STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235330	A. Building B. Wing	08/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Livingston	3003 W Grand River Howell, MI 48843

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to Intake #2584966Based on observation, interview and record review the facility failed to ensure residents received scheduled showers for one (R801) out of one resident reviewed for ADL (activities of daily living) care. Findings include:A complaint was filed with the State Agency (SA) that alleged there were not enough staff at the facility to ensure they received their showers.On 8/27/25 at approximately 9:30 AM, R801 was observed lying in bed. The resident was alert and able to answer all questions asked. When quired as to whether they received scheduled showers, R801 replied that they finally got a shower yesterday (8/26/25) but was not regularly receiving them and often only received a bed bath. R801 noted that they need a shower to ensure cleanliness.A review of R801's clinical record revealed the resident was initially admitted to the facility on [DATE] with diagnoses that included: type II diabetes and acute respiratory failure. A review of the resident's Minimum Data Set (MDS) dated [DATE] noted the resident had a Brief Interview for Mental Status (BIMS) score of 14/15 (intact cognition).A review of review of R801's TASK record for showers noted the resident was to receive showers on Tuesday and Fridays during the day shift. A 30 day look back recorded the following: Tuesday- 7/29/25 (shower), Friday -8/1/25 (bed bath), Tuesday -8/5/25 (bed bath), Friday-8/7/25 (nothing provided), Tuesday-8/12/25 (nothing provided), Friday-8/15/25 (shower), Tuesday-8/19/25 (bed bath), Friday-8/22/25 (nothing provided) and Tuesday-8/26/25 (shower). *It should be noted that there were no notes that indicated R801 refused showers on the dates nothing was provided. In addition, there were no notes that indicated R801 preferred a bed bath on the dates noted above.On 8/27/25 at approximately 3:30 PM, an interview was conducted with Certified Nursing Assistant (CNA) F who was assigned to R801. CNA F was asked about the facility's protocol pertaining to showers. CNA F reported that showers generally are given twice per week. CNA F was asked if they provided R801 with showers and/or bed baths and they noted that they give the residents showers as that is what they prefer.A request had been made for any grievances pertaining to R801. On 8/27/25 at approximately 3:40 PM, the Administrator reported that a grievance pertaining to showers was submitted yesterday (8/26/25) and had not been fully completed.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235330	A. Building B. Wing	08/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 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. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235330	A. Building B. Wing	08/27/2025

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to Complaint #2588818.Based on interview and record review, the facility failed to perform respiratory assessments upon admission and before and after breathing treatment administration for one (R802) of one resident reviewed for a change in condition. Findings include: A review of R802's clinical record revealed R802 was admitted into the facility on 5/23/25, readmitted on [DATE], and discharged on 8/11/25 with diagnoses that included: chronic respiratory failure with hypoxia (low oxygen level), chronic obstructive pulmonary disease (COPD), history of lung cancer, and end stage renal disease (ESRD). R802 was dependent on a mechanical ventilator for breathing, had a tracheostomy (a surgical hole in the windpipe to assist with breathing), and received renal dialysis. A review of a Minimum Data Set (MDS) assessment dated [DATE] revealed R802 had severely impaired cognition and was dependent on staff for care. Further review of R802's clinical record revealed R802 was transferred to the hospital on 6/17/25 and from there was admitted to an inpatient rehabilitation hospital until 8/5/25, at which time R802 was readmitted into the facility. A review of R802's progress notes revealed the following:On 8/5/25, a Respiratory Note documented, Resident re admitted to facility .Put on previous vent settings .A review of R802's Physician's Orders revealed from 5/30/25 until 6/19/25 the ventilator setting orders were as follows: Vent-Settings: Mode: PC (Pressure Control) RR (Respiratory Rate): 19 VT: 500 PEEP (Positive End Expiratory Pressure): +5Further review of R802's Physician's Orders revealed from 8/6/25 to 8/19/25 (after R802 returned from the hospital) the ventilator setting orders were as follows: Vent-Settings: Mode: AC (Assist Controlled) Vt: 400 RR: 16 PEEP: +5. It should be noted that the initial Respiratory progress note written when R802 returned to the facility on 8/5/25 noted R802 was put on the previous vent settings (prior to going to the hospital). However, the orders were different. A review of a Respiratory-Ventilator Resident Evaluation dated 8/5/25 revealed the settings were correct to the current physician's order, but the documentation in the progress note was not accurate. Further review of the evaluation revealed the documented vital signs on that date (8/5/25) were vital signs from 6/17/25, the day R802 was transferred to the hospital. A review of a Respiratory-Breathing Treatment assessment dated [DATE] at 11:40 PM, completed by Respiratory Therapist (RT) 'B', revealed R802 received a breathing treatment. The assessment had a section to assess the resident's breath sounds and vital signs Pre (before) and Post (after) the breathing treatment was administered. The vital signs documented for this breathing treatment were the same date and time for pre and post treatment and they were dated and timed as follows: O2 sats and Respiration: 8/10/25 at 3:06 PM (approximately eight and a half hours prior to the administration of the breathing treatment) and Pulse: 8/10/25 at 5:39 PM (six hours prior to the administration of the breathing treatment). A review of a Respiratory-Breathing Treatment assessment dated [DATE] at 4:59 AM, completed by Respiratory Therapist (RT) 'B', revealed R802 received a breathing treatment. The vital signs documented for this breathing treatment were the same date and time for pre and post treatment and they were the same vital signs documented on the previous assessment. O2 sats and Respiration: 8/10/25 at 3:06 PM (approximately 14 hours prior to the administration of the breathing treatment) and Pulse: 8/10/25 at 5:39 PM (approximately 11.5 hours prior to the administration of the breathing treatment). A review of R802's care plans revealed a care plan initiated on 8/6/25 that noted, Resident has an impaired pulmonary/respiratory status related to vent dependency and tracheostomy . Interventions included, Administer medications as ordered. Observe for effectiveness and report adverse side effects to Physician .On 8/27/25 at 1:36 PM, a telephone interview was attempted with RT 'B'. RT 'B' was not available for interview prior to the end of the survey.On 8/27/25 at 1:55 PM, an interview was conducted with Respiratory Director (RTD) 'E'. When queried about the progress notes documenting put on previous vent settings instead of documenting the vent settings, RTD 'E' said they were short of staff and probably did it to save time. When queried about the process for assessing a resident on a mechanical ventilator on admission and whether vital signs should be taken at the time of the assessment, RTD 'E' said they should. When queried about how residents on mechanical ventilators were assessed when given a breathing treatment, RTD 'E' said the RT took breath sounds and vital signs before the treatment was administered and then they would go back in after the treatment and recheck breath sounds and redo the vital signs. At that time, the breathing treatment evaluations from 8/10/25 and 8/11/25 were reviewed with RTD 'E'. RTD 'E' reported they used the previous set of vitals taken by nursing. When queried about how the RT would know if the breathing treatment was effective if they used vital signs from eight to 14 hours earlier