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	03/19/2026

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

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to maintain best practices in the food service area resulting in the potential to spread food borne illness to all residents that consume food from the kitchen. Findings Include:On 03/18/2026 at 8:21 AM an interview with Food Service Director (FSD) A regarding the frequency of use of the meat slicer found it is used periodically.On 03/18/2026 at 8:43 AM observed dried debris at the bottom of two clean equipment utensil bins.On 03/18/2026 at 9:09 AM an interview with FSD A found the cooks are responsible for cleaning and sanitizing clean utensil bins daily.On 03/18/2026 at 9:32 AM observed dried food debris accumulated on the underside of the meat slicer blade. When pointing out food debris, FSD A stated I see what you are talking about.According to the 2022 FDA Food Code section 4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils. (A) EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be clean to sight and touch.On 03/18/2026 at 8:39 AM observed a 2 x 2 opening in tiled floor area near dishwashing area, filled with soiled standing water. During this observation when asked about the standing water FSD A indicated it was not an open drain and that it is where a pipe used to be and is closed off but collects water when mopping. FSD A indicated maintenance could be asked to fill it in.According to the 2022 FDA Food Code section 6-501.11 Repairing. PHYSICAL FACILITIES shall be maintained in good repair.On 03/18/2026 at 8:50 AM observed wall air ventilation cover between the 3-comp sink and hood cooking area with dust and soil build up and speckled black/brown build up on the adjacent ceiling tiles in an area approximately 2' x 2'. On 03/18/2026 at 9:10 AM an interview with FSD A regarding with soiled ceiling tiles found maintenance will come and clean as needed. When asked if it looked like it needed cleaning, FSD A replied yes.On 03/18/2026 at 9:13 AM observed Director of Maintenance (DM) E wipe ceiling with a cloth. When wiped, the buildup was removed from the ceiling.On 03/18/2026 at 12:08 PM observed the kitchen air conditioning window unit located above the three-compartment sink with an accumulation of dust and soil.According to the 2022 FDA Food Code section 6-501.12 Cleaning, Frequency and Restrictions. (A)PHYSICAL FACILITIES shall be cleaned as often as necessary to keep them clean.On 03/18/2026 at 8:45 AM observed water droplets in three stacked quarter pans located on the clean equipment rack in the kitchen.On 03/18/2026 at 9:40 AM an interview with FSD A regarding storage of wet stacked clean equipment found that staff know to air dry pans and ensure there are no droplets before storing.According to the 2022 FDA Food Code section 4-901.11 Equipment and Utensils, Air-Drying Required. After cleaning and SANITIZING, EQUIPMENT and UTENSILS: (A) Shall be air-dried before contact with FOOD. On 03/18/2026 at 8:52 AM observation of the two-door cooler found a full pan with a facility marked label indicating it was potato salad. The pan was observed tightly wrapped in plastic wrap with condensation on the interior. An interview at this time with [NAME] B found the potato salad was cooling from room temperature and had been prepared at 8:00 AM using room temperature canned cooked diced potatoes and additional ingredients. [NAME] B indicated that sometimes they pre-chill the ingredients but hadn't today. A temperature of the potato salad was taken at this time and found to be 56-57 F.On 03/18/2026 at 1:09 PM an interview with [NAME] B found they had moved the potato salad into two shallow pans to help it cool faster. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observation of the potato salad found it separated into two pans and loosely covered with plastic wrap. A temperature of the potato salad was taken and found to be at 44 F after five hours since preparation.On 03/18/2026 at 1:10 PM an interview with FSD A found the temperature should be between 30-41 F now. FSD A indicated they would take the temperature again and discard the potato salad if it was not in range.On 03/18/2026 at 1:58 PM FSD A indicated they had discarded the potato salad.A record review of the facility provided document entitled Food Safety Requirements states, When preparing food, staff shall take precautions in critical control points in the food preparation process to prevent , reduce, or eliminate potential hazards . Cooling- various strategies (e.g., placing foods in shallow pans, cutting roasts into smaller portions, utilizing ice water baths, and stirring periodically) shall be implemented to cool foods so that the total time for cooling does not exceed 6 hours.According to the 2022 Food Code, 3-501.14 Cooling. (B) TIME/TEMPERATURE CONTROL FOR SAFETY FOOD shall be cooled within 4 hours to 5oC (41oF) or less if prepared from ingredients at ambient temperature, such as reconstituted FOODS and canned tuna.According to the 2022 FDA Food Code section 3-501.15 Cooling Methods. (A) Cooling shall be accomplished in accordance with the time and temperature criteria specified under S 3-501.14 by using one or more of the following methods based on the type of FOOD being cooled: (1) Placing the FOOD in shallow pans; (2) Separating the FOOD into smaller or thinner portions; (3)Using rapid cooling EQUIPMENT; (4) Stirring the FOOD in a container placed in an ice water bath; (5) Using containers that facilitate heat transfer; (6) Adding ice as an ingredient; or (7) Other effective methods. (B) When placed in cooling or cold holding EQUIPMENT, FOOD containers in which FOOD is being cooled shall be: (1) Arranged in the EQUIPMENT to provide maximum heat transfer through the container walls; and (2) Loosely covered, or uncovered if protected from overhead contamination as specified under Subparagraph 3-305.11(A)(2), during the cooling period to facilitate heat transfer from the surface of the FOOD.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation, interview, and record review the facility failed to maintain general cleanliness and repair of the premises as well as proper storage of clean and sanitary supplies. This resulted in an increased potential for contamination and a possible decrease in satisfaction of living affecting all residents. Findings Include:On 03/18/2026 at 9:50 AM observed black debris accumulated on the inside shelf of the cabinet located under the sink in the nourishment room. Further observation of the sink drain found multiple straws within as a possible clogging factor.On 03/18/2026 at 10:08 AM observed an assortment of discarded items layering the bottom of the clean linen transfer bin under the inside support floor (used to help bring linen near the top of the bin).An interview at this time with Housekeeping Manager (HM) C regarding expectations for frequency of cleaning bins found it should be cleaned after every load.On 03/18/2026 at 10:10 AM observed the cold-water handle missing from the handwash sink in the laundry room. An interview with HM C at this time found that the cold water shut off valve can be turned on and off to adjust the water temperature and the repair request is in the building maintenance electronic request system (TELS).On 03/18/2026 beginning at 10:12 AM an environmental tour was conducted with HM C and District Manager (DM) D.On 03/18/2026 at 10:18 AM observed wooden shelving units for clean linen storage in the B hall. Shelves were observed worn and rough to the touch.On 03/18/2026 at 10:20 AM observed wooden shelving units for clean linen storage in the A hall. Shelves were observed worn and rough to the touch.On 03/18/2026 at 10:23 AM observation of the SPA room in A hall found a pile of wet linen on the shower bed mat. Further observation found brown and white residue in the creases throughout the shower bed mat surface. Upon lifting the mat, a white residue was observed along the underside. Additional observation found a brown semi-solid substance was at the floor drain, DM D acknowledged the substance.On 03/18/2026 at 10:30 AM an interview with CNA F found the shower bed is used infrequently, but stated it does not look clean, and that they would clean it before use.On 03/18/2026 at 10:34 AM observation of SPA room B hall found black spots on the caulk along the floor wall juncture at the perimeter of the shower stall.On 03/18/2026 at 10:35 AM observation of the SPA room D hall found black spots on the caulk along the floor wall juncture at the perimeter of the shower stall. An interview with DM D found that a request was in TELS currently and indicated it had been sprayed with bleach a few days prior.On 03/18/2026 at 10:41 AM observation of the SPA room C hall found green and black buildup on the caulk along the floor wall juncture at the perimeter of the shower stall. Further observation found dripping water coming from the center crease of a shower bed mat, this area was soiled with brown residue.On 03/18/2026 at 10:43 AM observed wooden shelving units for clean linen storage in the C hall. Shelves were observed worn and rough to the touch.On 03/18/2026 at 3:22 PM observation of SPA room A hall found green and brown buildup on the caulk along the floor wall juncture at the perimeter of the shower stall.On 03/18/2026 at 3:33 PM observation of the SPA room D hall found a heating unit on the far wall with two corroded panel edges not covered creating sharp exposed surfaces. Further observation found a red/brown smear on the seat of shower chair in a shower stall.A record review of the facility provided document entitled Collection, Sorting, Handling, and Transportation of Soiled Linens states, Clean linens should be sorted, packaged, transported, and stored in a manner that prevents the risk of contamination by dust, debris, or other soiled items . Transport clean linens to patient care areas on designated linen carts or within designated containers that are regularly (e.g., daily) cleaned.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation, interview, and record review, the facility failed to maintain the cleanliness of tube feeding poles for two residents (R1 and R4) of two resident rooms reviewed for cleanliness. Findings include: R4 On 3/17/2026 at 10:52 AM, R4 was observed in bed asleep. An observation of the resident's tube feeding pole was observed to have a buildup of dried brown tube feeding liquid. On 3/18/2026 at 9:04 AM and on 3/19/2026 at 9:36 AM, the tube feeding pole was observed in the same soiled manner. R1On 3/17/2026 at 11:00 AM, R1 was observed in bed asleep. An observation of the resident's tube feeding pole was observed to have a buildup of dried brown tube feeding liquid.On 3/19/2026 at 9:38 AM, the tube feeding pole was observed in the same soiled manner. On 3/19/2026 at 12:29 PM, Unit Manager J and surveyor observed the tube feeding pole of R1 and acknowledged the soiled manner of tube feeding pole. Unit Manager J was asked whose responsibility is it to ensure the cleanliness of the tube feeding poles, and she explained it is housekeeping's responsibility. On 3/19/2026 at 1:08 PM, the Director of Nursing was asked about the dirty tube feeding poles and explained the cleaning of the poles is housekeeping's responsibility. A review of the facility's, Resident-Patient Room Cleaning policy revealed the following, .Medical Devices. Cleaning and disinfecting medical devices and hardware is limited to noncritical devices that are at ow risk for exposure to blood, bodily fluids, secretions, or excretions .

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to develop and implement care planned interventions for two residents (R70 and R86) of four residents reviewed for care plans. Findings include: R70 On 3/17/2026 at 11:04 AM, R70 was observed lying in bed with both hands contracted inward towards their wrist without hand splints. On 3/18/2026 at 10:00 AM and on 3/19/2026 at 10:00 AM and 12:38 PM, R70 was observed lying in bed with both hands contracted inward towards their wrist without hand splints. A review of R70's care plan did not reveal a care plan to address R70's hand contractures or extremity impairments. A review of R70's medical record noted, R70 was admitted to the facility on [DATE], transferred to the hospital on 3/10/26, and readmitted on [DATE] with diagnosis of Nontraumatic Intracerebral Hemorrhage. A review of R70's Nursing readmission Evaluation dated 3/17/2026 revealed, . Part 2 - V 6. Section VII: Musculosketetal 5. Range of motion 1. Limitations. Specify ROM limitation(s) contracted -upper and lower extremities. 6. immobilizer: a. Yes. Location of immobilizer -Lower extremities- boots support . On 3/19/2026 at 2:59 PM, the acting Director of Nursing (ADON) was asked about R70's care plan regarding the interventions for R70's hand impairments. The ADON explained R70 had not been screened by therapy since R70 had been readmitted . The ADON explained the screening by therapy start the development of R70's care plan. R86 On 3/17/2026 at 10:38 AM, R86 was observed in bed, lying on a standard facility mattress. A review of R86's medical record revealed they were admitted into the facility on [DATE] with diagnoses of Abnormal Posture, Other Lack of Coordination, and Difficulty in Walking. Further review revealed they were cognitively intact and required two-person assist with Activities of Daily Living. A review of the Incident and Accident report revealed R86 sustained an unwitnessed fall on 2/14/26. The incident description noted the following, Nurse was called to see resident in room. Nurse came to resident and nurse observed resident laying on the floor between [their] bed and the cupboard in [their] Rt (right) side of the body @ (at) 105am .Resident stated, 'My Rt leg got stocked (stuck) in the bed sheet and trying to get it off and turned loosed (lost) balance and fall.' Notes. Resident is alert and oriented x 3 (person, place and time). Has lack of perimeter awareness. Resident rolled out of bed. Corrective action to provide a perimeter mattress. A review of R86's care plan revealed the following, Focus: Resident is at risk for falls/injury related to debility and impaired vision. 2/3/2026 Considered a high fall risk per MD (medical doctor). Fall with (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	no injury. 2/14/26 Fall with no injury. Date Initiated: 02/14/2026. Interventions: Perimeter mattress / scoop mattress. Date Initiated: 02/14/2026 . On 3/19/2026 at 12:00 PM, R86's bed was observed without a scoop/perimeter mattress in place. On 3/19/2026 at 1:08 PM, the Assistant Director of Nursing (ADON) was asked about R86 being care planned for a scoop/perimeter mattress but not having one in place. The ADON did not provide an explanation and indicated she would look further into it. On 3/19/2026 at 11:10 AM, a care plan policy was requested from the facility and not received by the end of the survey.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to implement interventions to promote wound healing for two residents (R7, R36) of five residents reviewed for management of pressure ulcer wounds. Findings include: R36 On 03/17/2026 at 10:04 AM, R36, was observed on their back in bed. Both shoulders were flat on the bed with the head of the bed up around 30 degrees. No devices were observed at the sides of the torso to offload pressure, and a specialty or low air loss mattress was not in place. R36 did not respond verbally to the call of their name or the knock on the door. The legs of R36 were flexed at the knees so that the heels were up toward and near the buttocks (a frog legged appearance). Certified Nursing assistant (CNA) L reported the position of the legs as normal for R36, and they had not seen the legs to fully extend. At 12:55 PM and 1:38 PM, R36 was observed in bed as before. At 4:38 PM, 5:09 PM and 5:32 PM, R36 was observed in a similar position on their back in bed, legs flexed at the knees and the feet and heels toward the buttocks. The right leg was up slightly higher than the left which was in contact with the bed. R36's wheelchair had a formed fitting seat with a pommel at the front, hard side bolsters, and soiled seat cushion. On 03/18/2026 at 8:23 AM, R36 was observed on their back in bed, knees flexed as before, dressed in a hospital style gown with the call pad at their right shoulder. Both shoulders contacted the bed surface. The covers were off and no devices were observed at the sides of the torso to offload pressure from the sacrum. Staff were seen to enter the room and cover up R36. The position of R36 was unchanged. At 9:31 AM and 10:26 AM, R36 was on their back in bed as before with the covers off, no socks or pants on, and no devices were observed at the sides of the torso. At 10:36 AM, an observation of the sacral wound was completed with the wound care nurse and CNA L. The sacrum had an open wound that was bleeding. The open area was about a quarter in size wound but elongated. A picture was taken by the wound nurse. The open wound had a grapefruit size area of darkened purple and red maroon color which surrounded it. It appeared as a deep tissue injury (Purple or maroon area of discolored intact skin due to damage of underlying soft tissue). A secondary area of yellowish/white scar tissue was observed below the open wound. The wound nurse was asked about R36 and reported R36 does not move themself and not able to move off the wound and has to be rotated. At 12:21 PM, R36 was seated on their lower back and buttocks in a Geri-chair recliner on the right side of the bed. No devices were observed at the sides to offload pressure from the sacral area and buttocks. The head of the recliner was up around 45-60 degrees, the knees remained flexed and the feet came together at the bottom edge of the recliner seat. At 2:12 PM, R36 was observed to be in the recliner as before. CNA L entered the room and returned R36 to bed. At 3:52 PM, R36 was observed to be on their back in bed. A pillow was at the right side of the torso. The right shoulder of R36 was turned up slightly; the sacral area was observed to be on the bed surface. At 4:07 PM, CNAs O and P reported R36 as having ongoing red or purple areas to the buttocks and the knee/leg contractures since admission. They further reported R36 does not move on their own but may shake or make small movements with the torso. At 4:25 PM, R36 was on their back in bed with the head up around 30 degrees. No devices or pillows were at the sides of the torso, and the shoulders and sacral area were in contact with the bed. On 03/19/2026 at 8:38 AM, 9:29 AM, 9:58, and 10:37 AM, R36 was seated in the Geri-chair recliner with the head up around 45-60 degrees with no pillows or devices at the sides. The knees were flexed so the feet were toward the center of the body and in the top portion (well) of the footrest. At 10:43 AM, R36 had been returned to bed.A review of the record for R36 revealed R36 was admitted into the facility on [DATE]. Diagnoses included Cerebral Palsy and Contractures of the Knees and Elbows. The Minimum Data Set (MDS) assessment dated [DATE] documented severely impaired cognition and dependence on staff for all activities of daily living and rolling left and right in bed, bed to chair transfers and mobility. A review of the record for R36 revealed a note dated 03/17/26 by the Nurse Practitioner (NP) which documented a sacral (lower back/tailbone area) wound at a stage two (Partial thickness loss of (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough or bruising. May also present as an intact or open/ruptured blister. Two dietary notes dated 02/13/26 and 03/17/26 also documented the stage two sacral wound. A review of the 03/16/26 sacral wound assessment by unit manager (UM) N, documented the wound area as 5.93 (centimeters) cm long by 5.28 cm; pain with wound care, surrounding tissue as fragile. A review of the wound pictures back through 01/07/26 revealed a history of smaller open and bloody areas across the observed wound area. The area of purple and red surrounded and encompassed the wounds. The wound area measurement increased and decreased week to week. The 03/16/26 wound measurement was larger than the previous measurement from 03/09/26. A review of the active care plan revealed: Resident is at risk for impaired skin integrity related to contracture of (Left)(Right) elbow incontinence immobility recurrent (moisture associated skin damage) MASD to BIL buttocks (history) HX of contact dermatitis, moderate protein-calorie malnutrition. chronic stage ii sacrum. Date Initiated: 07/08/2025. Revision on: 02/18/2026 .Assist resident with turning and repositioning as needed . Date Initiated: 07/08/2025. Resident has an (Activities of Daily Living) ADL self-care performance deficit related to Cerebral Palsy, generalized weakness, impaired ability to make self understood, shortness of breath (SOB) Date Initiated: 07/08/2025. Revision on: 08/13/2025 .Ambulation: Resident uses a Geri chair for ambulation X1 assist Date Initiated: 07/08/2025. Revision on: 07/31/2025 . Bed Mobility: 2 person assist . Date Initiated: 07/08/2025. Resident has an impaired neurological status related to cerebral palsy, seizure disorder Date Initiated: 07/08/2025. R7 On 03/17/2026 at 12:06 PM, 12:47 PM, 1:45 PM, and 2:15 PM, R7 was seated in their wheelchair with both heels resting on the front edge of the footrest without PRAFOS boots (pressure relieving ankle foot orthoses) in place. A review of the record documented bilateral wounds to the heels. At 5:19 PM, R7 was seated in their wheelchair with left heel on the footrest and the right heel hung over the front edge of the footrest. On 03/18/2026 at 8:12 AM, R7 was observed on their backside in bed, legs extended, with the head of the bed up 30-45 degrees and the PRAFO boots on. R7's glasses were in their lap. A low air loss mattress was active. At 9:24 AM, 10:25 AM, 12:36 PM, 2:11 PM and 4:26 PM, R7 was on their backside in bed and was sitting up with the head of the bed around 45-60 degrees with their glasses on. R7 did not have a pillow or device at the sides of the torso to offload pressure. On 03/19/2026 at 8:36 AM, R7 was on their back in bed, legs extended, PRAFO boots on, a low air loss mattress was in place, and the head of the bed was up around 20-30 degrees. At 9:29 AM, R7 had been served breakfast and was on their back in bed with the head of the bed up around 45-60 degrees. At 9:58 AM the breakfast tray had been removed and R7 was supine in bed with the head of the bed up around 45-60 degrees. At 10:37 AM, 11:12 AM and 11:59 AM, R7 was on their back in bed with the head of the bed up around 45-60 degrees. At 11:12 AM, R7 had reported their tailbone was sore. On 03/19/26 at 10:43 AM, Licensed Practical Nurse (LPN) V reported R36 as not ambulatory, has to be rotated, moved their hands mostly, alert to their name and non-verbal. LPN V reported R7 to be more alert than on admission and needed assistance to change position in bed.On 03/19/2026 at 10:53 AM, CNA L confirmed the need to reposition and change R36.On 03/19/2026 at 12:48 PM, the Therapy Director, reported R36 had their knees stuck in flexion and was dependent for dressing, feeding, bed mobility and log rolling and was last on therapy in 2023 as follow up screens had noted no changes in functional ability. R7 was noted currently on therapy, had a customized footrest, lower extremity swelling to the feet and legs, the inability to fully flex the legs independently and was a max assist for (bed mobility) log rolling in bed. On 03/19/2026 at 12:15 PM, the Acting Director of Nursing (ADON) reported a low air loss mattress had been considered for R36 but not yet implemented as there was a desire to get one with bolsters to also address the history of falls but one had not been found. A review of the current mattress manufacturer's specifications and manual documented it was for basic pressure redistribution and not rated for stage three or four pressure wounds. A review of the record for R7 revealed R7 was admitted into the facility on [DATE]. Diagnoses included Dementia, Pressure Ulcer of the Right Heel, and Muscle Wasting and Atrophy. The Active care plan documented: Resident has an ADL self-care (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	performance deficit related to pressure ulcer of right heel, extensive to total for most care. Date Initiated: 11/28/2025. Revision on: 03/05/2026 Bed Mobility extensive assist 2 person Date Initiated: 02/27/2026. Revision on: 03/05/2026. Resident has a need for indwelling catheter related to pressure ulcer(s) Date Initiated: 02/27/2026. Revision on: 03/05/2026. Resident has impaired skin integrity as evidenced by: (Right) heel (undetermined) UTD (Right) heel DTI (Left) lateral foot DTI intact blister scarring to (Bilateral) buttocks (cicatrix) intact. related to immobility underlying diagnosis incontinence . Assist resident with turning and repositioning as needed Date Initiated: 11/28/2025. Revised 03/05/26 . A review of the Rehab NP note dated 03/17/26 documented, .Mental Status: (alert and oriented) A & O X 2. (range of motion) ROM: (within functional limits bilateral upper extremities) wfl bue, (decreased bilateral lower extremities) dec ble Strength: significant weakness ble, Mobility Roll left and right = Substantial/maximal assistance Sit to lying = Substantial/maximal assistance, Sit to stand = Dependent Chair/bed-to-chair transfer = Dependent, Toilet transfer = Dependent . A review of the note dated 03/19/2026 at 12:16 PM by the wound care nurse documented: Skin Issue: .Location: Left lateral foot. Additional location information: (Left) heel Issue type: Pressure ulcer / injury. Pressure ulcer staging: Stage 4 Pressure ulcer / injury - full thickness skin and tissue loss. Wound was present on admission . Right lateral foot. Laterality / Orientation: Right. Issue type: Pressure ulcer / injury. Pressure ulcer staging: Stage 4 Pressure ulcer / injury - full thickness skin and tissue loss. Wound was present on admission . Right medial calf. Laterality / Orientation: Medial. Issue type: Pressure ulcer / injury. Pressure ulcer staging: Stage 2 Pressure ulcer / injury - partial thickness skin loss with exposed dermis. Wound was present on admission . Right gluteus (buttock). Laterality / Orientation: Lateral. Issue type: Moisture associated skin damage (MASD). Progress: Stalled: previously improving wound characteristics plateaued. MASD: IAD Incontinence Associated Dermatitis. Wound was present on admission . Painful: Yes . Pain description: Aching . Surrounding tissue: Dry / flaky . Scarring . Skin issue education: Turn every 2 hours . A review of the facility policy titled, Pressure Ulcer/Skin Breakdown - Clinical Protocol revised 03/20/24 revealed, Based on the comprehensive assessment of a resident, a resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and a resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice to promote healing, prevent infection, and prevent new ulcers from developing .

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	03/19/2026

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

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to maintain a medical record which reflects the resident's current status for the use of oxygen for one resident (R86) of one reviewed for respiratory care. Findings include: On 3/17/2026 at 10:38 AM, R86 was observed in bed. The resident was not observed receiving oxygen via nasal cannula, and there was not an oxygen concentrator or tank in the room. R86 explained they had a diagnosis of Sarcoidosis and was upset they had contracted pneumonia while residing in the facility. A review of R86's medical record revealed they were admitted into the facility on [DATE] with diagnoses of Interstitial Pulmonary Disease and Sarcoidosis of Lung. Further review revealed they were cognitively intact and required two-person assist with Activities of Daily Living. Further review of the medical record revealed an active order dated 12/22/25 indicating the following, Oxygen: Run @ (at) 2[x]L/MIN (liters per minute) VIA [x] N/C (nasal cannula) Continuous every shift for Sarcoidosis of Lung Notify MD (medical doctor) of SpO2 (saturation of peripheral oxygen) less than 92%. A review of R86's February and March Medication Administration Record (MAR) was reviewed and revealed the order was documented as administered 51 times between two shifts in the month of February, and 31 times between two shifts in the month of March. On 3/18/2026 at 12:30 PM, R86 was observed sitting in their wheelchair. The resident was observed not wearing any oxygen, and there was no oxygen concentrator or tank observed in the room. On 3/19/2026 at 12:29 PM, Unit Manager J was asked about R86's lack of use of oxygen. Unit Manager J entered into the resident's room and asked them about their oxygen in which R86 explained they hadn't had any oxygen in more than six weeks. On 3/19/2026 at 1:08 PM, the Assistant Director of Nursing (ADON) was asked about R86's order for oxygen. The DON did not provide an explanation and indicated she would contact the doctor for clarification. On 3/19/2026 at 11:10 AM, a policy for Physician's Orders was requested from the facility and not received by the end of survey.

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	235365	A. Building B. Wing	03/19/2026

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

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, interview, and record review, the facility failed to administer two medication doses correctly out of 32 opportunities for one of one resident (R97) resulting in a medication error rate of 6.25 percent. Findings include: On 03/18/2026 at 8:57 AM, Licensed Practical Nurse (LPN) K was observed to prepare six medications for R97. The divalproex sodium 125 (milligrams) MG Delayed Release Oral Capsule order documented to give six capsules for a combined dosage of 750 MG capsule. One 125 MG was placed into the medication cup. The calcium carbonate 750 MG Chewable Tablet documented one tablet was to be given. One 500 MG was dispensed into a second medication cup. The medications were brought to the room and administered to R97. Upon return to the medication cart the orders for the divalproex and the calcium carbonate were reviewed with LPN K. LPN K remarked I need to give more. On 03/19/2026 at 12:15 PM, the Acting Director of Nursing (ADON) reported there was a performance improvement plan in place related to the number of new nurses hired by the facility. The ADON reported they had heard about the administration of the incorrect calcium carbonate dosage but not the divalproex. A review of the facility policy titled, Medication Administration revised 01/17/23 revealed, .Compare medication source with (medication administration record) MAR to verify resident name, medication name, form, dose, route, and time of administration. Note - If medication dispensed in a different dose/quantity per dose (example 1/2 pill or give 2 pills) a sticker will be placed on the medication packaging to denote to check the MAR for clarification . Administer medication as ordered in accordance with manufacturer specifications .

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	03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview and record review, the facility failed to perform timely hand hygiene in one of one resident (R102) during medication passes. Findings include: On 03/18/2026 at 9:57 AM, Registered Nurse (RN) I was observed to move the medication cart to the opposite hall and prepare medications for R102. RN I removed three medications from the medication cart to administer to R102 via a feeding tube. RN I crushed two of the medications. The third was a liquid. RN I walked down to the room of R102. RN I set the medications down on the gown disposal bin and put on a gown and gloves. RN I picked up the medications and placed them on the tray table. RN I noted there was no water container for the administration of the medications. RN I removed the gown and gloves and exited the room. RN I walked down the hall passing hand sanitizer stations and went to the supply area and returned with a container and syringe. RN I returned to the entry of R102's room and donned a gown and pair of gloves and filled the container with some water from the sink and administered the three medications, the water and a carton of liquid nutrition to R102 via the feeding tube inserted into the abdomen. RN I rinsed the syringe and container at the sink and doffed the gloves and gown into the trash. RN I gathered the edges of the trash bag and exited the room with the trash bag in hand and went to the medication cart and pulled the keys from the rights smock pocket, unlocked the cart, returned keys to the pocket, and took trash down the hall to the soiled utility room. RN I returned to the medication cart. RN I was not observed to complete hand hygiene during the medication pass observation. When queried RN I reported they had done hand hygiene after the trip to the soiled utility room. On 03/19/2026 at 12:15 PM, the Acting Director of Nursing (ADON) recommended hand washing for twenty seconds before, during and after care that involves a feeding tube, urinary catheter or a wound. A review of the facility policy titled, Hand Hygiene revised 12/13/23 revealed, Policy: All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors . Definitions: Hand hygiene is a general term for cleaning your hands by handwashing with soap and water or the use of an antiseptic hand rub, also known as alcohol-based hand rub (ABHR). Policy Explanation and Compliance Guidelines: 1. Staff will perform hand hygiene when indicated, using proper technique consistent with accepted standards of practice. 2. Hand hygiene is indicated and will be performed under the conditions listed in, but not limited to, the attached hand hygiene table. 3. Alcohol-based hand rub is the preferred method for cleaning hands in most clinical situations (*see notation for C-diff). Wash hands with soap and water whenever they are visibly dirty, before eating, and after using the restroom . a. The use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves, and immediately after removing gloves Hand Hygiene Table: Either Soap and Water or Alcohol Based Hand Rub: Hands are visibly dirty . between resident contacts . after handling contaminated objects . before applying and after removing personal protective equipment (PPE), including gloves . before preparing or handling medications . before and after handling clean or soiled dressings, linens . Before performing resident care procedures, before and after providing care to residents in isolation, after handling items potentially contaminated with blood, body fluids, secretions, or excretions, when, during resident care, moving from a contaminated body site to a clean body site