STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235365	A. Building B. Wing	05/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Livonia	29270 Morlock Livonia, MI 48152

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to Intake 3018720 Based on interview and record review, the facility failed to accurately document the completion of bladder scans following the removal of a catheter for one resident (R901) of one reviewed for urinary retention. Findings include:A review of documentation submitted to the State Agency revealed R901 was transferred from the facility to the hospital for abdominal pain where it was alleged the resident had retained a significant amount of urine into their abdomen.A review of R901's medical record revealed they were admitted into the facility on [DATE] and discharged to the hospital on [DATE]. R901 was admitted into the facility with diagnoses which included Displaced Oblique Fracture of Shaft of Left Femur, Diabetes, and Hypertension. Further review revealed the resident was cognitively impaired and required 1-2 people for assistance with activities of daily living. Further review of the medical record revealed the following progress note:11/29/2025 11:03 (11:03am) Progress Note: Contacted [physician] . informed [them] that night nurse took out patients (name of indwelling catheter) at 6 am. Patient had (name of indwelling catheter) for urine retention and needs to schedule appointment with urologist. [Physician] ordered bladder scans. Orders placed and continue to monitor patient.A review of R901's medical record revealed the following physician order dated 11/29/25 and discontinued on 12/22/25, Order Summary: Bladder scan q (every) 6 hours. Every 6 hours for bladder retention. Further review of the resident's medical record revealed another physician order dated 11/29/25 however, it was created on 12/19/25 (9 days after the resident discharged), Bladder scan q 6 hours. Contact provider if over 500 cc (cubic centimeters, metric unit used to measure amount of urine).Further review of the medical record revealed the December 2025 Medication Administration Record (MAR) revealing several bladder scans had not been completed:12/1/25: Missing two documented bladder scans12/2/25: No documented bladder scans12/3/25: Missing two documented bladder scans12/4/25: Missing two documented bladder scans12/5/25: Missing two documented bladder scans12/6/25: No documented bladder scans12/7/25: No documented bladder scans12/8/25: No documented bladder scans12/9/25: No documented bladder scansOn 5/27 at 12:19 PM, an interview was completed with Assistant Director of Nursing (ADON) regarding the lack of documented bladder scans. The ADON explained an audit had been completed on the resident's medical record after they had discharged , and it had been discovered the physician's order for the blader scans had been inputted into the medical record incorrectly, and as a result, the volume of urine completed during the bladder scans had not been completed. The ADON explained that nursing was measuring the resident's output however, it was acknowledged it hadn't been documented. Regarding the missing documented bladder scans, the ADON acknowledged the missing dates, and did not provide additional information regarding this. A review of the facility's Medication Orders did not address documentation and ensuring physician orders are carried out per professional standards.

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