STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235650	A. Building B. Wing	09/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Milford	555 Highland Ave Milford, MI 48381

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. Based on observation, interview, and record review, the facility failed to properly use a Hoyer mechanical lift to transfer one resident (R51) of two residents reviewed for accidents, resulting in the mechanical lift falling on R51 causing a laceration to their head requiring a trip to the emergency room for imaging and treatment with staples to close the wound. Findings include: On 9/24/25 at 12:27 PM, a review of R51's progress notes was conducted and revealed the following: A nursing progress note entered into the record by Nurse 'I' dated 6/13/25 at 11:31 PM that read, Cena (nurse aide) informed me that lodger was being transferred to shower chair and hoyer tip <sic> and bumped her head. 1 inch laceration noted .New order to send to hospital noted . A nursing progress note entered into the record by Nurse 'J' dated 6/14/25 at 3:36 AM that read, (Ambulance Company) transported Lodger to (Hospital Name) for eval. (evaluation) due to head injury . A nursing progress note entered into the record by Nurse 'J' dated 6/14/25 at 4:45 AM that read, Lodger return with EMS (Emergency Medical Services). Recieved [sic] 6 staple [sic] to injury on top of head. Ct (CT scan) to cerical [sic] spine and head negitive [sic] for fracture . On 9/24/25 at 1:30 PM, a review of a facility investigation file regarding R51's accident involving the Hoyer lift was reviewed and revealed an incident/accident report dated 6/13/25 completed by Nurse 'I' with a note entered onto the report by the facility's Director of Nursing (DON) on 6/30/25 that read, .Resident was being transferred via a hoyer [sic] lift when the lift tipped over and bumped resident in the head. Hoyer base legs were not spread open fully. Education given to staff involved . Continued review of the file revealed a Total Mechanical Lift Competency Checklist and an Education Training for the topic, Hoyer Lift Procedure. The Education Training read, When transferring a resident with a Hoyer the support legs need to be in the spread position . The competency checklist and education training forms in the file were noted to be signed by both CNA (Certified Nurse Aide) 'K, and CNA 'L'. On 9/24/25 at 1:44 PM, a phone call was placed to CNA 'K'. A voicemail was left, however; the call was not returned by the end of the survey. On 9/24/25 at 2:45 PM, an interview was conducted with R51. They were asked about the incident and in detail described CNA 'K' and another CNA (whose name they did not recall) were transferring them from the bed to the shower chair via the Hoyer lift. They said after they were in the shower chair the lift tipped over and hit them on their head causing a wound. They said, they didn't lose consciousness but, There was blood everywhere. They further expressed fear of being transferred in the Hoyer again after the accident. On 9/24/25 at approximately 3:30 PM, an interview was conducted with the facility's Director of Nursing, and they indicated the Hoyer lift was not set up properly by the CNA's during the transfer causing it to tip and strike R51 in the head. A review of a facility provided policy titled, Safe Lifting and Movement of Residents revised 1/2022 was conducted, however; the policy did not address the steps in the procedure to properly set up a Hoyer mechanical lift.

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 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 timely preventative interventions for pressure injury for one (R30) of one Resident reviewed for pressure injury prevention/management. Findings include:R30A review of R30's electronic medical record (EMR) revealed that they were admitted to the facility on [DATE] with diagnoses that included diabetes, heart failure, chronic kidney disease, depression and bladder dysfunction. Based on R30's Minimum Data Set (MDS) assessment dated [DATE], R30 needed substantial staff assistance for their mobility in bed. A Brief Interview of Mental Status (BIMS) completed on admission R30 had a score of 15/15 (indicative off intact cognition). A wound care provider note dated 6/17/25 revealed that R30 had a recommendation for a wheelchair cushion. An initial observation was completed on 9/23/25, at approximately 10:15 AM. R30 was observed sitting in their wheelchair on a Hoyer lift (total body lift) sling with no wheelchair cushion. An initial interview with R30 was completed during this observation. They were asked how they were doing, and R30 mentioned that they had sores on their bottom. When asked further they reported that they had the sores when they came to the facility, and they felt like the sores had gotten worse. When further asked about treatment, R30 reported that CNA H was putting some cream on their bottom, and they were not getting any wound treatment from nursing. When asked how they knew about the status of the sore they reported that their bottom was very sore, and they could feel it. When asked if they had any type of support/cushion on their wheelchair, R30 reported that they did not have one and demonstrated that they did not have one. R30 was sitting on top of a Hoyer sling and there was no cushion on their wheelchair. R30 was queried if they ever had one and they reported that they did not have one. There were no cushions or any other positioning devices in the room or in the bathroom. When queried how long they were sitting up in their wheelchair, R30 reported that they stayed up in wheel wheelchair till 8 or 9 PM at times, except when they needed a brief change. A follow up observation was completed later that day at approximately 1:50 PM. During this observation completed from the room entrance R30 was observed in bed receiving care. R30's wheelchair was parked near the foot end of the bed and there was no cushion or any type of pressure reducing support surface on the wheelchair.On 9/24/25 another follow-up observation was completed at approximately 10:20 AM. R30 was observed in their bed. They were queried about how they were doing. R30 reported that their bottom was very sore. R30 stated, They tell me it is not open, but I can't see it. R30's wheelchair was observed parked in the bathroom with a Hoyer lift sling and no cushion or any other supportive surface on the wheelchair. On 9/24/25 at approximately 11:55 AM R30 was observed sitting in their wheelchair. When asked how they were doing they reported again that their bottom was sore. They were sitting on top of the Hoyer lift sling and there was no cushion or any other type of pressure reducing support surface on their wheelchair.An observation of R30's buttock/sacral area was completed on 9/25/25 at approximately 8:30 AM with Wound Care Coordinator (WCC) M. During the observation R30 reported that pain in their bottom felt like a sun burn. The observation revealed bilateral buttocks were red and appeared inflamed. Left buttock was observed with an approximate 0.5 centimeter (cm) oval shaped excoriation (skin tear). A pinpoint sized opening on the coccyx (tailbone) was observed surrounded by reddened inflamed skin. While performing the observation, WCC M had acknowledged that the pinpoint area on the coccyx and left buttock excoriation were new. When questioned WCC M about R30's skin condition on the buttock, WCC M reported that the concern was first brought to their attention on 9/24/25 by the surveyor.Review of R30's care plan revealed that resident was at risk for impaired skin integrity due to their diagnoses and impaired mobility. Interventions listed on the care plan dated 6/5/25 and after did not reveal preventative measures that included the recommendation of a wheelchair cushion by the wound care provider dated 6/17/25. An interview with Licensed Practical Nurse (LPN) N was completed on 9/24/25 at approximately 12:20 PM. They were queried about the (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	about the facility's protocol on preventative interventions or pressure ulcer for residents who had a history of pressure ulcer and or at risk. LPN N indicated multiple interventions including the use of a wheelchair cushion. When queried about where they would find the information, they reported that it would be on the resident's care plan.An interview was completed with Wound Care Coordinator (WCC) M 9/20/25, at approximately 12:40 PM. They were queried about the facility process for initiating/continuing preventative interventions for residents who had a history of pressure ulcer with limited mobility at risk for recurrence. WCC M added that every resident should have a regular cushion, and they were unsure why R30 did not have anything on their wheelchair. They were notified of the concern, and they reported that they understood the concern. On 9/25/25 at approximately 9:35 AM, the DON (Director of Nursing) came and reported that R30 had a BIMS score of 11/15 (moderate cognitive impairment) and were being followed by their psychiatric services team as R30 had some delusions. When they were queried further on how these would impact the observations of R30 not having any support surface on their wheelchair, the observation of buttock area with new pressure injury and R30's complaints of pain, the DON did not provide any further explanation and reported that they agreed on the concerns. Review of facility provided document titled Pressure Injury Prevention Guidelines with a revision date of 3/20/24 read in part, Policy: to prevent the formation of avoidable pressure injures and to promote healing of existing pressure injuries, it is the policy of this facility to implement evidence-based interventions for residents who are assessed at risk or who have pressure injury present:Policy Explanation and Compliance Guidelines:1. Individualized interventions will address specific factors identified in the resident's risk assessment, and any pressure injury assessment (e.g. moisture management, impaired mobility, nutritional deficit, staging and wound characteristics).2. The goal and preferences of the resident and/or authorized representative will be included in the plan of care.3. Interventions will be implemented in accordance with physician orders, including the type of prevention devices to be used and, for tasks, the frequency for performing them.4. In the absence of prevention orders, the licensed nurse will utilize nursing judgement in accordance with pressure injury prevention guidelines to provide care and will notify the physician to obtain orders.5. Prevention devices will be used in accordance with manufacturer recommendations (e.g. heel floatation devices, cushion, mattress).6. Interventions will be documented in the care plan and communicated to all relevant staff.

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure social work services were implemented in a timely and efficient manner for one (R7) out of one resident reviewed for Social Service/Advanced Directives. Findings include:A review of R7's clinical record noted the resident was admitted to the facility on [DATE] with diagnoses that included: congestive heart failure, fatty liver and dementia with mood disorder. A review of the resident's Minimum Data Set Assessment (MDS) dated [DATE] noted the resident had a Brief Interview for Mental Status (BIMS) score of 6/15 (severely cognitively impaired).Continued review of R7's record noted, in part, the following:[DATE]: Nurse's Note: Pt (patient) educated, understood and signed psych medication consent form.Both forms given to social worker.XXX[DATE]: Consent of Psychoactive Medication Therapy: .Psychoactive Medication Order: Quetiapine/Seroquel 25 mg (an antipsychotic primarily used to treat bipolar and/or schizophrenia) .Specific Condition to be Treated: Depression.The Beneficial Effects Expected from the Medication: Improved Function ability.Specific side effects (checked for) Antidepressant. *It should be noted that the consent to treat was signed by R7XXX[DATE]: Order: Quetiapine 25 MG (milligrams).Give 1 tablet by mouth in the morning for depression.XXX[DATE]: Encounter: .R7.admitted to the SNF (skilled nursing facility) .after hospitalization for generalized weakness and difficulty ambulating.Nursing staff report no acute overnight issues. Hospital records were reviewed at transfer.Anti-psychotic medication use: Patient is not (emphasis added) on an antipsychotic medication.Gradual dose reduction does not have apply as the patient is not currently on an antipsychotic medication. (Authored by physician O). *It should be noted that R7 was administered the medication Quetiapine/Seroquel starting [DATE] and was not discontinued by the end of the SurveyXXX[DATE]: Advanced Directives Acknowledgement/CPR (cardiopulmonary resuscitation): .Resident is unable to make choice and does not have a representative at this time. Resident will remain a full code and receive CPR until otherwise determined. *This form was signed by Social Service Worker (SSW) F on [DATE].A Durable Power of Attorney Form dated [DATE] was found in R7's electronic record and documented that the resident had agreed to appoint a Durable Power of Attorney (hereinafter DPOA G) as their agent in the event they are unable to participate in medical treatment decisions. *It should be noted that there was no documentation in R7's electronic record that noted the resident had been deemed incompetent to make medical treatment decisions and/or confirm that they were not able to make Advanced Directive choicesXXX[DATE]: Encounter .Acute urinary tract infection.with increased confusion and lethargy.Start antibiotic treatment. On [DATE] at approximately 9:25 AM an interview was conducted with Social Worker Director (SSD) E and Social Service Worker (SSW). F. SSD E reported they had been the Director since [DATE] and noted that they were not a licensed social worker but worked with Regional Director P. SSD E noted that they generally work with residents that are at the facility long term. They also noted that SSW ?F works with those who are the facility short term. It was also noted that SSW F is not a social worker. SSD E was asked if they were familiar with R7 and whether they knew that the resident was capable of signing consent for the antipsychotic medication Seroquel on [DATE] but not capable of signing the Advanced Directive Acknowledgment/Code Status on [DATE]. When asked if at that time, R7 had been deemed incompetent, they replied no. SSD E further reported that a psychiatrist had deemed R7 incapable of making decisions on [DATE] but they were awaiting a signature from R7's physician. *It should be noted that no documentation regarding competency was found in R7's electronic record. SSD E was able to provide a document that had only been signed by a licensed psychiatrist on [DATE].On [DATE] at approximately 9:48 AM, R7 was observed sitting in their wheelchair. They were alert and able to answer most questions asked. R7 was asked if staff had ever discussed end-of-life/code status wishes. R7 stated he could not recall but noted that they wished to be DNR (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(do-not-resuscitate). R7 was also able to name the person listed as their DPOA and noted they should be aware of their choices. R7 was not aware of any medication they had consented for.A return interview was conducted with both SWD E and SSW F on [DATE] at approximately 10:30 AM. SWD E' was asked how they determined R7 was not capable of expressing their Advanced Directives/CPR Consent form. SSD E reported that they had determined R7 had a low BIMS score. SSW F also noted that R7 was confused as to where they resided and who they lived with and determined the resident was not capable of determining their wishes. SWD E was asked about the consent for the Antipsychotic Seroquel and what indicated they were capable of making the choice to take the medication based on depression/dementia diagnoses and were there any social worker notes indicating they and or SSW F met with R7. SWD E reported that there were no notes to review.The facility policy titled, Social Services (revised [DATE]) was reviewed and documented in part: Policy: The facility regardless of size, will provide medically related social services to each resident.The social worker, or social service designee, will complete an initial.assessment of each resident.Any need for medically-related social services will be documented in the medical record.The social worker, or social service designee, will pursue the provision of any identified need for medically-related social services.Attempt to meet the needs of the resident may include.Assisting residents with advance care planning.Identifying and promoting individualized, non-pharma logical approaches to care that meet the mental and psychological needs of each resident.