

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235486	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/23/2025
NAME OF PROVIDER OR SUPPLIER Medilodge of Richmond		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>(continued on next page)</p>

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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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake 1183138Based on observation, interview, and record review, the facility failed to ensure necessary grooming and hygiene (shaving and nail care) was provided for two (Residents #40 and #13) of four residents reviewed for activities of daily living (ADLs) assistance. Findings include:R40On 07/21/2025 at 10:49AM, R40 was observed lying supine in bed with the head of the bed slightly elevated. R40's fingernails were irregular in length, some approximately a quarter inch past the tip of the finger, and visibly dirty. R40 was unshaven with an approximate eighth inch black stubble, and the toenails were long (eighth to quarter inch beyond the tips of his toes) and crusted. On 07/22/2025 at 3:20 PM, R40 was asked about facial hair and nails and R40 reported they preferred to be clean shaven and have their fingernails and toenails trimmed and kept clean. On 07/22/2025 at 3:25 PM, R40 was observed being repositioned and provided incontinence care by Certified Nursing Assistant's (CNA) M and N. R40's fingernails and toenails were long, and R40 was unshaven as on 07/21/2025. When asked about the policy for shaving and trimming nails, both CNAs stated, It should be done on shower day. A review of the medical record for R40 revealed they were admitted to the facility on [DATE]. Diagnoses included Arthritis, Contracture of Muscle Upper Arm, Chronic Respiratory Failure, and High Blood Pressure. The Minimum Data Set (MDS) assessment dated [DATE] indicated they were dependent on staff for all ADLs. The care plan identified an ADL self-care performance deficit, with interventions for assistance with personal hygiene and bathing. A review of the CNA documentation, plan of care response history, and progress notes for the past 30 days revealed no documentation revealed eight showers were completed without documentation of refusals related to grooming care, including nail care or shaving. R13 On 07/21/2025 at 10:48 AM, R13 was observed lying supine in bed with head of the bed almost flat. R13 's fingernails were long and curled around the tips of his fingers and visibly dirty. R13 was unshaven with a thick, unkempt goatee. Long nose hairs were observed extending into their mustache area. The remainder of their facial hair was unshaven with an approximate one fourth to one half inch black stubble and extended beyond the appearance of a five o'clock shadow. On 07/21/2025 at 1:10 PM, R13 was observed with the head of the bed up, having just finished lunch. Facial hair and fingernails were observed as previous noted. On 07/22/2025 at 8:19 AM, R13 was observed in bed with the head of the bed slightly elevated with a large pillow to the left side. R13's facial hair remained unshaven with the thick, unkempt goatee, long nose hair which extended into the mustache area, and dark facial hair covering the cheeks and chin, consistent with the prior day's observation. On 07/22/2025 at 12:44 PM, an interview was conducted with R13's son regarding grooming. The son expressed concern about the length of R13's facial and nose hair and fingernails. R13's son indicated R13 would want to be kept neatly shaved, nose hair trimmed, and fingernails cleaned. On 07/23/2025 at 8:44 AM, R13 was observed in bed with the head of the bed slightly elevated. R13's fingernails remained long, curled, and visibly dirty. The facial hair, including the unkempt goatee and extended nose hairs, appeared unchanged from the prior observations on 07/21/2025 and 07/22/2025. A review of the medical record for R13 revealed they were admitted to the facility on [DATE]. Diagnoses included Stroke, Kidney Disease, Heart failure, and Diabetes. The MDS assessment dated [DATE] documented increased need for assistance with ADLs and severely impaired cognition. The care plan identified an ADL self-care performance deficit, with interventions for one person assistance with personal hygiene and bathing. On 07/22/2025 at 4:45 PM, Licensed Practical Nurse (LPN) Q unit manager, and Registered Nurse (RN) R unit manager, were interviewed regarding the facility's grooming policy related to fingernail care, toenail care, and shaving. Both staff stated that grooming should be completed on shower days and as needed (PRN). If a resident refused their care, the CNA was expected to notify the nurse. The nurse will speak to the resident, and if the refusal continues, the family and physician are notified, and a progress note is documented in the medical record. On 07/23/2025 at 8:44 AM, an interview was conducted with CNAs O and P. Both CNAs stated R40 and R13 don't refuse care. CNA O stated, (R40) received a shower on 07/21/2025 but, due to staffing issues, they did not have time to shave (R40) or clean (R40) nails. On 07/23/2025 at 12:15 PM, the Director of Nursing (DON) reported their expectations for grooming care, including fingernail, toenail, and shaving hygiene were that grooming should be completed on shower days and as needed (PRN). If a resident refuses care, staff are expected to notify the nurse. The nurse is responsible for speaking with the resident, and if the refusal continues, the family is notified and the refusal documented in the medical record. A review of the facility policy Activities of Daily</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure that ordered laboratory work was completed for one (R34) of three residents reviewed for laboratory services. Findings include: A review of the medical record for R34 revealed they were admitted to the facility on [DATE] with diagnoses of high blood pressure, atrial fibrillation, respiratory failure and diabetes. The care plan, dated 09/25/2023, identified the resident as having impaired cardiovascular status and diagnostic testing should be completed as ordered. An order for routine laboratory testing, including a complete blood count (CBC/Diff) with differential, and comprehensive metabolic panel (CMP) was entered for R34. Documentation date 02/28/2025 indicated the lab was unable to obtain a sufficient blood sample, noting, Couldn't get a vein quantity not sufficient. A review of the medical record revealed no evidence that a follow-up attempt was made to redraw the laboratory tests, and there was no documentation to indicate the physician was notified. On 07/22/2025 at 2:45 PM, an interview was conducted with R34's physician regarding their expectations when laboratory staff are unable to obtain sufficient blood from a resident. The Physician confirmed they would expect the lab would be redrawn if the initial attempt was unsuccessful saying, I want it done or to be notified if unable to complete. On 07/22/2025 at 2:53 PM, Unit managers Licensed Practical Nurse (LPN) Q and Registered Nurse (RN) R reported if a laboratory redraw is needed, a new requisition must be entered into (name of electronic medical record system) and (name of laboratory service provider) is expected to follow up. During the interview, both unit managers attempted to locate laboratory results for R34 and were unable to find them. On 07/23/2025 at 12:11 PM, interview with Director of Nursing (DON) reported their expectations for handling unsuccessful laboratory draws. The DON reported when laboratory staff are unable to obtain a sufficient sample of blood, a new requisition should be completed and entered into (name of electronic medical record system). The laboratory is then expected to follow up and complete the lab work. On 07/23/2025 and 07/24/2025 three attempts to call (name of laboratory service provider) were made with no return call. A review of the facility policy, Laboratory and Diagnostic Guidelines, dated 01/01/2022, revealed, the guideline is set up to track the timely completion, reporting and monitoring of laboratory and diagnostic tests, results, and notifications which are used to monitor resident status and/or therapeutic medication levels. The physician should be notified of all refused lab or diagnostic test orders and reason why.</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p>(continued on next page)</p>

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>This citation pertains to intake 1183138. Based on observation, interview and record review, the facility failed to ensure sufficient staff to provide timely care to seven (R5, R18, R33, R34, R40, R95, and R99) of 24 residents. Findings include: On 07/21/25 at 9:38 AM during the initial screening of the facility residents: R95 reported Sometimes there is a long wait, like a half hour or more, when you push the call light for staff to come help you. R95 reported, It takes a half hour or so for call lights to be answered. R95 further reported they required assistance to eat and some staff don't like to feed (the residents). On 07/21/2025 at 10:19 AM, R33 was sitting up in bed dress in a hospital style gown. R33 reported concerns about not enough briefs and not enough staff. R33 reported they have waited longer than 30 minutes to get out of bed when they ask because they are a two-person transfer and their CNA has to go to another hall to get help. On 07/21/2025 at 10:30 AM, R5 was observed to be in bed connected to a tube feeding pump. The pump had a screen which read inactive and made a beeping sound. The sound was audible from the hallway. At 11:08 AM, the pump continued to be idle and beeping. On 07/21/2025 at 10:38 AM, R34 was observed sitting up in bed with oxygen in use. The resident's call light was observed to be on the floor, out of the resident's reach. Staff were observed to enter and exit the room, and the call light remained on the floor. The resident was reported by staff to be dependent on staff for care. At 1:34 PM, R34's call light continued to be in the same place on the floor, out of reach. Staff were observed entering and exiting the room to assist the resident with lunch; however, the call light remained on the floor throughout the interactions and was not repositioned within the resident's reach. At 2:46 PM, R34 was observed to be repositioned and Certified Nursing Assistant (CNA) O was observed to struggle while they tried to get the call light out from under the wheel on the bed. CNA O reported they carried a pager for notification when the call lights are activated. CNA O further reported they were assigned 15 residents and would have to get help with the residents who require mechanical lifts. On 07/21/2025 at 11:03 AM, R118 reported they felt the facility was short staffed as lights not answered quickly and many residents on their hall require two people. On 07/21/2025 at 11:34 AM, the visitor of resident R18 and R18 were interviewed. They verbalized the facility was short staffed and one nurse may have two units to cover. They further noted at nights and on the weekends, it seems like no one is at the facility with one CNA and one nurse. They also noted no one picks up the phone and medications may not be given on time on weekends. On 07/21/2025 at 12:01 PM, Licensed Practical Nurse (LPN) S reported they had a split assignment for the day as a nurse had called in. LPN S reported they had residents on the north and south side of the facility and was assigned 26 residents. It was observed the two units were separated by two common areas and the snack bar. On 07/21/2025 at 10:40 AM, R99 commented they received cold food every day and feel they are the last one served (this was observed for two meals.) R99 commented there was not enough staff to get to them timely. It was further reported CNAs are supposed to ask about preferences for the planned menu items, but they don't always come. The delivery of trays for the lunch meal was observed for R99's hall. It took 27 minutes for the CNAs to get to the unit of R99 and begin to pass trays and 11 more minutes to complete the tray pass. A noted on the cart indicated the trays should not remain on the cart for 15 minutes or more. On 07/21/25 at 12:49 PM, R118 reported the facility was consistently short staffed and that led to tray delivery delays. On 07/22/2025 at 1:21 PM, Registered Nurse (RN) T was asked about staffing and reported call ins were the primary concern. LPN U reported there is a call in from a nurse almost daily and the standard of practice was to move staff around rather than replacing the nurse. On 07/22/25 at 1:49 PM, during the group meeting, the attendees verbalized concerns with call light in reach and long wait times for assistance when call light are turned on. On 07/22/2025 at 12:35 PM, the Medical Director was asked about staffing and reported staffing does come up in the Quality Assurance meetings and refers to getting more new hires. The Medical Director commented it would be nice to be able to round with the nurse to discuss medical issues, admitting it may be hard to find one not busy. On 07/23/2025 at 8:44 AM, CNA O reported R40 had a shower on 07/21/205 but do to staffing they just didn't have time to shave and do R40's fingernails. R40 was observed to be unshaven and with long, soiled fingernails on 07/21/25, 07/22/25 and 07/23/25. On 07/23/2025 at 3:35 PM, the Staffing Coordinator (Staff V) reported the staff postings provided were incorrect and did not reflect the true staffing on for the day. When asked what the biggest challenge for staffing nurse and CNAs, Staff V reported call-ins. It was noted six or seven nurses is the goal, but they have also started to use med techs (assisting with medication pass duty). Staff V noted each nurse should have around 17 residents. It was noted five nurses were on for 07/21/25. Staff V noted two med techs</p>		

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. (continued on next page)		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on observation, interview, and record review, the facility failed to ensure meals were palatable and served in a timely manner for six residents (R21, R27, R33, R38, R99, R118) reviewed for food concerns from a census of 119 residents. Findings include: On 07/21/25 at 10:06 AM, during the initial screening, R21 reported their breakfast was cold today. On 07/21/2025 at 10:19 AM, during the initial screening, R33 stated, The food sucks. On 07/21/25 at 10:45 AM, R27 reported, they take good care of me, but the food is terrible, dried-up meat and almost choked on a hot dog. On 07/21/25 at 10:08 AM, R38 reported the meat can be tough and chewy, the eggs are served cold, and the Caesar salad was made with iceberg lettuce and served with Italian or ranch dressing. On 07/21/2025 at 10:40 AM, R99 reported the food is cold at one meal or another almost every day. R99 went on to say the oatmeal was served without brown sugar when requested so they had to buy their own; Staff can't or don't read the food tickets so R99 does not receive what is requested; They do not always get cereal or what was requested; The tater tots and hamburger were served cold, and fries were still frozen. R99 reported they feel they are the last to be served since they are at the end of the hall. On 07/21/2025 at 12:22 PM, the food tray cart was observed on the 600 unit. Staff were observed to walk down the hall and past the food cart; At 12:25 PM, dietary staff dropped a food tray cart on the 700 unit. One staff member was passing trays; At 12:47 PM, the cart from the 600 unit was moved to the 800 unit. At 1:00 PM, R99 was served their food. 38 minutes after the cart was delivered onto the unit. At 1:01 PM R99 reported the food was warm but not hot. On 07/21/2025 at 12:49 AM, R118 reported they feel the resident council and food committee meetings do not make much difference with the same complaints about food every month and the kitchen blames the CNAs for cold food. R118 feels at times the food is cold to begin with. R118 commented they told the facility they honestly think the dietary staff don't read the menu when residents send them back. R118 reported the chicken on their plate could be warmer and part of the issue is that the facility was short staffed all the way around. On 07/22/2025 at 11:44 AM, the lunch food tray cart was observed at the entrance to the 700 unit. At 12:18 PM, a food tray cart had not made it to the 800 unit. On 07/22/2025 at 12:51 PM, R99 was observed to have the turkey rice casserole, snap peas, a roll, and chocolate cake on their lunch plate. R99 reported they did not want any of it except the cake and that no one had come and asked them what they wanted. A review of the meal ticket revealed no changes or substitutions had been made on the ticket. 07/22/2025 1:09 PM, Certified Nursing Assistants (CNA) X and Y reported the procedure was to have the next day's meal tickets reviewed with the resident to determine their food preferences and then the CNA would sign the meal ticket when reviewed and return it too dietary. On 07/22/25 at 1:49 PM, during the group meeting, R8 reported the food was a joke and were served frozen fries. R118 reported they do have food council meetings, and they brought up the food was cold, and it was blamed on the CNAs for leaving the door to the cart open. R118 further noted the cold stuff is not cold and the ice cream was like soup. A review of the food committee minutes received for February 2025, March 2025, May 2025 and June 2025 documented consecutive cold food or timely delivery complaints. A review of the monthly Resident Tray Assessment Report received, documented an audit of one lunch meal with the last one completed on 06/02/25. On 07/23/2025 at 8:02 AM, the food tray cart was observed on the 700 unit, one staff was observed to begin delivery of the food trays; At 8:06 AM, a second staff was observed to pass trays on 700 unit; At 8:10 AM, the tray cart to was delivered to the 600 unit, At 8:21 cart was observed at the entry to 600 hall as before. Staff had started distribution of trays, and the cart was moved to the end of the hall then moved to the 800 unit. At 8:34 the meal tray for R99 was delivered. 24 minutes after arrival on the floor. The meal ticket was observed with preferences and noted corn flakes. R99 was served frosted flakes. R99 reported they did not get the plain corn flakes they had requested. Oatmeal was delivered per the ticket, but the requested brown sugar was not seen in the oatmeal or on the tray. On 07/23/2025 at 1:55 PM, the identified concerns were reviewed with the Dietary Manager (DM). The dietary manager confirmed the procedure was for CNAs to bring out the meal tickets the night before, review the menu items with the resident and then sign and return it. The DM reported the resident should be offered a second or third alternate to the main menu item. The DM reported the time the food cart was delivered to the floor was also documented. Dietary brings out the paper and once the food cart is delivered, they then have a nurse or CNA sign off. The signing of any paper was not observed to occur during the tray pass observation. The DM also noted the time it takes to fill the cart while in the kitchen was up to 15 minutes. When asked about the food committee, the DM noted they actively attended the meetings. A review of the facility policy titled</p>		