STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235486	A. Building B. Wing	01/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Richmond	34901 Division Road Richmond, MI 48062

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to Intake 2709236.Based on observation, interview, and record review, the facility failed to ensure two-person assistance to prevent a fall from the bed during care for one resident (R901) of three residents reviewed for falls, resulting in pain and a left leg laceration that became infected, required surgical debridement, and requires continued wound treatment. Findings include: Review of Intake 2709236 revealed an allegation that R901 fell from their bed on 12/06/25 while being provided incontinence care. The allegation indicated that one staff member was providing the care rather than two staff that was required.Review of the facility record revealed R901 was admitted into the facility on [DATE] and their diagnoses included Congestive Heart Failure, Morbid Obesity, and Abnormal Posture. The Minimum Data Set (MDS) assessment dated [DATE] included a Brief Interview for Mental Status (BIMS) score of 14/15 indicating intact cognition.On 01/07/26 at 12:09 PM, R901 was interviewed in their room. The resident was observed in bed. Although the resident's bed was wider than standard, there appeared to be limited space on either side of the bed to accommodate rolling side to side in the bed. When queried regarding any recent falls R901 reported they had a fall out of the bed three or four weeks ago. The resident indicated they are supposed to have two staff members to complete incontinence care and there was a Certified Nursing Assistant (CNA) who thinks they can do it without help. R901 reported the staff is [CNA A]. R901 reported they questioned CNA A about not having a second person to assist and the CNA indicated they didn't need any help because they were strong enough to handle it alone. R901 reported the CNA rolled them onto their left side during the brief change and they fell off the bed on the opposite side. When asked if they were injured from the fall the resident stated I was in a lot of pain. I have a lot of arthritis, and it hurt all over. I hit my head, and I had a huge gash on my leg. I had to go to the hospital, and they had to put 16 stitches in my leg.Further review of R901's record revealed the following active Activities of Daily Living (ADL) care plan interventions: Toileting: Extensive two-person assist with check, changes, and bed pan (most recently revised 12/04/25) and Bed Mobility: Extensive two-person assist (Most recently revised 5/19/25). Review of R901's progress notes revealed a 12/06/25 note authored by Licensed Practical Nurse (LPN) B documenting they received a report R901 had fallen out of bed, Resident was laying slightly on the right side. Resident was bleeding from behind left ear and LLE (left lower extremity).On 01/07/26 at 2:30 PM, LPN B was interviewed via phone and reported they did recall R901 having a fall on 12/06/25. When asked to describe their understanding of what happened LPN B reported CNA A was changing the resident and the resident fell from the bed. They indicated they were not aware of anyone else being present during the incident. When asked what their understanding of R901's required assistance for a brief change was, LPN B reported they knew R901 require two-person assistance.Attempts to call CNA A were unanswered and the voice mailbox was full.Review of R901's current physician orders revealed the resident did receive intravenous (IV) antibiotic treatment for (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 0689 Level of Harm - Actual harm Residents Affected - Few	infection of the leg laceration as well as wound vac (mechanical wound evacuation device) and continued wound care treatment as well as oral medication treatment for pain control.On 01/07/26 at 3:00 PM, the facility Director of Nursing (DON) was interviewed and said their understanding was R901's care plan for two-person assistance pertained primarily to concerns of the resident's history of accusatory behaviors rather than physical safety concerns during bed mobility/brief changes. In reviewing the care plan the DON acknowledged the resident's care plan specified extensive two-person assist for check/change and bed mobility in addition to the issue of potential behaviors. The DON confirmed R901's left leg laceration became infected requiring debridement, IV antibiotics, wound vac, and continuing wound treatment.On 01/07/26 at 4:35 PM, the facility Administrator (NHA) was interviewed and reported their expectation is that staff would follow the plan of care regarding assistance level provided during care.Review of the facility policy Fall Prevention Program dated 10/26/23 revealed the policy statement Each resident will be assessed for the risks of falling and will receive care and services in accordance with the level of risk to minimize the likelihood of falls.