STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235282	A. Building B. Wing	06/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Kalamazoo	1701 S 11th Street Kalamazoo, MI 49009

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake #3030592Based on observation, interview, and record review the facility failed to ensure residents were assessed to be appropriate for self-administration of medications for 1 (Resident #104) of 1 resident reviewed for medication administration resulting in medications being left unsecured at resident's bedside, residents self-administering medications without staff assessment, and the potential for negative outcomes from taking/instilling too much or too little medications.Findings include:Resident #104Review of a Face sheet revealed Resident #104 was a male who originally admitted to the facility on [DATE] and had pertinent diagnoses which included: fracture of right radius (fracture of the right arm) and type 2 diabetes (a metabolic disorder that occurs when the body becomes resistant to insulin or when the pancreas fails to produce enough insulin).In an observation and interview on 6/9/26 at 9:16 am, Resident #104 was observed pushing the buttons and adjusting his insulin pump. Resident #104 reported he was protective of his pump. Resident #104 reported his insulin was special and hard to get and he managed his insulin pump himself. When asked if the facility assisted him with refilling the cartridge on his insulin pump, Resident #104 reported, no, I do it and it's all in the top drawer; Resident #104 gestured to the dresser stand in the room. Observed in the top drawer was a light blue transparent plastic adapter with two exposed needles and a Humulin R U-500 insulin pen with no label or name on it. Prior to opening the drawer Resident #104 stated Don't reach in the drawer, the needles are exposed and they are on both ends.Review of Resident #104's medical record on 6/9/26 revealed no noted documented self-administration of medication assessment.Review of Nursing admission Evaluation-Part 2 for Resident #104 dated 5/22/2026 at 12:48 pm, and reviewed on 6/11/26 revealed .Does the resident wish to self-administer medications- (answered) No.Review of Care Plan for Resident #104 revealed .Focus-Resident has Dexcom insulin pump, Resident prefers to maintain self.Goal-Resident will have reduced complications related to altered metabolic status . Interventions-administer insulin per orders.all initiated on 5/27/26 and Resident wears insulin pump and dexacom glucose monitor (continuous blood glucose monitoring system).initiated 6/4/26.Review of Medication Administration Records for Resident #104 on 6/11/26 from May and June 2025 revealed no noted documentation indicating any administration of Humulin R U-500 insulin. Review of Order Summary for Resident #104 revealed .Resident uses Dexcom insulin pump per home settings. started on 5/22/26.In an interview and observation on 6/10/26 at 9:52 am, Licensed Practical Nurse F reported she does nothing with Resident #104's insulin pump. LPN F reported Resident #104 has his supplies, he fills the pump, he administers the insulin, and they had extra pen (insulin pens) in the medication room. LPN F demonstrated two boxes labeled with Resident #104's name from a different pharmacy and reported they were his home supply; they were not from the facility's pharmacy.In an interview on 6/10/26 at 9:58 am, Registered Nurse (RN) D reported Resident #104 managed his own insulin pump and he had no idea how it worked.In an interview on 6/10/26 at 10:10 am, Nurse Practitioner (NP) HH reported she allowed Resident #104 to keep his insulin pump while in the facility. NP HH reported she reminded staff to complete the necessary assessments and gave a verbal order to Unit Manager (UM) H for Resident #104's insulin pump and for his Humulin R U-500 insulin to be ordered from the pharmacy. NP (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235282	A. Building B. Wing	06/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Kalamazoo	1701 S 11th Street Kalamazoo, MI 49009

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	HH reported they talked about him managing his insulin pump and she had notified staff that he was able to manage his insulin pump. In a telephone interview on 6/10/26 at 10:48 am, LPN N reported Resident #104 had his insulin pump all under control, his family had his extra supplies, and she does nothing with it.In an interview and observation on 6/10/26 at 12:30 pm, Resident #104 reported the staff had never assessed him for self-administration of medications. Resident #104 indicated all of the same supplies were still in the top drawer of the dresser, and gestured to the dresser where a light blue transparent plastic adapter with two exposed needles and a Humulin R U-500 insulin pen with no label or name on it was again observed and Resident #104 again issued the verbal [NAME] to not reach into the drawer due to exposed needles. In an interview on 6/11/26 at 9:23 am, Minimum Data Set/Registered Nurse (MDS/RN) E reported Resident #104 wanted to use his insulin pump since admission and was assessed able to self-administer medications. MDS/RN E was unable to locate a self-administer medication assessment for Resident #104.In an interview on 6/11/26 at 10:00 Director of Nursing (DON) B reported the physician order for Resident #104's insulin pump was his home settings. DON B was unable to explain what the specifics for Resident #104's home settings. DON B reported Resident #104 managed his insulin pump and he monitored his blood sugar readings and would report the information to the staff. DON B reported any open insulin should be kept locked in the medication cart, not in the resident's room unless there was a secure way to maintain the medication.In an interview on 6/11/26 at 10:00 am, Regional Nurse Consultant (RNC) OO reported Resident #104's insulin pump supplies to refill his insulin pump needed to be stored in a secure manner.In an interview on 6/11/26 at 10:16 am, Um H reported Resident #104 managed his insulin pump. UM H reported she did not complete an assessment for Resident #104 to self-administer medications. UM H confirmed there was not order in place for Resident #104 to self-administer medications. Review of facility policy Medication- Resident Self-Administration of with a revision date of 01/30/2024 revealed .a resident may only self-administer medications after the facility's interdisciplinary team has determined which medications may be self-administered safely.The results of the interdisciplinary team assessment are recorded in the resident's medical record.Bedside medication storage is permitted only when it does not present a risk to confused residents who wander into the other resident's rooms or to confused roommates of the resident who self-administers medications.lockable drawers or cabinets are required only if locked storage is ineffective.the medications provided to the resident for bedside storage are kept in the containers dispensed by the provider pharmacy.Medications stored at the bedside are reordered in the same manner as other medications.Diabetic residents with attached insulin pumps for glucose control will follow the physician's orders for basal rates and/or bolus doses, blood glucose checks, and changing of infusion sets/tubing, cartridges, reservoirs, or syringes for the insulin and will notify staff of any changes in glucose readings, skin, changes, at the site insertions or pain a the delivery site.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235282	A. Building B. Wing	06/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Kalamazoo	1701 S 11th Street Kalamazoo, MI 49009

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 0627 Level of Harm - Actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake #3005153 and #3005264Based on interview and record review the facility failed to ensure a safe discharge for 1 (Resident #103) of 2 residents reviewed for transfer and discharge, when on 5/4/26 at approximately 11:45 pm, Resident #103 was not allowed back into the building upon her return from an evaluation and subsequent diagnosis of a UTI (urinary tract infection) at a local acute care emergency department. This deficient practice resulted in Resident #103 being without food, shelter, medications, or resources for safety; further resulting in Resident #103 experiencing feelings of fear, anger, and mental anguish. Findings include:Resident #103Review of a Face sheet revealed Resident #103 was a female who originally admitted to the facility on [DATE] and had pertinent diagnoses which included: acute diastolic (congestive) heart failure (chronic condition where the heart is unable to pump enough blood to meet the body's needs), type 2 diabetes (a metabolic disorder that occurs when the body becomes resistant to insulin or when the pancreas fails to produce enough insulin) and unspecified abnormalities of gait (walking) and mobility.Review of Nurses' Notes for Resident #103 dated 5/4/26 at 15:23 (3:23pm) revealed Resident presented with altered mental status, not maintaining normal activities or eating and drinking normally. On call and mgmt (sic) notified. Resident sent to (Name Omitted) local emergency department.Review of Prehospital Care Report Summary from (Name Omitted) ambulance service for Resident #103 revealed .5/4/26 call received 14:50:44 (2:50 pm) .patient contact 14:59:44 (2:59 pm) .Left scene 15:35:55 (3:35 pm) at destination: 15:55:19 (3:55pm) .it was noted the patient had difficulties finding words. She would attempt to say a word then say it incorrectly. She was aware the words she was saying were incorrect but was unable to say the correct words.In an interview on 6/9/26 at 2:10 pm, Social Service Director (SSD) O reported Resident #103 was in the building only a short time and was sent all of the sudden to the hospital. SSD O was unsure if Resident #103 returned to the building. SSD O stated we were told she (Resident #103) did not want to accumulate anymore of a bill and did not want to come back to the facility from the hospital. In an interview on 6/9/26 at 2:25 pm, Unit Manager (UM) H reported Resident #103 was very confused and off from her baseline. UM H reported Resident #103 was diagnosed with a UTI at the hospital and she chose to go home from there. UM H reported medically Resident #103 could have returned to the facility from the hospital, but she ?had a balance' (unpaid bill at the facility).In an interview on 6/9/26 at 2:32 pm, Business Office Manager (BOM) M reported when Resident #103 admitted on [DATE] to the facility she did not have active Medicare insurance. BOM M reported Resident #103 had accrued a balance of $3051 from a previous stay that ended in June 2025; and Resident #103 still had that outstanding balance. BOM M reported they did not find out that Resident #103 did not have Medicare insurance until after she was admitted to the facility. BOM M reported Resident #103 went to the hospital on 5/4/26 and did not return to the facility.In a telephone interview on 6/9/26 at 3:55 pm, Resident #103 stated they would not let me back in because I had no insurance. Resident #103 reported she was able to straighten out her insurance, and that she had insurance coverage on 5/4/26, when the facility refused to allow her to return. Resident #103 reported she knew she owed them money and she was working with them on repayment and when she came back from the hospital, the staff was instructed to not let her in the building. Resident #103 stated They were not going to let me in that building, period.In a telephone interview on 6/9/26 at 3:45 pm, Paramedic (PM) S reported he was dispatched to (Name Omitted) emergency department parking lot to escort Resident #103 back into the emergency department after she was denied access at the facility. PM S reported the transport driver had returned to the emergency department parking lot with Resident #103, after the facility refused to allow her to come inside. PM S reported the (Name Omitted) ambulance service had to generate a call for service for PM S to escort Resident #103 into the emergency department since she had been discharged from the (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235282	A. Building B. Wing	06/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Kalamazoo	1701 S 11th Street Kalamazoo, MI 49009

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 0627 Level of Harm - Actual harm Residents Affected - Few	same emergency department about an hour before. PM S reported the first crew who originally transported Resident #103, the emergency department staff, the transport driver, nor Resident #103 were notified that Resident #103 was being discharged when she was picked up from the facility.Review of Prehospital Care Report Summary for Resident #103 dated 5/5/26 revealed .call received 00:14:39 (12:14 am).patient contact 00:14:59 (12:14 am).Left scene 00:15:07 (12:15 am).at destination 00:15:08 (12:15 am).Narrative History Text.The patient was being discharged from ER (emergency room) and transported via (Name omitted) to (Name omitted) facility.the facility she was transported from earlier that day. The facility refused to accept the patient back and (Name omitted) returned to the ER with the patient. As the patient is not fully alert and oriented, she needed to be re-registered and admitted to the ER.In a telephone interview on 6/10/26 at 8:01 am, Licensed Practical Nurse (LPN) I reported she was told Resident #103 wanted to go home from the hospital and that was her discharge plan. LPN I reported Resident #103 tried to come back into the facility in the middle of the night, and she was not let back into the building.In a telephone interview on 6/10/26 at 9:29 am, Registered Nurse (RN) G reported she was the nurse working the night shift on 5/4/26 to 5/5/26 when Resident #103 tried to return to the facility. RN G reported she was told in report that ?we weren't supposed to take her back'. RN G reported the hospital called the facility multiple times and she repeatedly told them she was not allowed to take Resident #103 back. RN G reported she called Nursing Home Administrator (NHA) A and was told to turn her (Resident #103) away. RN G reported Resident #103 returned with (name omitted) transport company and she met Resident #103 at the doors of the building and stood out there with her until (name omitted) transport company took her back. RN G stated My hands were tied; they told me not to take her back.In an interview on 6/10/26 at 10:12 am, NHA A reported Resident #103 admitted to the facility on [DATE] and her skilled payer (Medicare insurance) was not active. NHA A reported they spoke to Resident#103 about her patient pay amount, and how they would have to bill for her stay. NHA A reported there was a huge miscommunication with the hospital, and she had a clarifying phone with the hospital the next day. When directly asked if Resident #103 had returned to the facility following an evaluation in the emergency department and was denied re-entry to the building, NHA A stated yes, she (Resident #103) did return to the building and was not let in.Review of Discharge Information for Resident #103 ED (emergency department) visits revealed Discharge information date/time 5/4/26 at 2323 (11:23 pm) Urinary Tract infection.Review of ED Notes/Provider Notes for Resident #103 on 5/5/26 at 12:48 am revealed .Chief Complaint patient present with SNF (skilled nursing facility) placement.just discharged from (Name omitted) ED, (Name omitted) facility sent pt (patient) back and refused to accept her back d/t (due to) not having insurance.Review of Medical Decision Making for Resident #103 dated 5/5/26 from (name omitted ED) revealed .was previously seen here today in the ED and after being transported to (Name Omitted) she was subsequently denied access to the facility as she had been discharged from the facility earlier this morning. According to the patient as well as the paramedics.they were not made aware that the patient was discharged .primary concern for this patient was trying to determine whether or not she could be discharged to (Name omitted) facility or home.PT (physical therapy) note from 4/30/26 reports that patient required placement for further therapy due to weakness.I did try to talk to her about her plan for going home and what would happen if she were to fall at home.mentioned that she does not have a phone at this time because her phone recently broke. This further increased my suspicion that this patient would not be safe to be discharged home.Throughout the ED course, patient did exhibit waxing and waning confusion.This further led me to believe that this would be an unsafe discharge home.Review of Discharge Planning for Resident #103 from (Name Omitted) ED, 5/5/26 Post discharge MSW reached out to (Name Omitted) facility as they state that pt cannot return to their facility due to insurance coverage. (Name Omitted) facility states that pt's insurance expired on 4/30, this was discovered on 5/4 and pt was discharged . Then they sent pt to (Name omitted) ED as pt has had difficulty speaking for the past 3 days. They state pt was discharged at 3:00pm. MSW spoke with (Name omitted) NHA A regarding this, (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235282	A. Building B. Wing	06/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Kalamazoo	1701 S 11th Street Kalamazoo, MI 49009

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 0627 Level of Harm - Actual harm Residents Affected - Few	(Name Omitted) NHA A stated she does not know the discharge disposition of pt at this time but believes that she was supposed to go home. (Name Omitted) NHA A did not provide information on the circumstances of the medical needs of the pt after the discharge was completed however states they are two separate things. (Name Omitted) NHA A states that pt is not authorized to return as she was discharged earlier in the day due to insurance and pt does not have new authorization.In a follow up telephone interview on 6/10/26 at 3:10 pm Resident #103 reported she thought she would get more of what she needed by returning to the facility for therapy. Resident #103 reported the facility knew she was coming back from the ED, she arrived very late at night, it was raining, and she had to knock on the door. Resident #103 reported a nurse came to the door and said, I can't let you in. Resident #103 stated I thought she was joking. But then I realized she was serious and I was mad. Resident #103 reported the nurse told her she had no insurance, and Resident #103 stated that wasn't true. Resident #103 stated I was to be blocked from the building and I was, it completely blew my mind; I was upset, and at that point, I had nowhere to go. I had been discharged from (Name omitted) hospital to go to (Name omitted) facility they won't' accept me; it's the middle of the night and I'm in the rain trying to figure out what do I do now. Resident #103 stated The driver took me back to the hospital, because I had no place else to go. I waited for hours, it was such a fiasco, I felt like I had been gutted, they wouldn't take care of me when they said that they would. Resident #103 reported she had no identification, no money, and no information when she left the facility that day. Resident #103 stated I was angry, hurt, upset and scared, I had no place to go, and I had no idea the facility would go this far, but they did not let me back in that building.In a subsequent interview on 6/11/26 at 11:20 am, NHA A reported Resident #103 was never discharged from the facility; she was scheduled to be discharged that day and was transferred to the hospital due to a change in condition and was to discharge from the hospital to home.In a subsequent interview on 6/11/26 at 1:00 pm, SSD O reported there was not a discharge plan in place for Resident #103 at the time she was transferred to the hospital on 5/4/26. SSD O reported Resident #103 had been in the building ?for a brief time, over a weekend' and she had not had a chance to talk to Resident #103 about her discharge plan. SSD O reported they had not had a '72-hour' care conference for Resident #103 before she had transferred from the facility to the hospital.In an interview on 6/11/26 at 1:06 pm, Medical Records/admission (MR/A) LL reported Resident #103's 72-hour care conference was scheduled on Tuesday, May 5, 2026, the day after she was transferred to the hospital. MR/A LL reported when an admission occurs on a Friday, typically the 72-hour care conference was scheduled on the following Tuesday, as they cannot happen before the first 72 hours the resident was in the building.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235282	A. Building B. Wing	06/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Kalamazoo	1701 S 11th Street Kalamazoo, MI 49009

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 - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake #3030592Based on observation, interview, and record review the facility failed to maintain professional standards of nursing practice for 1 (Resident #104) of 4 resident reviewed for professional nursing standards resulting in ordered medications not being obtained from a pharmacy, no monitoring of home medication use, medications left unsecured at resident's bedside, and the potential for negative outcomes from taking/instilling too much or too little medications.Findings include:Resident #104Review of a Face sheet revealed Resident #104 was a male who originally admitted to the facility on [DATE] and had pertinent diagnoses which included: fracture of right radius (fracture of the right arm) and type 2 diabetes (a metabolic disorder that occurs when the body becomes resistant to insulin or when the pancreas fails to produce enough insulin).In an observation and interview on 6/9/26 at 9:16 am, Resident #104 was observed pushing the buttons and adjusting his insulin pump. Resident #104 reported he was protective of his pump. Resident #104 reported the facility was unable to provide him with his insulin Humulin R U-500 because it was special and hard to get and he had family bring in his supply from home. When asked if the facility assisted him with refilling the cartridge on his insulin pump, Resident #104 reported, no, I do it and it's all in the top drawer.Review of Care Plan for Resident #104 revealed .Focus-Resident has Dexcom insulin pump, Resident prefers to maintain self.Goal-Resident will have reduced complications related to altered metabolic status . Interventions-administer insulin per orders.all initiated on 5/27/26 and Resident wears insulin pump and dexacom glucose monitor (a continuous blood glucose monitoring system).initiated 6/4/26.Review of Medication Administration Records for Resident #104 on 6/11/26 from May and June 2025 revealed no noted documentation indicating any administration of Humulin R U-500 insulin. Review of Order Summary for Resident #104 revealed .Resident uses Dexcom insulin pump per home settings. started on 5/22/26.In a telephone interview on 6/10/26 at 9:15 am, Pharmacy Phone Tech (PPT) Z reported Humulin R U-500 insulin was available through the facility's pharmacy, and that medication was not listed on Resident #104's profile. When queried, PPT Z reported the medication was never ordered or dispensed for Resident #104; the pharmacy had not supplied the facility with Humulin R U-500 for Resident #104.In an interview and observation on 6/10/26 at 9:52 am, Licensed Practical Nurse F reported Resident #104 had his supplies, he filled the pump, he administered the insulin, and the facility had extra pens (insulin pens) in the medication room. LPN F demonstrated two boxes of Humulin R U-500 insulin pens, labeled with Resident #104's name, from a different pharmacy and reported they were his home supply; they were not from the facility's pharmacy.In an interview on 6/10/26 at 10:10 am, Nurse Practitioner (NP) HH reported she allowed Resident #104 to keep his insulin pump while in the facility. NP HH reported she gave a verbal order to Unit Manager (UM) H for Resident #104's insulin pump use per his home settings and for his Humulin R U-500 insulin to be ordered from the facility's pharmacy. NP HH reported she had met with Resident #104 a few days after he admitted and during that meeting, she had observed that he was almost out of insulin in his pump. NP HH reported they talked about him managing his insulin pump and NP HH inquired if Resident #104 had an insulin supply available from home as he needed more in the facility and she knew it would not be delivered to the building before he was completely out. NP HH reported she assured Resident #104 that the facility could obtain his ?rare' insulin from their pharmacy. NP HH reported Resident #104 agreed, and had someone bring insulin to the facility to use until his supply could be delivered from the pharmacy. In a telephone interview on 6/10/26 at 10:48 am, LPN N reported Resident #104 had his insulin pump all under control, his family had his extra supplies, and she did nothing with it.In an interview and observation on 6/10/26 at 12:30 pm, Resident #104 reported the staff had never acquired his insulin and he was still using his supply from home.In an interview on 6/11/26 at 9:23 am, Minimum Data Set/Registered Nurse (MDS/RN) E reported the facility had not ordered any insulin for Resident #104 during his (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235282	A. Building B. Wing	06/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Kalamazoo	1701 S 11th Street Kalamazoo, MI 49009

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 - Few	stay.In an interview on 6/11/26 at 10:00 Director of Nursing (DON) B reported the physician order for Resident #104's insulin pump was his home settings. DON B was unable to explain what the specific settings were for Resident #104's home settings. DON B reported she had confirmed the pharmacy had Humulin R U-500 available, but Resident #104 had his own supply. DON B reported Resident #104 managed his insulin pump and he monitored his blood sugar readings and would report the information to the staff. DON B reported her expectations were that staff was monitoring Resident #104's insulin use, pump, and blood sugar readings and that it was documented in his medical record.Review of Resident #104's medical record on 6/11/26 revealed no documentation regarding insulin use via his insulin pump.In an interview on 6/11/26 at 10:00 am, Regional Nurse Consultant (RNC) OO confirmed there was no documentation in Resident #104's record indicating staff was monitoring the use of an insulin pump, or insulin self-administration by Resident #104.In an interview on 6/11/26 at 10:16 am-UM H reported she Resident #104 managed his insulin pump, the staff did not manage it. UM H reported the facility would typically use up all the supplied home medications and then order the next supply from the pharmacy.Review of facility policy Medication- Resident Self-Administration of with a revision date of 01/30/2024 revealed .a resident may only self-administer medications after the facility's interdisciplinary team has determined which medications may be self-administered safely.The results of the interdisciplinary team assessment are recorded in the resident's medical record.Bedside medication storage is permitted only when it does not present a risk to confused residents who wander into the other resident's rooms or to confused roommates of the resident who self-administers medications.lockable drawers or cabinets are required only if locked storage is ineffective.the medications provided to the resident for bedside storage are kept in the containers dispensed by the provider pharmacy.Medications stored at the bedside are reordered in the same manner as other medications.Diabetic residents with attached insulin pumps for glucose control will follow the physician's orders for basal rates and/or bolus doses, blood glucose checks, and changing of infusion sets/tubing, cartridges, reservoirs, or syringes for the insulin and will notify staff of any changes in glucose readings, skin, changes, at the site insertions or pain a the delivery site.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235282	A. Building B. Wing	06/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Kalamazoo	1701 S 11th Street Kalamazoo, MI 49009

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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake #3030592Based on observation, interview and record review, the facility failed to ensure nursing staff were adequately trained and evaluated for competencies specifically related to the management of an insulin pump for 1 (Resident #104) of 1 reviewed for the management of an insulin pump. This deficient practice had the potential to result in ineffective medication therapy, complications, and adverse reactions. Findings include:Resident #104Review of a Face sheet revealed Resident #104 was a male who originally admitted to the facility on [DATE] and had pertinent diagnoses which included: fracture of right radius (fracture of the right arm) and type 2 diabetes (a metabolic disorder that occurs when the body becomes resistant to insulin or when the pancreas fails to produce enough insulin).In an observation and interview on 6/9/26 at 9:16 am, Resident #104 was observed pushing the buttons and adjusting his insulin pump. Resident #104 reported he was protective of his pump. Resident #104 reported he managed his insulin pump and the facility staff did not. Resident #104 stated .they don't have a clue how to work this. Review of Care Plan for Resident #104 revealed .Focus-Resident has Dexcom insulin pump, Resident prefers to maintain self.Goal-Resident will have reduced complications related to altered metabolic status .all initiated on 5/27/26 and Resident wears insulin pump and dexacom glucose monitor (a continuous blood glucose monitoring system) .initiated 6/4/26.In an interview on 6/10/26 at 9:52 am, Licensed Practical Nurse F reported she does nothing with Resident #104's insulin pump. LPN F reported she had no idea how Resident #104's insulin pump worked.In an interview on 6/10/26 at 9:58 am, Registered Nurse (RN) D reported he had no idea how Resident #104's insulin pump worked. In a telephone interview on 6/10/26 at 10:48 am, LPN N stated .Resident #104 had his insulin pump all under control, I do nothing with it. LPN N reported she did not know how to work Resident#104's pump.In an interview on 6/11/26 at 9:23 am, Minimum Data Set/Registered Nurse (MDS/RN) E reported the staff did not know how to use Resident #104's insulin pump and she had not provided any staff education or training on an insulin pump.In an interview on 6/11/26 at 10:00am, Director of Nursing (DON) B reported she did not know how to work Resident #104's insulin pump and had not provided any training or education to the nursing staff. When queried, DON B reported she did not know if the staff knew how to manage Resident #104's insulin pump or not.In an interview on 6/11/26 at 10:16 am, UM H reported she did not know how to manage Resident #104's insulin pump.In an interview on 6/11/26 at 11:00 am, Nursing Home Administrator (NHA) A reported the nursing staff had not been assigned, nor completed any competency evaluation related to the management of an insulin pump.