STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235300	A. Building B. Wing	08/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Taylor	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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	This citation pertains to intake 2583399.Based on interview and record review, the facility failed to timely notify the guardian of a resident fall for one resident (R101) out of four residents reviewed for falls. Findings include:Record Review of R101's Electronic Health Record (EHR) revealed admission to the facility on 7/24/25 with diagnoses which included Unspecified Fracture of Right Femur, Chronic Lymphocytic Leukemia of B-Cell Type, Legal Blindness. Date of discharge 7/31/25 at 8:11 AM to acute care hospital.Review of 101's Brief interview for Mental Status (BIMS) assessment performed on 7/29/25 revealed a BIMS of 8/15 moderately impaired cognition. R101 is listed as having a guardian. Review of R101's functional abilities status revealed substantial/maximal assistance for bed mobility and dependent for transfers.On 8/21/25 at 9:05 AM, Certified Nursing Assistant (CNA) C was interviewed and said that on 7/29/25 at approximately 6:30 AM, she found R101 on the floor next to the bed. CNA C notified Licensed Practical Nurse (LPN) D and together they put R101 back in bed. CNA C said she did not notice anything new wrong with R101, no new injury. CNA C said that she worked with R101 on 7/30/25 and at approximately 11:00 PM while providing care she noticed something wrong with R101's left leg. CNA C said she immediately notified LPN E.On 8/21/25 at 9:30 AM, Guardian staff member (G) B was interviewed and said that the Guardian office was not notified of R101's fall on 7/29/25. G B revealed that the guardian office was notified of R101's transfer to the hospital on 7/31/25 by LPN E due to leg injury. However, the guardian office was not notified of R101's fall or how the left leg was injured.On 8/20/25 at 12:01 PM, LPN D was left a voicemail for an interview request with no return phone call.Record review of R101's progress note, created 7/31/25 at 9:43 AM, effective date 7/29/25 at 7:00 AM late entry completed by LPN D revealed in part: Nurse quickly went to get the CNA to help transfer the resident back to bed. Prior to the fall, resident was administered her pain medication. Physical assessment was conducted; no visual injury noticed. No injuries were observed at the time of the incident. Agencies/People notified Responsible Party/Family Member Guardian 7/31/25 at 9:08 AM.On 8/20/25 at 1:00 PM the Director of Nursing (DON) was interviewed and said R101's guardian, physician and herself were not notified of the fall that occurred on 7/29/25 until 7/31/25. The DON further said that the guardian, physician and herself should have been notified immediately of the fall due to probable injury. Review of the facility policy titled Incidents and Accidents Reporting date reviewed/revised 8/11/22 revealed in part: It is the policy of this facility for staff to utilize electronic and/or approved forms to report, investigate, and review any accidents or incidents that occur or allegedly occur, on facility property and may involve or allegedly involve a resident. The following incidents/accidents require an incident/accident report but are not limited to falls. The supervisor or other designee will be notified of the incident/accident. The nurse will notify the resident's practitioner to inform them of the incident/accident, report any injuries or other findings, and obtain orders, if indicated, which may include transportation to the hospital dependent upon the nature of the injury(ies). The resident's family or representative will be notified of the incident/accident and any orders obtained or if the resident is to be transported to the hospital. The nurse/designee will enter the incident/accident information into the appropriate form/system within 24 hours of occurrence and will document all pertinent information. If an incident/accident was witnessed by other people, the supervisor or designee will obtain the witness' account.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (continued on next page)

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	This citation pertains to intake 2583399.Based on interview and record review, the facility failed to report an injury of unknown origin to the State Agency (SA) for one resident (R101) out of four residents reviewed for injuries of unknown origin. Findings include:On 7/31/25 the State Agency (SA) received a complaint from Adult Protective Services regarding R101 sustaining a fractured leg.Record Review of R101's Electronic Health Record (EHR) revealed admission to the facility on 7/24/25 with diagnoses which included Unspecified Fracture of Right Femur, Chronic Lymphocytic Leukemia of B-Cell Type, Legal Blindness. Date of discharge 7/31/25 at 8:11 AM to acute care hospital.Review of 101's Brief interview for Mental Status (BIMS) assessment performed on 7/29/25 revealed a BIMS of 8/15 moderately impaired cognition. R101 is listed as having a guardian. Review of R101's functional abilities status revealed substantial/maximal assistance for bed mobility and dependent for transfers.On 8/21/25 at 9:05 AM, Certified Nursing Assistant (CNA) C was interviewed and said that on 7/29/25 approximately at 6:30 AM, she found R101 on the floor next to the bed. CNA C said she notified Licensed Practical Nurse (LPN) D and together they put R101 back in bed. CNA C said she did not notice anything wrong with R101, or a new injury. CNA C further said that she worked with R101 on 7/30/25 and at approximately 11:00 PM while providing care she noticed something wrong with R101's left leg. CNA C said she immediately notified LPN E.On 8/20/25 at 1:16 PM, LPN E was interviewed and said she worked on 7/30/25 and became aware of R101's left leg injury around 11:30 PM. LPN E said she immediately notified the doctor. LPN E further said she notified the Director of Nursing (DON) and Nursing Home Administrator (NHA).On 8/20/25 at 11:25 AM Certified Occupational Therapist Assistant (COTA) G and Physical Therapist Assistant (PTA) H were interviewed and said they worked with R101 on 7/29/25 through 7/30/25 and did not notice anything changes in condition during the therapy sessions.On 8/21/25 at 9:30 AM, Guardian staff member (G) B was interviewed and said that the Guardian office was not notified of R101's fall on 7/29/25. G B revealed that the guardian office was notified of R101's transfer to the hospital on 7/31/25 by LPN E due to a leg injury however the guardian office was not notified of R101's fall or how the leg injury occurred.On 8/20/25 at 12:01 PM, LPN D was left a voicemail for an interview request with no return phone call.Record review of R101's progress note date created 7/31/25 at 9:43 AM, effective date 7/29/25 at 7:00 AM late entry completed by LPN D revealed in part: Nurse quickly went to get the CNA to help transfer the resident back to bed. Prior to the fall, resident was administered her pain medication. Physical assessment was conducted; no visual injury noticed. No injuries were observed at the time of the incident. Agencies/People notified Responsible Party/Family Member Guardian 7/31/25 at 9:08 AM. Review of the progress note dated 7/30/25 at 11:47 PM, revealed Resident resting in bed, writer noted left leg twisted and a bulge in left hip. Dr. phoned.On 8/20/25 at 1:15 PM, the NHA was interviewed and said LPN E notified her of R101's inured left leg. The NHA further said she did not notify the SA of R101's injured left leg or conduct an investigation and should have.Review of the facility policy titled Incidents and Accidents Reporting date reviewed/revised 8/11/22 revealed in part: It is the policy of this facility for staff to utilize electronic and/or approved forms to report, investigate, and review any accidents or incidents that occur or allegedly occur, on facility property and may involve or allegedly involve a resident. The following incidents/accidents require an incident/accident report but are not limited to falls. The supervisor or other designee will be notified of the incident/accident. The nurse will notify the resident's practitioner to inform them of the incident/accident, report any injuries or other findings, and obtain orders, if indicated, which may include transportation to the hospital dependent upon the nature of the injury(ies). The resident's family or representative will be notified of the incident/accident and any orders obtained or if the resident is to be transported to the hospital. The nurse/designee will enter the incident/accident information into the appropriate form/system within 24 hours of occurrence and will document all pertinent information. If an incident/accident was witnessed by other people, the supervisor or designee will obtain the witness' account.Review of the facility policy titled reporting Alleged Violations date reviewed/revised 1/10/24 revealed in part: The purpose of this policy is to assure that alleged violations are reported immediately to the facility administrator and other officials as required by State and Federal Guidelines. The facility must ensure:1. Alleged violations involving abuse, neglect, exploitation, or mistreatment are reported in accordance with State and Federal Guidelines. This includes injury of unknown source and misappropriation of resident property.2. If the alleged violation involves abuse or results in serious bodily injury it must be reported immediately but no later than 2 hours after the allegation in made 3. If the alleged violation does not

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	This citation pertains to intake 2583399.Based on interview and record review, the facility failed to investigate an injury of unknown origin for one resident (R101) out of four residents reviewed for injuries of unknown origin. Findings include:On 7/31/25 the State Agency (SA) received a complaint from Adult Protective Services regarding R101sustaining a fractured leg.Record Review of R101's Electronic Health Record (EHR) revealed admission to the facility on 7/24/25 with diagnoses which included Unspecified Fracture of Right Femur, Chronic Lymphocytic Leukemia of B-Cell Type, Legal Blindness. Date of discharge 7/31/25 at 8:11 AM to acute care hospital.Review of 101's Brief interview for Mental Status (BIMS) assessment performed on 7/29/25 revealed a BIMS of 8/15 moderately impaired cognition. R101 is listed as having a guardian. Review of R101's functional abilities status revealed substantial/maximal assistance for bed mobility and dependent for transfers.On 8/21/25 at 9:05 AM, Certified Nursing Assistant (CNA) C was interviewed and said that on 7/29/25 approximately at 6:30 AM, she found R101 on the floor next to the bed. CNA C notified Licensed Practical Nurse (LPN) D and together they put R101 back in bed. CNA C said she did not notice anything wrong with R101 or new injury. CNA C further said that she worked with R101 on 7/30/25 and at approximately 11:00 PM while providing care she noticed something wrong with R101's left leg. CNA C said she immediately notified LPN E.On 8/20/25 at 1:16 PM, LPN E was interviewed and said she worked on 7/30/25 and became aware of R101's left leg injury around 11:30 PM. LPN E said she immediately notified the doctor. LPN E further said she notified the Director of Nursing (DON) and Nursing Home Administrator (NHA).On 8/20/25 at 11:25 AM Certified Occupational Therapist Assistant (COTA) G and Physical Therapist Assistant (PTA) H were interviewed and said they worked with R101 on 7/29/25 through 7/30/25 and did not notice anything changes in condition during the therapy sessions.On 8/21/25 at 9:30 AM, Guardian staff member (G) B was interviewed and said that the Guardian office was not notified of R101's fall on 7/29/25. 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