

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235487	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/23/2026
NAME OF PROVIDER OR SUPPLIER Medilodge of West Bloomfield		STREET ADDRESS, CITY, STATE, ZIP CODE 6950 Farmington Rd West Bloomfield, MI 48322	
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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to Intake Number(s): 3034017. Based on observation, interview, and record review, the facility failed to report an injury of unknown origin to the State Agency for one (R205) of two residents reviewed for abuse. Findings include: On 6/23/26 at 12:20 PM, R205 was observed not in their room. R205 was in an office with the unit managers. At that time, staff brought R205 into their room where they were observed to repeatedly climb out of the wheelchair and was difficult for the staff to redirect. A review of R205's clinical record revealed R205 was admitted into the facility on 2/10/26 and readmitted on [DATE] with diagnoses that included: aphasia (difficulty speaking), Alzheimer's Disease, and dementia with severe agitation. A review of a Minimum Data Set (MDS) assessment dated [DATE] revealed R205 had severely impaired cognition and daily wandering behaviors. A review of a Nurses' Notes progress note dated 5/27/26, written by Unit Manager, Licensed Practical Nurse (LPN) 'D', revealed, Resident observed with bruising to right forearm and swelling to right elbow. Resident unable to state what happened or identify cause of injury. Nurse Practitioner notified of findings. New order received for X-ray of right elbow/forearm. A review of a Progress Note - General dated 5/27/26, written by LPN 'B' revealed, Patient was observed to have light purple bruising located on the back of right upper arm and elbow. Swelling was noted around elbow. Doctor, DON (Director of Nursing), and guardian were notified of finding. Xray of the right arm was ordered. On 6/23/26 at 1:01 PM, all incident reports and investigations for R205 since 5/12/26 were requested from the Administrator. On 6/23/26 at 1:26 PM, the Administrator provide incident reports for R205. However, there were no incident reports or investigations for 5/27/26 to address the bruising and swelling to R205's arm/elbow. On 6/23/26 at 2:40 PM, an interview was conducted with LPN 'B' via the telephone. When queried about the facility's process when a resident was identified to have an injury of unknown origin, LPN 'B' reported they completed a change of condition assessment, a risk assessment (incident report), and contacted the physician, DON, and the resident's responsible party. LPN 'B' reported they were required to notify the Administrator who was the Abuse Coordinator, as well. When queried about the bruising and swelling to R205's right arm on 5/27/26 and what was done about that, LPN 'B' reported they observed the bruising and swelling, completed a skin assessment and a risk assessment, and reported the injury to the nurse manager and Administrator. On 6/23/26 at 2:46 PM, an interview and conducted with the DON. When queried about the lack of incident report and investigation for the bruising and swelling to R205's right arm/elbow documented on 5/27/26, the DON reported there was an incident report for that. When queried about how it occurred, the DON reported the Administrator would have any investigation into it. On 6/23/26 at 3:04 PM, an interview was conducted with the Administrator. When queried about whether the bruising and swelling of unknown origin to R205's arm was reported to him on 5/27/26, the Administrator reported it was reported to him and investigated by the DON who determined R205 was walking in the hallway and leaned on the wall. The Administrator explained it was not reported to the State Agency because it was investigated and the cause was determined by the DON. When queried about where the investigation was documented as it was not provided, the Administrator (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
--	-------	-----------

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235487	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/23/2026
NAME OF PROVIDER OR SUPPLIER Medilodge of West Bloomfield		STREET ADDRESS, CITY, STATE, ZIP CODE 6950 Farmington Rd West Bloomfield, MI 48322	
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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	reported it would be included with the incident report. At that time, the incident report and investigation were requested. A review of an incident report/risk assessment form for R205 dated 5/27/26 revealed the following. .Other Skin Injury .Pt (patient) was observed to have bruising to backside of upper right arm and elbow. Bruising appears light purple in color. Swelling is noted around elbow .Incident was not witnessed .Resident Unable to give Description . There was no investigation included with the incident report to explain how the injury occurred. On 6/23/26 at approximately 3:45 PM, the Administrator was asked if there was any additional information regarding the bruising and swelling to R205's right arm on 5/27/26. The Administrator reported they did not have any more information. A review of a facility policy titled, Abuse, Neglect and Exploitation, revised 1/10/24, revealed, in part, the following, .The facility will have written procedures that include .Reporting of alleged violations to the Administrator, state agency .and to all other required agencies .within specified timeframes as required by state and federal regulations .Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or .Not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury . The facility's policy did not include any specific protocols that addressed injuries of unknown origin.		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235487	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/23/2026
NAME OF PROVIDER OR SUPPLIER Medilodge of West Bloomfield		STREET ADDRESS, CITY, STATE, ZIP CODE 6950 Farmington Rd West Bloomfield, MI 48322	
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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to Intake Number(s): 3034017. Based on observation, interview, and record review, the facility failed to thoroughly investigate an allegation of verbal and physical abuse by a staff member for one (R205) of two residents reviewed for abuse. Findings include: A review of a Facility Reported Incident (FRI) submitted to the State Agency revealed a family member alleged they witnessed a staff member verbally and physically abuse R205 (yelled at and grabbed her arm). A review of R205's clinical record revealed R205 was admitted into the facility on 2/19/26 and readmitted on [DATE] with diagnoses that included aphasia (difficulty speaking), Alzheimer's disease, and dementia with severe agitation. A review of a Minimum Data Set (MDS) dated [DATE] revealed R205 had severely impaired cognition and daily wandering behaviors. On 6/23/26 at 12:20 PM, R205 was observed repeatedly standing up from the wheelchair while in her room with staff present. R205 appeared difficult to redirect. R205 was making noises but did not speak words. On 6/23/26 at 1:20 PM, an interview was conducted with Witness 'C' via the telephone. Witness 'C' explained they were a caregiver for another resident (not R205) who resided in the facility. Witness 'C' said they did not know the exact date but was almost positive it was a Monday. They went to the nurses' station on the 1st floor to ask for a cup of ice for their family member who was a resident there. They observed (R205) behind the desk and reported they often observed them there. Witness 'C' said R205 only made noises and did not talk and often stood up from the wheelchair. On that particular day, the nurse or nurse aide who was behind the desk was busy doing something and the resident tried to stand up from the wheelchair. Witness 'C' explained the nurse or nurse's aide (they were not sure of their name or their title) yelled, Oh we are not doing this today! and when (R205) continued to try to get out of the wheelchair, the staff member grabbed the older woman's (R205) arm very aggressively and yanked her down into the wheelchair. Witness 'C' said they were not sure who the staff member was. Witness 'C' reported they spoke directly to the Administrator about it. When queried about what the person looked like, Witness 'C' said they were a dark-skinned woman with smooth, shoulder length hair that was curled under like a [NAME] and they were about average build. A review of an investigation conducted by the facility revealed the following: The incident was discovered on 5/12/26 at 2:55 PM and it occurred on 5/11/26 at 4:00 PM. The Incident Summary noted, On 5/12/26, (R205's) daughter reported to the social worker that a 'nurse' with short-hair yelled at her mother to sit down; when she would not sit, the 'nurse' grabbed her arm to sit her down. There was not a specific perpetrator identified; facility to review staff assignments. A Statement provided by Social Worker (SW) 'E' noted it was not R205's family member who reported the incident and instead it was Witness 'C' who was the caregiver of another resident who resided in the facility. It was documented in statement that Witness 'C' said that a nurse with short hair yelled at (R205) to sit down. When (R205) did not sit down, she grabbed her arm and made her sit down. It was documented that happened at the A/B Nurse Station. Around 4pm on Monday (5/11/26). A Statement from Witness 'C' noted, .There was an elderly lady that sits at the nurse station and there were two staff at the desk with the lady. One walked away, and the lady stood up and the staff told her to sit down. The lady didn't sit down, and the staff yanked her arm to get her to sit down. I believe it was Monday (5/11/26). I don't think there was any ill will, I think it was just frustration. It just looked aggressive. The third and final Statement was from Licensed Practical Nurse (LPN) 'F' who said they had not worked prior to 5/14/26. There were no additional statements included in the investigation with any staff who worked on 5/11/26 when the alleged abuse occurred. A review of a typed summary of the facility's investigation revealed, . (Witness 'C') reported to the social worker that a 'nurse' with short hair, yelled at (R205) to sit down. When (R205) did not sit, (Witness 'C') alleged that the staff member grabbed (R205's) arm to make her sit. (Witness 'C') was unable to identify a perpetrator. The facility reviewed staffing assignments and could not determine a specific (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235487	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/23/2026
NAME OF PROVIDER OR SUPPLIER Medilodge of West Bloomfield		STREET ADDRESS, CITY, STATE, ZIP CODE 6950 Farmington Rd West Bloomfield, MI 48322	
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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	perpetrator .Due to her cognitive status, (R205) is unable to be interviewed for this investigation .The facility interviewed (Witness 'C') .The facility asked (Witness 'C') id [sic] she could give a more detailed description of the perpetrator to which she stated light-skinned African-America [sic], smaller, with short-hair. She did not recognize the alleged perpetrator and could not specify what color scrubs the staff member was wearing .became unsure of when the allegation happened stating that it could have been the week prior, but believed it happened on Monday (5/11/26) .The facility interviewed the staff on the unit. The staff acknowledged that (R205) is busy and impulsive, but usually able to be redirected. The staff on the unit deny willfully abusing or hurting (R205) .The facility could not verify (Witness 'C's) allegation of abuse . There was no evidence provided regarding the staff on the unit that were interviewed other than LPN 'F' who did not work on 5/11/26. On 6/23/26 at 3:04 PM, an interview was conducted with the Administrator who was the Abuse Coordinator for the facility. When queried about what was done to attempt to identify the potential alleged perpetrator, the Administrator reported staff were interviewed. When queried about why LPN 'F' was interviewed when she did not work on 5/11/26 and if any other staff were interviewed, the Administrator reported he did not interview any other staff. A review of a facility policy titled, Abuse, Neglect and Exploitation, revised on 1/10/24, revealed, in part, the following, .Investigation of Alleged Abuse, Neglect and Exploitation .An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse neglect or exploitation occur .Written procedures for investigations include . Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations .Focusing the investigation on determining if abuse, neglect, exploitation, and/or mistreatment has occurred, the extent, and cause .Providing complete and thorough documentation of the investigation .		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235487	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/23/2026
NAME OF PROVIDER OR SUPPLIER Medilodge of West Bloomfield		STREET ADDRESS, CITY, STATE, ZIP CODE 6950 Farmington Rd West Bloomfield, MI 48322	
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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to Intake Number(s): 3041709 and 3040038. Based on observation, interview, and record review, the facility failed to conduct ongoing and complete skin assessments and administer treatment according to physician's orders for two (R204 and R205) of three residents reviewed for wounds. Findings include: R204 A review of a complaint submitted to the State Agency revealed it was alleged that R204's wounds were not properly attended to and daily wound care was not performed. A review of a Grievance and Satisfaction Form dated 4/15/26 completed by R204's family member revealed the following grievance, .My wife needs her wound care done often and for 3 days her wound care was not done. Her gauze [sic] and wrap had fallen off & we asked several times and each time we were told it was about to get done .We are just worried about wound care not getting done . A review of R204's clinical record revealed R204 was admitted into the facility on 3/23/26 and discharged on 4/23/26 with diagnoses that included: heart failure, osteomyelitis (bone infection) of left ankle and foot, severe protein-calorie malnutrition, peripheral vascular disease (PVD), and adult failure to thrive. A review of a Minimum Data Set (MDS) assessment dated [DATE] revealed R204 had intact cognition, was dependent for bed mobility, and had four venous or arterial ulcers that were present upon admission into the facility. A review of a Nursing admission Evaluation for R204 completed on 3/23/26 revealed R204 had the following skin impairments: Right foot .Other .Amputation . A review of R204's SW-Skin Issues Assessments revealed an assessment was completed on 3/24/26 and noted the following: Right Dorsum (upper surface) foot .Other skin issue .Present on admission .1.79 (cm - centimeters) x 5.29 (cm). There was no further documented description of the skin issue to include what type of skin impairment it was. Right Lateral midfoot (outer portion of the middle foot) .Other skin issue .Present on admission .2.53 (cm) x 2.68 (cm). There was no further documented description of the skin issue to include what type of skin impairment it was. Front right lateral lower leg .Abrasion .Present on admission .1.5 (cm) x 0.78 (cm) .Further review of R204's SW-Skin Issues assessment revealed they were assessed on 3/31/26. However, there were no measurements, description, or documentation of what kind of skin impairment they were. There were no other SW-Skin Issues assessments completed between 3/31/26 and R204's date of discharge on [DATE]. A review of R204's Physician's Orders and Treatment Administration Records (TAR) for March and April 2026 revealed the following: An order initiated on 3/24/26 for Foot wound Clean wound with betadine and pad heel with 4 x 4 gauze. Wrap entire foot and ankle with kerlix gauze and secure with tape. Bilateral. Every day shift AND as needed. (The Skin Issues assessments mentioned above did not document any impairment to the left foot.) According to the TARs, the treatment was not administered on 3/31/26, 4/4/26, 4/10/26, 4/13/26, 4/14/26, and 4/19/26. There was no documentation that indicated why the treatments were not completed. An order initiated on 3/25/26 for Right calf wound Cleanse wound with Normal Saline, apply Triad with foam dressing. Change dressing every 3 days or as needed every day shift every Mon (Monday), Wed (Wednesday), Fri (Friday) AND as needed. According to the Tars, the treatment was not completed on 4/10/26 and 4/19/26. An order initiated on 4/13/26 (20 days after admission) for Consult wound care clinic Re: Chronic arterial ulcers .foot .right calf . A review of a Physician Progress Note dated 3/25/26 revealed, .She follows with vascular and podiatry at (clinic name) for her wounds and also has a wound nurse which usually helps her once a week .multiple wounds over both lower extremities bilateral feet with necrotic changes on the right third toe right lateral foot right great toe .Arterial ulcer complicated with the peripheral arterial disease .Physical Exam .Extremities .present dressings intact bilateral feet right calf (There was no documentation of a physical assessment of each skin impairment at the time of that evaluation) .History of osteomyelitis in the right second toe status post amputation with necrotic changes currently also necrotic changes on third toe right lateral throat [sic] and right great toe Dry gangrene (dead tissue caused by lack of blood flow) likely with (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235487	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/23/2026
NAME OF PROVIDER OR SUPPLIER Medilodge of West Bloomfield		STREET ADDRESS, CITY, STATE, ZIP CODE 6950 Farmington Rd West Bloomfield, MI 48322	
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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	underlying chronic osteomyelitis with progressive bony changes without any acute changes or infection . A review of Physician Progress Notes dated 3/27/26, 4/8/26, 4/10/26, 4/15/26 revealed no documented description of each skin impairment. A review of a Physician Progress Note dated 4/13/26 revealed, .Dressings were intact on bilateral feet .Physical exam .noted dressing intact . There was no description, including measurements, of R204's wounds to the feet and lower leg. On 6/23/26 at 10:45 AM, an interview was conducted with the Wound Care Coordinator, Registered Nurse (RN) 'A'. RN 'A' explained they were the Assistant Director of Nursing (ADON) for the facility and recently stepped into the role of Wound Care Coordinator on 5/5/26 until the position was filled. When queried about the facility's protocol for assessing residents' skin upon admission and thereafter, RN 'A' reported the admitting nurse was responsible for the initial skin assessment. If any wounds were identified, they would take a photo using wound software and the software determined the measurements of the wounds. The admitting nurse was responsible for notifying the Wound Care Coordinator and the consulting Wound Provider, as well as management. RN 'A' reported the Wound Care Coordinator was responsible for assessing any wounds within 24 to 48 hours of admission or when a new wound was identified. RN 'A' said a Wound Provider came to the facility weekly. When queried about how wounds were monitored for improvement or worsening, RN 'A' reported when they rounded with the Wound Provider, a full evaluation was done and they were monitored at that time and any changes to treatments would be made. When queried about R204's lack of complete wound assessments on 3/24/26 and 3/31/26 and no assessments after that date, RN 'A' reviewed R204's clinical record and confirmed they were not complete and/or done at all after 3/31/26. RN 'A' confirmed there were missed treatments on the dates documented above and that there were no consultations by a Wound Provider prior to R204's discharge on [DATE]. RN 'A' reported a consult order should have been in place sooner than 4/13/26. RN 'A' was asked if they were aware of any identified concerns with skin management that the facility was working on and RN 'A' said they were unaware of any identified issues with skin management. On 6/23/26 at approximately 11:00 AM, an interview was conducted with the Director of Nursing (DON). The DON reported she became the DON two months ago. When queried about who was responsible to assess resident's skin upon admission, the DON reported the floor nurses were. The DON reported the Wound Provider was to be consulted and they would evaluate the resident on the next day they were in the building. When queried about the SW-Skin Issues assessment and what was to be included in the assessment, the DON reported it should document a thorough assessment of the wounds to include a description of the wound and the type of wound. At that time, the concerns with the lack of assessments and missed treatments for R204's wounds to their feet and leg were addressed with the DON. The DON reported that the resident was seen by the Physician. However, there should be documentation of the assessment of each wound to include a description and measurement of the wound in order to determine if it was improving or worsening. At that time, the DON was given the opportunity to provide any additional information regarding the care and treatment of R204's wounds. No additional information was provided prior to the end of the survey. R205 On 6/23/26 at 12:20 PM, R205 was observed to be in the office of the unit managers. Staff brought R205 to her room where she was observed repeatedly standing up from her wheelchair and difficult to redirect. R205 was making noise, but did not speak words. A review of R205's clinical record revealed R205 was admitted into the facility on 2/10/26 and readmitted on [DATE] with diagnoses that included: aphasia (difficulty speaking), Alzheimer's Disease, and dementia with severe agitation. A review of a MDS assessment dated [DATE] revealed R205 had severely impaired cognition. A review of a Pertinent Charting - Change in Condition progress note dated 6/22/26 revealed, Resident (R205) noted to be difficult to redirect throughout the shift and appeared increasingly agitated. I considered that a shower may be soothing and assist with calming the resident .During bathing, multiple areas of purple and blue bruising were observed on the coccyx and pubic area .Resident has remained free from falls or incidents during this shift. I inquired with assigned CNA (Certified Nursing Assistant) regarding any falls or incident during day shift; CNA (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235487	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/23/2026
NAME OF PROVIDER OR SUPPLIER Medilodge of West Bloomfield		STREET ADDRESS, CITY, STATE, ZIP CODE 6950 Farmington Rd West Bloomfield, MI 48322	
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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	denied any occurrences . On 6/23/26 at 12:30 PM, an observation of R205's abdominal, pelvic, and coccyx area was conducted with RN 'G' and RN 'H'. On R205's coccyx area, a dark purple discoloration the size of a large eggplant was observed. Purple circular bruising the size of a peach was observed to R205's pelvic area. A review of R205's weekly Skin Assessment forms revealed R205's skin was not assessed between the dates of 6/3/26 (readmission) and 6/22/26 when it was documented R205 had bruising to the pelvic and coccyx areas. On 6/23/26 at 2:20 PM, an interview was conducted with RN 'A'. When queried about how often residents skin was monitored for new skin impairments, RN 'A' reported the floor nurses were responsible to complete head to toe skin assessments on a weekly basis. The CNAs were responsible for reporting any skin changes to the nurse if identified during care. At that time, RN 'A' reviewed R205's clinical record and confirmed there were no skin assessments completed between 6/3/26 and 6/22/26. On 6/23/26 at 3:35 PM, a facility policy regarding skin management for non-pressure skin impairments was requested. It was not provided prior to the end of the survey.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235487	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/23/2026
NAME OF PROVIDER OR SUPPLIER Medilodge of West Bloomfield		STREET ADDRESS, CITY, STATE, ZIP CODE 6950 Farmington Rd West Bloomfield, MI 48322	
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 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** This citation pertains to Intake Number(s): 3041709 and 3040038. Based on interview and record review, the facility failed to conduct thorough and accurate skin assessments, ensure timely evaluation of existing pressure ulcers by a wound provider, administer wound treatments as ordered by the physician, and implement treatments in a timely manner for two (R203 and R204) of three residents reviewed for wounds. Findings include: R204 A review of a complaint submitted to the State Agency revealed it was alleged that R204's wounds were not properly attended to and daily wound care was not performed. A review of a Grievance and Satisfaction Form dated 4/15/26 completed by R204's family member revealed the following grievance, .My wife needs her wound care done often and for 3 days her wound care was not done. Her guaze [sic] and wrap had fallen off & we asked several times and each time we were told it was about to get done .We are just worried about wound care not getting done . A review of R204's clinical record revealed R204 was admitted into the facility on 3/23/26 and discharged on 4/23/26 with diagnoses that included: heart failure, osteomyelitis (bone infection) of left ankle and foot, severe protein-calorie malnutrition, peripheral vascular disease (PVD), and adult failure to thrive. A review of a Minimum Data Set (MDS) assessment dated [DATE] revealed R204 had intact cognition, was dependent for bed mobility, and had two stage II pressure ulcers (Partial-thickness skin loss with exposed dermis), one stage IV (intravenous) pressure ulcer (Full-thickness skin and tissue loss), and two unstageable pressure ulcers (Obscured full-thickness skin and tissue loss), that were present upon admission into the facility. A review of a Nursing admission Evaluation for R204 completed on 3/23/26 revealed R204 had the following skin impairments: .Coccyx (tailbone) .pressure .Left heel .pressure .Right heel .pressure .Right hip .pressure .Left hip .pressure . A review of R204's SW-Skin Issues Assessments revealed an assessment was completed on 3/24/26 and noted the following: Right Dorsum (upper surface) 1st metatarsal phalangeal joint (toe) .Pressure ulcer/injury .Present on admission .2.59 (cm - centimeters) x 2.17 (cm). There was no further documented assessment of the pressure ulcer to include the stage and presentation of the ulcer. Left heel .Pressure ulcer/injury .Present on admission .1.42 (cm) x 0.9 (cm). There was no further documented assessment of the pressure ulcer to include the stage and presentation of the ulcer. Coccyx .Pressure ulcer/injury .Present on admission .1.43 (cm) x 1.45 (cm). There was no further documented assessment of the pressure ulcer to include the stage and presentation of the ulcer. Front left trochanter (hip) .Pressure ulcer/injury .Present on admission .1.7 (cm) x 2.45 (cm) x 4 (cm - depth). There was no further documented assessment of the pressure ulcer to include the stage and presentation of the ulcer. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235487	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/23/2026
NAME OF PROVIDER OR SUPPLIER Medilodge of West Bloomfield		STREET ADDRESS, CITY, STATE, ZIP CODE 6950 Farmington Rd West Bloomfield, MI 48322	
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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Skin Issues assessment indicated R204 also had multiple non-pressure wounds to their right foot (dorsum and outside of midfoot). Further review of R204's SW-Skin Issues assessment revealed R204 was assessed on 3/31/26. However, there were no measurements, description, or staging of the pressure ulcers. There were no other SW-Skin Issues assessments completed between 3/31/26 and R204's date of discharge on [DATE]. A review of R204's Physician's Orders and Treatment Administration Records (TAR) for March and April 2026 revealed the following: An order initiated on 3/24/26 for Left Trochanter. Irrigate wound with wound solution and pat dry. Apply skin barrier film, allow to dry. Moisten kerlix roll with wound solution and squeeze out excess solution, lightly pack into wound bed. Cover with foam dressing. Every day shift AND .as needed. According to the TARs, the treatment was not administered on 3/31/26, 4/4/26, 4/10/26, 4/13/26, 4/14/26, and 4/19/26. There was no documentation that indicated why the treatments were not completed. An order initiated on 3/24/26 for Gently cleanse buttocks and sacral area with mild soap and water. Sprinkle antifungal powder into the area and gently rub in. Spray with skin barrier over powdered area allow to dry. Apply Zinc oxide paste to area. Every day and night shift AND .as needed. According to the TARs, the treatment was not completed on 3/31/26 day shift, 4/4/26 day shift, 4/10/26 day shift, 4/13/26 day and night shift, 4/14/26 day shift, and 4/19/26 day shift. An order initiated on 3/24/26 for Foot wound (the order did not specify which foot and did not indicate if this was for the pressure ulcer to the left heel or the non-pressure wounds to the right foot) Clean wound with betadine and pad heel with 4x4 gauze. Wrap entire foot and ankle with kerlix gauze and secure with tape. Bilateral (admission skin assessment mentioned pressure ulcers on right and left heel, but skin assessment on 3/24/26 and 3/31/26 only indicated a pressure ulcer to the left heel. It is unclear what wounds that order is treating). Every day shift AND .as needed. According to the TAR, this treatment was not completed on 3/31/26, 4/4/26, 4/10/26, 4/13/26, 4/14/26, and 4/19/26. An order initiated on 4/10/26 (17 days after R204 was admitted into the facility) for Wound consult: Clean Coccyx with NS (normal saline) pat dry and apply triad. An order initiated on 4/13/26 (20 days after R204 was admitted into the facility) for Consult wound care clinic Re: .left trochanter .foot .coccyx . A review of R204's progress notes revealed no documented thorough assessment of their pressure ulcers to the coccyx, trochanter, and heel(s) that included staging of the ulcers, measurements of the ulcers, or description of the ulcers. A review of a Physician Progress Note dated 3/25/26 revealed, .Multiple wounds over her hips and lower extremities .Chronic bilateral lower extremity and upper extremity wounds left heel osteomyelitis and left hip wound .Left foot wounds CT (Computed Tomography) scan showing concerns for calcaneus (heel) osteomyelitis . There was no documented measurements, description, or staging of the mentioned wounds. A review of Physician Progress Notes dated 3/27/26, 4/8/26, 4/10/26, 4/15/26 revealed no (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235487	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/23/2026
NAME OF PROVIDER OR SUPPLIER Medilodge of West Bloomfield		STREET ADDRESS, CITY, STATE, ZIP CODE 6950 Farmington Rd West Bloomfield, MI 48322	
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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	documented description, measurement, or staging of R204's pressure ulcers. A review of a Physician Progress Note dated 4/13/26 (20 days after R204 was admitted into the facility) revealed, .nursing staff were able to lay her on her back to examine her wound while sitting in the chair she complained of severe pain in her bottom unable to relax .Upon evaluation she does have chronic ulcerations in her perirectal areas, we well as her dressings were intact on bilateral feet also examined her left trochanter wound .Left trachanter [sic] wound deep and need further evaluation without abx (antibiotic) wound care referral ordered and informed nursing staff . A review of a Appointment/Transportation Note dated 4/16/26 revealed, Resident has a wound care appointment on Thursday 04/23/2026 . Further review of R204's clinical record revealed there was no order for a wound care consultation prior to 4/13/26, 20 days after R204 was admitted into the facility with multiple pressure ulcers. On 6/23/26 at 10:45 AM, an interview was conducted with the Wound Care Coordinator, Registered Nurse (RN) 'A'. RN 'A' explained they were the Assistant Director of Nursing (ADON) for the facility and recently stepped into the role of Wound Care Coordinator on 5/5/26 until the position was filled. When queried about the facility's protocol for assessing residents' skin upon admission and thereafter, RN 'A' reported the admitting nurse was responsible for the initial skin assessment. If any wounds were identified, they would take a photo using wound software and the software determined the measurements of the wounds. The admitting nurse was responsible for notifying the Wound Care Coordinator and the consulting Wound Provider, as well as management. RN 'A' reported the Wound Care Coordinator was responsible for assessing any wounds within 24 to 48 hours of admission or when a new wound was identified. RN 'A' said a Wound Provider came to the facility weekly currently. When queried about how wounds were monitored for improvement or worsening, RN 'A' reported when they rounded with the Wound Provider, a full evaluation was done and they were monitored at that time and any changes to treatments would be made. When queried about R204's lack of complete wound assessments on 3/24/26 and 3/31/26 and no assessments after that date, RN 'A' reviewed R204's clinical record and confirmed they were not complete and/or done at all after 3/31/26. RN 'A' confirmed there were missed treatments on the dates documented above and that there were no consultations by a Wound Provider prior to R204's discharge on [DATE]. RN 'A' reported a wound consult order should have been in place sooner than 4/13/26. RN 'A' was asked if they were aware of any identified concerns with skin management that the facility was working on and RN 'A' said they were unaware of any identified issues with skin management. On 6/23/26 at approximately 11:00 AM, an interview was conducted with the Director of Nursing (DON). The DON reported she became the DON two months ago. When queried about who was responsible to assess resident's skin upon admission, the DON reported the floor nurses were. The DON reported the Wound Provider was to be consulted and they would evaluate the resident on the next day they were in the building. When queried about the SW-Skin Issues assessment and what was to be included in the assessment, the DON reported it should document a thorough assessment of the wounds to include a description of the wound and the type of wound. At that time, the concerns with the lack of assessments and missed treatments for R205's pressure ulcers to their trochanter, coccyx, and heel(s) were addressed with the DON. The DON reported that the resident was seen by the attending physician. However, there should be documentation of the assessment of each wound to include a description and measurement of the wound in order to determine if it was improving or worsening. At that time, the DON was given the opportunity to provide any additional information regarding the care and treatment of R204's wounds. No additional information was provided prior to (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235487	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/23/2026
NAME OF PROVIDER OR SUPPLIER Medilodge of West Bloomfield		STREET ADDRESS, CITY, STATE, ZIP CODE 6950 Farmington Rd West Bloomfield, MI 48322	
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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the end of the survey. R203 A review of the medical record revealed that R203 was initially admitted to the facility in 2024 with a readmission date of 4/7/26 and diagnoses that included: sepsis, Bell's palsy, functional quadriplegia, and kidney failure. R203 required staff assistance for all Activities of Daily Living (ADLs). A review of a readmission Nursing note dated 4/8/26 at 6:07 AM, documented in part . Skin assessment completed, revealing multiple chronic pressure ulcers including stage 4 sacral ulcer with ongoing infection, as well as wounds to right posterior thigh/gluteal region, bilateral heels, left medial calf, right hip, and bilateral knees. Wound care orders reviewed and implemented per discharge instructions, including use of prescribed cleansing solutions, topical treatments, and appropriate dressings. Patient remains on pressure-relieving measures including specialty mattress and repositioning schedule. No new skin breakdown noted at this time. A review of the transferring hospital documents provided to the facility upon R203's readmission documented the following: An Internal Medicine consult dated 4/1/26 at 11:37 AM, documented in part . Septic shock likely secondary to infected sacral decubitus ulcer with suspected osteomyelitis of sacrum and coccyx. advance vascular dementia with bedbound status. remains under ICU (intensive care unit) care. Physical Exam. Skin. Stage 4 pressure ulcer to the right hip and left hips. Many of the other pressure ulcers are unstageable due to eschar overlying the areas. The hospital provided pictures of all identified wounds and noted the following in part, . Pressure injury heel left, Pressure injury heel right, Pressure injury hip left, Pressure injury hip right, Pressure injury leg lower left medial, Pressure injury leg lower right lateral, Pressure injury sacrum, Pressure injury anus, Pressure Injury knee left medial, Pressure Injury knee right medial, Pressure Injury leg lower left medial, Pressure Injury leg lower left posterior, Pressure Injury leg lower right posterior, Pressure Injury Penis. The resident was discharged back to the facility on 4/7/26. A review of the hospital discharge instructions provided to the facility upon R203's readmission documented the following in part, . Dakins (Half-Strength) Apply topically 2 (two) times daily. Per general surgery: Sacral wound care: pack wound with Wet to Dry Kerlix, secure with Allevyn twice per day with dankins <sic>. The hospital discharge documents did not contain treatment orders for R203's other pressure wounds. Review of the Physician orders and April 2026 Medication & Treatment Administration Records revealed the following: Acetic Acid Solution &dash; Apple to sacrum, right lateral knee topically every day shift for wound care. Started on 4/8/26 and the last application was noted on 4/15/26. The hospital wound orders were not implemented as directed by the hospital and no treatment was (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235487	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/23/2026
NAME OF PROVIDER OR SUPPLIER Medilodge of West Bloomfield		STREET ADDRESS, CITY, STATE, ZIP CODE 6950 Farmington Rd West Bloomfield, MI 48322	
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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	implemented for the resident's other multiple identified wounds. A review of the record revealed no documentation on why the hospital wound orders were not implemented as directed and failed to contain documentation on why treatment was not implemented for all of the resident's wounds. A review of a skin assessment dated [DATE] at 3:32 PM, documented the following . Are there any new abnormal skin areas? No. Are there any existing abnormal skin areas? Yes. List site(s) of any existing abnormal skin areas. Coccyx- Stage 4 Pressure ulcer. Stage 4 pressure ulcer to left hip. Stage 4 Pressure ulcer to right hip. Left lower leg (front)- Stage 4 pressure ulcer. Left heel- Stage 3 pressure ulcer. Right heel- Stage 3 pressure ulcer. Right knee (rear)- Stage 3 pressure ulcer. Right thigh (front)- Stage 3 pressure ulcer (inner thigh). Right lower leg (front)- Pressure ulcer. Right lower leg (rear)- Pressure ulcer. Left knee (front)- Stage 3 pressure ulcer. Left lower leg (front)- Stage 3 pressure ulcer. Tx (treatment in place) The review of the record revealed treatment was not in place for all of the identified wounds. The Medical record noted that R203 was transferred to the hospital on 4/16/26 for wound debridement. The resident did not return to the facility. On 6/23/26 at 2:24 PM, the Assistant Director of Nursing (ADON) who served as the Wound Care Coordinator (WCC) A in May 2026 was interviewed. WCC A explained they took over as the wound care coordinator in May 2026 until the recent hire of a Wound Nurse. WCC A stated there was another wound nurse prior to May 2026 however that nurse no longer worked at the facility. WCC A was asked if a resident came from the hospital with wound treatment orders to be implemented on their discharge instructions, what was the facility's protocol. WCC A stated they would implement the orders as noted on the hospital records. When asked the facility's protocol for a resident admitted with wounds that had no treatment orders provided and WCC A replied the nurses are responsible for calling the provider to initiate treatment to prevent delay. WCC A was asked if they could review the medical record of R203 with their team and provide an explanation or documentation on why treatment was not implemented as ordered for the sacral wound and why treatment was not implemented for R203's multiple other wounds upon readmission on [DATE] or again on 4/15/26 when the facility identified all of R203's wounds. WCC A stated they would review the record with their team and follow back up. At 2:47 PM, WCC A returned and reported they were unable to find anything but will continue looking. A review of a facility policy titled, Pressure Injury Prevention and Management, revised on 3/20/24 revealed, in part, the following. .Licensed nurses will conduct a full body skin assessment on all residents upon admission, weekly, and after any newly identified pressure injury. Findings will be documented in the medical record .Assessments of pressure injuries will be performed by a licensed nurse, and documented in the medical record .Interventions will be based on specific factors identified in the .skin assessment, and any pressure injury assessment .Evidence-based treatments in accordance with current standards of practice will be provided for all residents who have a pressure injury present .Treatment decision will be based on the characteristics of the wound, including the stage, size, amount of exudate, and presence of pain, infection, or non-viable tissue . No further explanation or documentation was provided by the end of the survey.		