator, and provided manual ventilation. RT ‘B' asked R501's family member to go get another staff member to assist, RN ‘A' came back to the room to get vital signs and called 911. The complainant said her biggest concern was why RN ‘A' did not send R501 to the hospital at 8:30 PM when it was concern about his breathing was first expressed by the family member. R501 was taken to the hospital around 9:20 PM. The complainant reported RT ‘B' provided tracheostomy care earlier in the shift around 7:30 PM and gave R501 a breathing treatment because he was wheezing. There was no follow up until she asked RN ‘A' to come in to assess R501 around 8:30 PM.On 11/12/25, an onsite investigation was conducted at the facility.A review of R501's clinical record revealed R501 was admitted into the facility on 9/24/25, readmitted on [DATE], and discharged to the hospital on [DATE] with diagnoses that included: acute and chronic respiratory failure with hypoxia, asthma, anoxic brain damage, and dysphagia (difficulty swallowing). A review of a Minimum Data Set (MDS) assessment dated [DATE] revealed R501 had severely impaired cognition, did not speak, was dependent on staff for all activities of daily living (ADLs) transfers, and bed mobility, had an indwelling urinary catheter, a feeding tube, and was on an invasive mechanical ventilator.A review of R501's progress notes revealed the following:On 10/28/25 at 7:15 PM (time stamped, but not created until later), RT ‘B' wrote a Respiratory Note that documented, Pt [patient] eval [evaluation] complete. Trach [tracheostomy - an opening surgically placed in the windpipe where a tube is placed to assist with breathing] care done, [NAME] [no apparent respiratory distress]. RT to follow-up. Pt displayed agonal breathing [gasping for air) and thready heart rate [weak pulse]. Pt sent out to hospital with unstable saO2 [oxygen saturation]. It should be noted RT ‘B' did not document R501's heart rate or oxygen level and in the same note documented R501 was not in respiratory distress.On 10/28/25 at 8:42 PM, it was documented in an Orders - Administration Note written by RN ‘A' that R501 received tramadol for pain and Resident repositioned at this time.There were no other progress notes written by RN ‘A' on the night shift of 10/28/25.A review of a SBAR [Situation Background Assessment Recommendation] Communication Form dated 10/28/25, completed by RN ‘A', revealed R501 had a change in condition which was documented as Respiratory Distress. It was documented it started on 10/28/25 and got worse. In the section for Treatment for last episode, it was left blank. R501's Most Recent Pulse was documented as 132 (beats per minute - bpm, which was an elevated abnormal heart rate) on 10/28/25 at 8:41 PM, approximately one hour prior to the creation of the SBAR form. At that same time, R501's O2 Sats were 99 percent on mechanical ventilation. It was documented that R501 had labored breathing and agonal breathing. In the section for the RN to document What do you think is going on with the resident?, RN ‘A' documented, n/a (not applicable). The Nursing Note section documented, Family called for Help in Resident's room, (RT ‘B') went into room, Rt called for the nurse. Upon entering room Resident was observed Agonal breathing and RT bagging resident, unable to stabilize breathing and oxygen level. 911