

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235300	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/23/2025
NAME OF PROVIDER OR SUPPLIER Medilodge of Taylor		STREET ADDRESS, CITY, STATE, ZIP CODE 23600 Northline Rd Taylor, MI 48180	

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. (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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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to Intake 1351543Based on observation, Interview, and record review, the facility failed to ensure a call light was answered within a timely manner for one resident (R906) out of six residents reviewed for call lights, resulting in the R906 being left of the toilet for an extended period, discomfort, disrespect, and feelings of anxiety.Findings include:On 7/22/25 at 12:35 pm, R906 was observed in their room sitting in a wheelchair. R906 was interviewed about the care received at the facility. R906 said they were not receiving good care. R906 stated they went to the bathroom on 6/21/25 around 1:30 pm. R906 said, I was able to put myself on the toilet.I put the call light on and waited almost two hours for staff to answer the bathroom call light. R906 stated their family was visiting and went looking for staff but could not find anyone to help. R906 was asked if family was able to assist and the resident said, No they can't help me. At this time, R906 said, I was begging for help.I was yelling please help me. It made me feel like I was not important. During the interview, R906 was crying uncontrollably while explaining what occurred.A review of R906 electronic medical records revealed an admission to the facility on 6/22/2022 with the diagnoses of Type 2 Diabetes Mellitus, Peripheral Vascular Disease, Atherosclerotic Heart Disease, Chronic Fatigue, Age-Related Macular Degeneration, and Adjustment Disorder with Mixed Anxiety and Depressed Mood. A review of R906's Brief Interview for Mental Status (BIMS) dated 5/10/2025 disclosed a score of 15/15 (cognitively intact). A review of R906's Minimum Data Set (MDS) dated [DATE] revealed R906 required partial to moderate assistance with toileting hygiene, substantial to maximal assistance with lower body dressing, supervision or touching assistance with toilet transfer. A review of R906 care plan revealed the following: Interventions-Toileting: 1 person assist, will request to be changed when needed.dated 8/15/2023 and revised on 6/23/2025.Intervention-Encourage resident to use call light when assistance is needed.dated 8/15/2023. A review of R906's progress notes revealed documentation by Unit Manager F dated 6/23/2025 at 2:05pm: On 7/23/25 at 9:28am, Unit Manager F was interview about R906 allegation of being left on the toilet from 1:30pm-3:15pm. Unit Manager F stated, I was told that lunch trays were delivered late that day. The two certified nurse assistants (CNA) were passing trays at this time. Unit Manager F said the call system will go to the CNA pager and after 10 minutes it will alert the nurse that the call light was on. Unit Manager F said, The CNAs and nurse were feeding residents and it would not be fair to stop feeding a resident to answer a call light. Unit Manager F said that R906 usually goes to the bathroom on their own and will need assistance with bowel movements. Unit Manager F said she educated the CNAs and the Nurse about answering call lights. On 7/23/25 at 10:15am, the NHA was interviewed about R906 being left on the toilet for an extended period. The NHA said, I spoke to (R906) and was made aware of being on the toilet for an extended time.This is not acceptable, and the staff was educated. A review of the facility's policy Call Lights: Accessibility and Timely Response dated 12/28/2023 revealed the following: Policy: The purpose of this policy is to assure the facility is adequately equipped with a call light at each residents' bedside, toilet, and bathing facility to allow residents to call for assistance. Call lights will directly relay to a staff member or centralized location to ensure appropriate response.Policy Explanation and Compliance Guidelines: 1.Staff are educated in the proper use of the resident call system, including how the system works and ensuring resident access to the call light.7. Any staff member who sees or hears an activated call light is responsible for responding. If the staff member cannot provide what the resident desires, the appropriate personnel should be notified.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>Based on observation, interview and record review the facility failed to ensure enhanced barrier precautions (EBP) were applied during wound care for one resident (R912) out of one resident reviewed for infection control. Findings include: Record review of R912's electronic medical records (EMR) revealed admission into the facility on 5/28/23 with a pertinent diagnosis of pressure ulcer of sacral area (upper buttocks) region Stage 4 (deep wound where bone and muscle can be observed). An observation conducted on 7/23/25 at 9:56 a.m. revealed a sign posted on the outside of R912's door instructing staff to wear personal protective equipment (PPE) during care. Additionally, a storage unit containing PPE was observed outside the resident's room. An observation on 7/23/25 at 10:00 am, was made of Licensed Practical Nurse (LPN) C entering R912's room without donning the required PPE. During the wound care procedure, after R912's soiled bandages were removed, the wound was observed with red-colored drainage. Record review of R912's physician's orders, dated 5/30/25 at 3:00 p.m., documented, use enhanced barriers while performing high-contact activity with the resident during every shift. Record review of R912's Enhanced Barrier Precaution care plan indicated that enhanced barrier precautions were to be implemented when providing high-contact resident care activities. These included dressing, bathing, transferring, personal hygiene, changing linens, changing briefs/assisting with toileting, device care: central lines, urinary catheters, feeding tubes, tracheostomy/ventilators, wound care, dialysis. This care plan was initiated on 04/01/2024. An interview conducted on 7/23/25 at 10:50 a.m. with LPN C, revealed that PPE should be worn during wound care procedures. During an interview on 7/23/25 at 11:15 a.m., the Assistant Director of Nursing (ADON) A, reported that PPE was required to be worn when performing wound care for R912. An interview on 7/23/25 at 11:45 a.m. with Infection Control Preventionist (IFC) D confirmed that staff are expected to consistently wear appropriate PPE during wound care and that staff had been in-serviced on these protocols on multiple occasions. Record review of facility's Policy, Enhanced Barrier Precautions documented, . It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms.</p>		