STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235022	A. Building B. Wing	04/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Clare	600 SE 4th Street Clare, MI 48617

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure professional standards of practice were followed regarding 1) administration of blood pressure medication with parameters and 2) treatment of hypoglycemic episodes for 2 residents (R6 and R85) of 7 residents reviewed. Findings include: Resident #6 (R6) Review of a Face Sheet revealed R6 admitted to the facility on [DATE] with pertinent diagnoses which included dementia and congestive heart failure. Review of R6's active Physician's Orders on 4/13/2026 revealed midodrine HCl tablet 2.5 mg (a medication that increases blood pressure), started 3/19/2026, give 1 tablet by mouth every 8 hours as needed for hypotension (low blood pressure) give if SBP (systolic blood pressure, the top number in the reading that measures the maximum pressure in your arteries when your heart beats) is less than 100 mmHg (millimeters of mercury). Further review of the Electronic Medical Record (EMR) revealed that R6's blood pressure had not been checked three times a day from 3/19/2026 to 4/13/2026. During this time frame R6's blood pressures were checked sporadically, sometimes once a day, sometimes twice a day, and other times it was not checked. Review of R6's Medication Administration Record (MAR) from 3/19/2026 to 4/13/2026 revealed midodrine was given only once in this timeframe, on 4/8/2026 at 7:22 PM. Review of R6's blood pressure readings between 3/19/2026 and 4/13/2026 revealed the following SBP readings below 100 mmHg with no documentation midodrine was administered-3/25/2026- 98/543/27/2026- 98/563/28/2026- 94/593/29/2026- 99/613/29/2026- 92/584/7/2026- 98/54 In an interview on 4/13/2026 at 3:33 PM, Licensed Practical Nurse (LPN) Unit Manager A reviewed R6's midodrine order and blood pressure readings and reported the order had been entered incorrectly. LPN Unit Manager A reported the report should have been written for the medication to be given 3 times a day unless the SBP was above 100 and corresponding blood pressure readings should have been ordered. LPN Unit Manager A reported it appeared R6 had missed doses of midodrine. Resident #85 (R85) Review of an Face Sheet revealed R85 admitted to the facility on [DATE] with pertinent diagnoses which included congestive heart failure, atherosclerotic heart disease (plaque buildup within artery walls), and type II diabetes. Review of R85's After Visit Summary revealed hospital discharge orders on 4/6/26 which included midodrine (a medication that increases blood pressure) 5 milligrams (mg), take 2 tablets 3 times a day (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	as needed and hold if systolic (the top number in the reading, measuring the maximum pressure in your arteries when your heart beats) blood pressure is greater than 100 mmHG (millimeters of mercury). Review of R85's Order Summary on 4/13/26 at 10:00 AM revealed the parameter (limit or boundary) for midodrine to hold medication if systolic blood pressure was greater than 100 mmHG was missing. In an interview on 4/14/2026 at 10:00 AM the Director of Nursing (DON) reviewed the midodrine order and confirmed the parameters recommended by the hospital should have been within the order. Review of facility policy/procedure Medication Administration, revised 1/17/2023, revealed staff were directed to obtain and record vital signs, when applicable or per physician's orders. Review of R85's Progress Note dated 4/10/26 at 12:05 PM revealed R85's blood glucose (main sugar found in the blood stream) was 39 mg/dl (milligram per deciliter) (normal range 70-100 mm/dl) and reflected R85 was given an 8-ounce orange juice and had been eating her lunch. Further review indicated R85's blood sugar would be rechecked after lunch. Review of R85's Order Summary Report revealed an active order If blood sugar less than (60) administer OJ, Food or glucose gel per manufacturer recommendation. Recheck in 15 minutes if no improvement notify MD as needed. Review R85's Electronic Medical Record (EMR) on 4/14/26 revealed her blood sugar on 4/10/26 at 5:11 PM was 74 mg/dl. The EMR did not reveal any further documentation. In an interview on 4/14/2026 at 10:07 AM Licensed Practical Nurse (LPN) L reported that a follow up blood sugar was obtained for R85 but not documented. LPN L reported she forgot to chart it. LPN L reported the primary physician was not notified of R85's blood sugar result of 39 mm/dl at 12:05 PM. LPN L reported that a blood sugar should have been obtained within 15 minutes from the first one with physician notification as indicated. In an interview on 4/14/26 at 10:10 AM the DON reported R85's blood sugar should have been rechecked as the physician order stated within 15 minutes and the nurse should have notified the physician if indicated. Review of facility policy/procedure Hypoglycemic Management, no revision date, revealed if the blood glucose reading is 70 mg/dl or below, the nurse will utilize the hypoglycemic protocol as per the practitioner's orders, with follow up blood glucoses as indicated, and notify the practitioner of the results as ordered.

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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 #2978434.Based on interview and record review, the facility failed to report an allegation of abuse to the state agency within 2 hours for 2 residents (R9 and R25) of 3 residents reviewed for abuse.Findings include:Review of a Face Sheet revealed R9 admitted to the facility on [DATE] with pertinent diagnoses which included dementia and anxiety.Review of a Face Sheet revealed R25 admitted to the facility on [DATE] with pertinent diagnoses which included dementia and anxiety.Review of the facility reported incident (MI-FRI #63868) revealed R25 struck R9's left arm with the back of his open hand on 3/11/2026 at 10:20 AM. Further review revealed this incident was reported to the state agency on 3/11/2026 at 1:52 PM.In an interview on 4/14/2026 at 10:15 AM, the NHA reported this allegation of abuse was not reported to the state agency within 2 hours because the day was very busy working through the incident.Review of facility policy/procedure Abuse Prevention Program, revised 2/22/2018, revealed .When an alleged or suspected case of mistreatment, neglect, injuries of unknown source, or abuse is reported, the facility. will immediately. no later than 2 hours if the event is an allegation of abuse. notify the following persons or agencies of such incident. the State licensing/certification agency responsible for surveying/licensing the facility.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure timely follow up for the monthly drug regimen review recommendations for 1 resident (R46) of 5 residents reviewed for unnecessary medication.Findings include:Review of an Face Sheet revealed R46 admitted to the facility on [DATE] with pertinent diagnoses which included chronic obstructive pulmonary disease, chronic kidney disease, and dementia. Review of R46's Pharmacist Monthly Medication Review dated 1/5/26 revealed a recommendation to evaluate the risks versus benefits and consider a gradual dose reduction to primidone (used to treat seizures), 50 milligrams (mg) give 0.5 tablet every day for 1 week, then discontinue. Physician response noted on 1/6/26 for hospice to evaluate the recommendation. Review of R46's Order Summary on 4/15/26 revealed an active order for primidone 50 mg to give 0.5 tablet by mouth twice daily. In an interview on 04/15/2026 at 9:48 AM, the Director of Nursing (DON) stated that he was unable to confirm that hospice had been notified to evaluate the recommendation dated 1/5/26 and the recommendation had not been evaluated.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation and interview, the facility failed to maintain general cleanliness and repair of the premises. This resulted in an increased potential for contamination and a possible decrease in satisfaction of living for residents. Findings include:On 04/13/2026 at 10:47AM, observed a trash can sitting under a leaking pipe in the basement area. The trash can was serving as a container and was overflowing with water; the overflow was running down the hallway towards a drain in the floor. When observation was pointed out to Certified Dietary Manager (CDM) R, CDM R stated that the maintenance department is aware of the leak, as they had told CDM R that the leak was coming from the ice machine drain line. On 04/13/2026 at 2:30PM observed that the water in the trash can, under the leaking pipe in the basement area, continued to overflow onto the floor. Maintenance Director (MD) H when asked who is responsible for emptying the water from the container, MD H responded that the maintenance department is responsible for emptying the water out. MD H proceeded to explain that the leak is coming from the metal pipe, which needs to be replaced to repair the leak. On 04/13/2026 at 2:31PM observed water dripping off the metal beam next to the pipe that is leaking. MD H stated the water is coming from the leaking pipe and running along the block ceiling and coming out at that point on the metal beam. MD H also stated repairs are on order to repair the leak to include partial removal of the block wall and ceiling to be able to access, remove and replace the piping and there is a needed tool on order to remove the block and cement wall and ceiling.On 04/14/2026 at 9:36AM, observed a green mold-like substance on the face of the mini-split (air conditioning) unit in the McKeevers dining room. Mini-split unit was not in use at time of observation. On 04/14/2026 at 10:01AM, interviewed Housekeeping Manager (HM) S, regarding who is responsible for cleaning the mini-split unit; HM S stated it is the responsibility of the maintenance department because they would have to physically remove the front of the unit to clean it. On 04/14/2026 at 12:53PM, interviewed MD H regarding procedures to bring the mini-split units back in use, MD H stated the maintenance crew removes the front of the unit, uses a foaming cleaner to clean the unit prior to turning on the mini-split units. On 04/14/2026 at 12:54PM, during interview with MD H, MD H was asked for a timeline for the repair of the leak in the basement. MD H stated there currently isn't a timeline for repair because they are waiting for the tool, needed for the removal of the ceiling and wall, before starting repair of the leak.