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	10/30/2025

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 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. (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 0742 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 intake 2647121Based on interview and record review, the facility failed to provide behavioral health services for one resident (R901) of three residents reviewed for Changes in condition. Findings include:On [DATE] a concern submitted to the State Agency was reviewed which alleged R903 did not have any support services while at the facility. On [DATE] the medical record for R903 was reviewed and revealed the following: R903 was initially admitted to the facility on [DATE] and had diagnoses including Opioid dependence, depression and Dependence on renal dialysis. A Psychiatry Initial Evaluation dated [DATE] revealed the following: Chief Complaint-Depression, anxiety and insomnia-History of Present Illness- .was initially admitted to [Name of facility] on 5-9-2025 for long-term care due to requiring 24-hour assistance with ADLs (activities of daily living), skilled nursing care, and medication management. Social worker requested psychiatric evaluation regarding patient's increased symptoms of ongoing moderate depression, anxiety, and insomnia .Resident reports his mood has been down with ongoing anxiety and depression. He denies ever seeing a psychiatrist and reports starting Celexa in the hospital for depression. He reports sleeping poorly, though his appetite is very good. Resident attributes his ongoing depression to being homeless and states he will be in the facility long-term as he has no place to go Additional Notes Patient presents with increased symptoms of ongoing moderate depression, anxiety, and insomnia, which prompted the current psychiatric evaluation .Assessment and Plan- Major depressive disorder, single episode, moderate. Patient presents with ongoing moderate depression related to his current life circumstances, including homelessness. He reports his mood has been down .Plan is to increase Celexa from 20mg (milligrams) to 30mg daily for ongoing depression. Recommend psychotherapy for ongoing depression. Patient is in agreement with plan of care A Social Service evaluation dated [DATE] revealed the following: Date of most recent PHQ-9 (Patient Health Questionnaire)-[DATE]. PHQ-9 Score-15 (moderately severe depression).A Nurse Practitioner note dated [DATE] revealed the following: .He expresses concerns with his neuropathic pain that is not being treated well by existing regiment of oxycodone 10 mg twice a day and Suboxone 4 mg twice a day. I tried to find out if the patient was on Suboxone prior to his hospitalization to [local hospital] and it appears that it was initiated there. I am trying to coordinate him with the specialty clinic for addiction and withdrawal management that will do a better job with Suboxone dosage adjustment A Nurse Practitioner note dated [DATE] revealed the following: CHIEF COMPLAINT .Follow-up on the blood sugar management and other chronic issues .He agreed to my plan: referring him to the addiction specialist to titrate his Suboxone and to endocrinology if we are not able to take his blood sugars under control A Psychiatry follow up note dated [DATE] revealed the following: .He states that he had a PCP (primary care Physician) in [last state lived] and used to be on Xanax 1 mg twice daily for 2 years. He has been off Xanax for the last 6 months because his PCP did not want to prescribe it along with his OxyContin, which he has been on for at least 2 years. It is documented on a progress note of [DATE] that patient is being referred to an addiction specialist to titrate his Suboxone. He complains of chronic depression and anxiety because of his health issues and because he is homeless and does not know what the future holds for him. He admits to poor motivation and no ambition to do anything. He does not like to go to activities .He gives a history of suicide attempt 2 years ago when he injected himself with Windex cleaning solution, but it had no effect whatsoever and did not even make him ill. He states that he was depressed because his mother had died in 2020 from a fentanyl overdose .He complains of insomnia despite taking melatonin 3 mg nightly and trazodone 50 mg nightly. He is currently also on citalopram 30 mg daily. His weight was 143.6 pounds 5 days ago. He is wondering if he can go back on Xanax. I informed him that I am going to wean him off the Celexa since it has proven to be ineffective, and we will start him on Cymbalta which can help for his depression, anxiety, diabetic neuropathy, and chronic pain. He was in agreement with this plan .Assessment and Plan-Major depressive disorder, recurrent, moderate-Patient presents with chronic depression related to health issues and homelessness. Reports poor motivation and no ambition to do anything. Denies current suicidal ideation. Plan is to taper citalopram (Celexa) as it has proven ineffective: 20 mg daily for 1 week, then 10 mg daily for 1 week, then discontinue. Starting duloxetine (Cymbalta) 30 mg every morning for 1 week, then increasing to 60 mg every morning to address depression. Patient is in agreement with plan of care .Generalized anxiety disorder-Patient reports ongoing anxiety related to health issues and uncertain future. Duloxetine (Cymbalta) 30 mg every morning for 1 week, then increasing to 60 mg every morning will also address anxiety