

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235507	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/17/2025
NAME OF PROVIDER OR SUPPLIER Medilodge of Plymouth		STREET ADDRESS, CITY, STATE, ZIP CODE 395 W Ann Arbor Trail Plymouth, MI 48170	

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 0912</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms.</p> <p>Based on observation, interview and record review, the facility failed to provide at least 80 square feet per resident in eight of fifteen resident bedrooms (#109, 110, 111, 112, 113, 114, 115 and 116) and at least 100 square feet in one of five single bedrooms (room#102), resulting in the potential for inadequate space. Observations of resident rooms made on 7/17/25 at 2 P.M., during the environmental tour and review of the facility bed count information sheet with the Regional Director of Operations, who was familiar with facility room waivers, identified the following: Room # Square feet beds 102 81 1 1109 143 2 2110 143 2 2111 143 2 2112 143 2 2113 143 2 2114 143 2 2115 143 2 0116 143 2 2 The health and safety of the residents was not affected by the room size. Interviews with the residents noted no complaints concerning room size.</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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