STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235284	A. Building B. Wing	05/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Midland	4900 Hedgewood Drive Midand, MI 48640

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to transcribe and initiate a medication order timely for 1 resident (Resident #1) out of 9 residents reviewed. Findings include:Review of a facility Face Sheet reflected R1 admitted to the facility on [DATE] with diagnoses that included cerebral infarction (ischemic (reduced blood flow) stroke), aphasia (a communication disorder resulting from damage to brain areas controlling language, usually caused by stroke or head injury) following cerebral infraction, and rheumatic mitral valve disease. Review of a hospital After Visit Summary (AVS) dated 12/24/25, reflected R1 was to be given enoxaparin 40 mg (milligram)/0.4 mL (milliliter) syringe commonly known as: LOVENOX Inject 0.4 mL (40 mg total) under the skin every 12 (twelve) hours. Lovenox is an anticoagulant. Review of a Nurses' Notes dated 2/12/26 at 3:50 PM reflects Resident (R1) returns from cardiology appt (appointment) with consultation form: TEE (Transesophageal Echocardiogram), (name of physician) to complete, start Eliquis (oral anticoagulant) 5mg po (orally) every 12 BID (twice a day) DC (discontinue) Lovenox, consult (name of physician) at (name of health system) follow up 5.21.26 at 10:50 AM with (name of physician). Review of the February 2026 Medication Administration Record (MAR) reflected the order for Lovenox was discontinued on 2/12/2026. The February 2026 MAR reflected the order for Eliquis 5mg PO BID was not initiated until 2/18/26, six days later. Review of a Progress Notes dated 2/25/2026 at 8:00 AM reflected General: [AGE] year-old female patient seen today to follow-up on her lab work. Patient (R1) was recently started on Eliquis by vascular surgeon secondary to a DVT (deep vein thrombosis, a blood clot). Labs have been ordered weekly for monitoring and these labs exhibit a hemoglobin of 6.6 (normal hemoglobin for an adult female is 12.0-15.5 grams per deciliter). There have been no reports of black or bloody stools (an indication of a gastrointestinal bleed). I will place her Eliquis on hold for 3 days and set her up for a transfusion of 2 units of packed red blood cells. I have also started her on Carafate (a prescription medication used to treat and prevent duodenal ulcers by forming a protective, healing barrier over them) 1 g (gram) 3 times daily along with PPI (proton pump inhibitor). We will continue monitoring her lab work weekly and trend her hemoglobin. She is in no acute distress. During an interview on 5/12/2026 at 9:26 AM, the Director of Nursing (DON) reported when a resident goes out for an appointment they are sent with a consultation sheet which is returned to either the charge nurse or the unit manager upon return from the appointment. If orders are to be changed or initiated, either the charge nurse or the unit manager input the orders into the Electronic Medical Record. If there are any questions about the orders, the charge nurse or unit manager will contact the physician for clarification. After any orders are addressed, the consultation sheet is placed in the physician notification book for review. The DON was not able to explain why six days had elapsed before R1's Eliquis order was entered. Review of a Nurses' Notes dated 3/2/2026 at 10:03 AM reflected noted pt (R1) to have hematoma above left eye, NP (nurse practitioner) visit new order to send to ER (Emergency Room) for CT (computed tomography). Spoke with (name of POA for R1) he stated he wants to see of family can transport. d/t pt not having money for EMS (emergency medical services) bill. called (proper name), stated will be here to transport. Review of a hospital Plan dated 3/2/26 reflected Subsegmental pulmonary emboli: Troponin (measures the level of cardiac-specific proteins (continued on next page)

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

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	in the blood, which are released when the heart muscle is damaged) 0.083. BNP (brain natriuretic peptide) 2720 (normal BNP is generally less than 100 pg (picograms)/mL.) CT (computed tomography) chest with contrast demonstrates filling defects in the right lower lobe subsegmental pulmonary artery branch and right middle lobe subsegmental pulmonary artery branch consistent with pulmonary emboli (a life-threatening blockage of a main artery in the lung, usually caused by a blood clot (deep vein thrombosis or DVT) that travels from the legs or pelvis) without right heart strain. Trend troponin. Limited echocardiogram ordered. Initiate patient on heparin drip with pharmacy to dose. Discussed this with patient's daughter at bedside. Unable to count as Eliquis failure due to multiple breaks in therapy. Please see below. History of DVT in the left peroneal vein: DVT in the left peroneal vein noted during hospitalization 12/12/2025. Patient (R1) was discharged on twice daily Lovenox injections. (R1) was switched to Eliquis 5 mg twice daily when she saw cardiology 2/12/2026. Per the notes, it appears that patient's Lovenox was stopped that same day however (R1) was not initiated on Eliquis until the evening of 2/18. Holding Eliquis, heparin drip as above.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure medications and controlled substances were secured and/or destroyed as required for four residents (R3, R4, and R5, and R6).Findings Include:During an observation on [DATE] at 8:12 AM, a plastic up containing a syringe with clear liquid and a glucometer and alcohol swab was observed on top of a medication cart. No staff were in the vicinity of the medication cart. An independently ambulatory resident was approximately 15 feet away from the unattended cart and medication. During an observation and interview on [DATE] at 8:15 AM, Licensed Practical Nurse (LPN) A approached the medication cart and said the syringe contained insulin for Resident #3 (R3). LPN A said he left the medication unattended because he had to go to the medication room to obtain medication that was not in the cart. LPN A unlocked and opened the top drawer of the medication cart where 3 clear plastic medication cups containing pills were stacked together. LPN A reported the medication cups contained controlled substances for R3, R4, and R5. A clear plastic cup containing a reddish-pink fluid was also preset. LPN A reported the liquid medication was for R6. During an observation and interview on [DATE] at 8:18 AM, the Director of Nursing (DON) was informed of the findings and observed the preset medications with LPN A. A narcotic count was completed, and it was identified that LPN A documented the controlled substances ordered for R3, R4, and R5 were allegedly withdrawn from the double locked compartment at 7:00 AM. LPN A said they had already been documented as given on the Medication Administration Record (MAR) for each resident. Each order for controlled substances was reviewed during the narcotic count, and it was identified that each of the doses was scheduled (to be given at specific intervals) and were not as needed. The DON instructed LPN A to dispose of the insulin injection and said they would waste the controlled substances. During an observation and interview on [DATE] at 8:35 AM, the DON walked away to obtain a jug of drug buster (a drug disposal system). LPN A was observed emptying each plastic med cup containing controlled substances into the sharps container affixed to the medication cart. The DON reapproached the medication cart and confirmed they had not witnessed the waste of medication and proceeded to instruct LPN A how to document a wasted drug on the controlled substance log. The DON said the Electronic Medical Record (EMR) would need to be corrected to reflect the medications had NOT been given as ordered and the provider would need to be contacted to address the late administration of each of the doses of medication. Review of a facility policy Medication Storage revised [DATE] reflected It is the policy of this facility to ensure all medications housed on our premises will be stored according to the manufacturer's recommendations and sufficient to ensure proper sanitation, temperature, light, ventilation, moisture control, segregation, and security. The policy specified: c. During a medication pass, medications must be under the direct observation of the person administering medications or locked in the medication storage area/cart. a. Schedule II drugs and back of stock of Schedule III, IV, and V medications are stored under double lock and key. b. Schedule II controlled medications are to be stored within a separately locked, permanently affixed compartment when other medications are stored in the same area, such as in refrigerator. Review of a facility policy Medication-Destruction of Unused Drugs revised [DATE] reflected All unused, contaminated, or expired prescriptions shall be disposed of in accordance with state laws and regulations (refer to any state-specific requirements). The policy specified 1. Drugs will be destroyed in a manner that renders the drug unfit for human consumption and disposed of in compliance with all current and applicable state and federal requirements. 5. Non-controlled and schedule V controlled drugs must be destroyed in the presence of two (2) licensed nurses. Schedule II, III, and IV controlled drugs must be destroyed by the Director of Nursing Services (DON) and another licensed nurse. (Unless state regulations require Pharmacist) . (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	14. Staff shall contact the provider pharmacy if they are unsure of proper disposal of methods for a medication.