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	08/07/2025

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

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(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 observation, interview, and record review, the facility failed to follow professional standards of nursing practice for 5 residents (Resident #45, #47, #95, #53, and #29) out of 20, reviewed for medication administration.Findings: Resident #45 (R45) Review of an admission Record revealed R45 was an [AGE] year-old male, admitted to the facility on [DATE], with pertinent diagnoses which included: diabetes. Review of R45's Order Summary dated [DATE]-[DATE] revealed, metFORMIN HCl Oral Tablet 500 MG (Metformin HCl) Give 1 tablet by mouth one time a day.Hold if BSL (blood sugar level) is less than 120 mg/dl To be administered at 8:00 AM. Review of R45's Blood Sugar Summary and July Medication Administration Record revealed: *On [DATE] R45's blood sugar was 108 and the metformin was administered. *On [DATE] R45's blood sugar was 103 and the metformin was administered. *On [DATE] R45's blood sugar was 88 and the metformin was administered. *On [DATE] R45's blood sugar was 116 and the metformin was administered. Review of R45's Order Summary dated [DATE]-present revealed, metFORMIN HCl Oral Tablet 500 MG (Metformin HCl) Give 1 tablet by mouth two times a day.Hold if BSL is less than 120 mg/dl. To be administered at 8:00 Am and 8:00 PM. Review of R45's Blood Sugar Summary and July and August Medication Administration Record revealed: *On [DATE] R45's morning blood sugar was 88 and the metformin was administered. *On [DATE] R45's evening blood sugar was not assessed, and the metformin was administered. *On [DATE] R45's evening blood sugar was not assessed, and the metformin was administered. *On [DATE] R45's morning blood sugar was 95, and the metformin was administered. (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	*On [DATE] R45's evening blood sugar was not assessed, and the metformin was administered. *On [DATE] R45's evening blood sugar was not assessed, and the metformin was administered. *On [DATE] R45's morning blood sugar was 103, and the metformin was administered. *On [DATE] R45's evening blood sugar was not assessed, and the metformin was administered. *On [DATE] R45's morning blood sugar was 93, and the metformin was administered. Review of R45's Electronic Medical Record revealed no documentation pertaining to the administration of the metformin outside of the ordered parameters. Resident #47 (R47) Review of an admission Record revealed R47 was an [AGE] year-old female, admitted to the facility on [DATE], with pertinent diagnoses which included: diabetes. Review of R47's Order Summary dated [DATE] revealed, HumaLOG Solution 100 UNIT/ML (Insulin Lispro (Human)) Inject 3 unit subcutaneously before meals for diabetes Hold if BSL is less than 120 mg/dl. To be completed at 7:00 AM (morning), 12:00 PM (afternoon), and 6:30 PM (evening). Review of R47's Blood Sugar Summary and July and August Medication Administration Record revealed: *On [DATE] at 12:56 PM R47's blood sugar was 116. R47's blood sugar was not assessed for the evening dose of Humalog and the result from 12:56 PM was utilized. R47's evening dose of Humalog was administered. *On [DATE] R47's blood sugar was 118 and the morning dose of Humalog was administered. *On [DATE] R47's blood sugar was 118 and the afternoon dose of Humalog was administered. *On [DATE] R47's blood sugar was 93 and the afternoon dose of Humalog was administered. *On [DATE] R47's blood sugar was 110 and the morning dose of Humalog was administered. *On [DATE] R47's blood sugar was 120 and the morning dose of Humalog was documented as 4-Vitals Outside of Parameters for Administration and the Humalog was not administered. Review of R47's Electronic Medical Record revealed no documentation pertaining to the administration of the Humalog outside of the ordered parameters or the withholding of the Humalog on [DATE]. Resident #95 (R95) Review of an admission Record revealed R95 was a [AGE] year-old male, admitted to the facility on [DATE], with pertinent diagnoses which included: heart disease and hypertension. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R95's Order Summary dated [DATE] revealed, Cozaar Tablet 25 MG (Losartan Potassium) Give 0.5 tablet by mouth one time a day.Hold if SBP (systolic blood pressure [top number]) is less than 120 mmHg. To be administered at 8:00 AM. Review of R95's Blood Pressure Summary and July and August Medication Administration Record revealed: *On [DATE] R95's morning blood pressure was 115/61 and the Cozaar was administered. *On [DATE] R95's morning blood pressure was 108/51 and the Cozaar was administered. *On [DATE] R95's morning blood pressure was 108/80 and the Cozaar was administered. *On [DATE] R95's morning blood pressure was 115/59 and the Cozaar was administered. *On [DATE] R95's morning blood pressure was 100/57 and the Cozaar was administered. *On [DATE] R95's morning blood pressure was 100/62 and the Cozaar was administered. *On [DATE] R95's morning blood pressure was 115/60 and the Cozaar was administered. *On [DATE] R95's morning blood pressure was not assessed and the Cozaar was administered. *On [DATE] R95's morning blood pressure was not assessed and the Cozaar was administered. *On [DATE] R95's morning blood pressure was 117/62 and the Cozaar was administered. *On [DATE] R95's morning blood pressure was 108/60 and the Cozaar was administered. *On [DATE] R95's morning blood pressure was 98/56 and the Cozaar was administered. *On [DATE] R95's morning blood pressure was 108/54 and the Cozaar was administered. *On [DATE] R95's morning blood pressure was 114/56 and the Cozaar was administered. *On [DATE] R95's morning blood pressure was 106/58 and the Cozaar was administered. *On [DATE] R95's morning blood pressure was 109/47 and the Cozaar was administered. *On [DATE] R95's morning blood pressure was 115/56 and the Cozaar was administered. Review of R95's Electronic Medical Record revealed no documentation pertaining to the administration of the Cozaar outside of the ordered parameters or without an assessment. Resident #53 (R53) Review of an admission Record revealed R53 was an [AGE] year-old male, admitted to the facility on [DATE], with pertinent diagnoses which included: hypotension. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R53's Order Summary dated [DATE] revealed, Midodrine HCl Oral Tablet 10 MG (Midodrine HCl) Give 1 tablet by mouth three times a day for hypotension Hold if SBP greater than 140. To be administered at 8:00 AM, 2:00 PM, and 8:00 PM. Review of R53's Blood Pressure Summary and July Medication Administration Record revealed: *On [DATE] R53's blood pressure was 136/61 at 8:24 AM and the Midodrine was administered. R53's blood pressure was not assessed for the 2:00 PM dose of Midodrine and the result from 8:24 AM was utilized. R47's 2:00 PM dose of Midodrine was administered. *On [DATE] R53's blood pressure was 125/52 and the 8:00 PM dose of Midodrine was administered. *On [DATE] R53's blood pressure was not assessed prior to the administration of the 2:00 PM dose of Midodrine. R53's morning blood pressure result was utilized and the Midodrine was administered. *On [DATE] R53's blood pressure was not assessed prior to the administration of the 2:00 PM dose of Midodrine. R53's morning blood pressure result was utilized and the Midodrine was administered. *On [DATE] R53's blood pressure was not assessed prior to the administration of the 2:00 PM dose of Midodrine. R53's morning blood pressure result was utilized and the Midodrine was administered. Review of R53's Electronic Medical Record revealed no documentation pertaining to the administration of the Midodrine outside of the ordered parameters or the lack of assessment prior to the administration. During an interview on [DATE] at 8:20 AM, Licensed Practical Nurse (LPN) S reported that vital signs should be obtained prior to the administration of a medication with ordered parameters. LPN S reported that the EMAR (electronic medication administration record) shows the entire ordered with parameters and prompts the licensed nurses and medication aides to document the vital sign results which also serves as a reminder to obtain the vital signs prior to the administration of the medication. During an interview on [DATE] at 12:45 PM, Director of Nursing (DON) and Regional Nurse (RN) T confirmed medication had been administered outside of parameters. DON and RN T reported that they had been working with the providers to discontinue parameters for residents that had been on medications long term with stable vital signs to promote a more homelike environment. DON and RN T reported that the expectation for licensed nurses and medication aides was to follow the provider ordered parameters and ensure vital signs and blood sugar were obtained prior to the administration of the medications. The DON and RN T were provided the above findings. No documentation disputing the findings were received prior to survey exit. Review of the facility policy Medication Administration dated [DATE] revealed, .8. Obtain and record vital signs, when applicable or per physician orders. When applicable, hold medication for those vital signs outside the physician's prescribed parameters. R29 Review of the medical record reflected R29 initially admitted to the facility [DATE] with a pertinent diagnosis of Type 2 Diabetes Mellitus. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 7:20 AM a review was conducted of the A Hall medication cart for rooms 9 through 15 with Registered Nurse (RN) R. The review revealed one [NAME] SoloStar Pen Injector (insulin pen) labeled for R29 and dated as placed in service on [DATE]. Review of the Doctor's Orders for R29 reflected an order for Lantus SoloStar Subcutaneous Pen Injector with the instructions to inject 17 units subcutaneously at bedtime with a start date of [DATE]. Review of the Lantus SoloStar Subcutaneous Pen Injector manufacturer's product information sheet, use and storage recommendations, reflected Only use your pen for up to 28 days after its first use. Throw away the Insulin (name of product) pen you are using after 28 days, even if it still has insulin left in it. Review of a calendar revealed that 28 days after [DATE] was [DATE] which indicated the one Lantus SoloStar injector pen for R29 in the medication cart remained available for continued use. Review of the Medication Administration Record (MAR) for [DATE] for R29 reflected the Resident had received two doses ([DATE] and [DATE]) from two different nurses after the manufacturer's recommended expiration date. The policy provided by the facility titled Medication Storage last reviewed/revised [DATE] was reviewed. The policy reflected, Policy: It is the policy of this facility to ensure all medications housed on our premises will be stored according to the manufacturer's recommendations. The policy provided by the facility titled Medication Administration last reviewed/revised [DATE] was reviewed. The document reflected Policy: Medications are administered by licensed nurses or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice in a manner to prevent contamination or infection. And 12, Identify expiration date. If expired, notify nurse manager.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation and interview, the facility failed to have an active plan for reducing the risk of legionella and other opportunistic pathogens of premise plumbing (OPPP). This deficient practice has the increased potential to result in waterborne pathogens to exist and to spread in the facility's plumbing system and an increased risk of respiratory infection among any or all the residents in the facility.Findings include:On 08/05/2025 at 1:20 PM, observation noted during walkthrough of the facility with Maintenance Director (MD) D; three dead end lines under the dirty dish side of the ware washing area. In that area, two of the dead-end lines are coming off the hot water line to the dish machine, another dead-end line with a faucet handle is closest to the current garbage disposal. When MD D was asked what the lines were for, he indicated they were not in use and was unsure what the lines had been used for or when they were removed from service. During a discussion regarding the dead-end lines in the kitchen and the facility's flushing schedule, MD D stated they are currently not flushing the dead-end lines in the kitchen area. On 08/05/2025 at 1:30 PM, observation of shower room located between A and B hall, a shower faucet handle and an uncapped pipe, coming out of the wall. MD D indicated that the faucet was not in use, and the line was not being flushed. When the shower faucet handle was turned on water came out of the pipe.Review of Operation Maintenance and Control Limits document, undated, on 08/05/2025 indicates that facility will flush low-flow pipe runs, dead legs and infrequently used fixtures weekly. On 08/05/2025 3:35 PM, observation during walkthrough of kitchen with Regional Maintenance Director (RMD) Q, a dead-end line with faucet handle under the clean dish side of the dish machine area. RMD Q stated he was unaware of that line being there and the dead-end line was not part of the flushing schedule.

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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 accurately assess and measure a pressure ulcer for 1 resident (R13) of 2 residents reviewed for pressure ulcers.Findings include:Review of an admission Record revealed R13 admitted to the facility on [DATE] with pertinent diagnoses which included spina bifida and a pressure ulcer on left buttock.Review of R13's preadmission wound Visit Note Report, dated 7/3/2025, revealed she had a stage IV pressure ulcer on her left buttock measuring 4.4 cm long, 3 cm wide, and 2.2 cm deep.In an observation on 8/6/2025 at 2:59 PM in R13's room, left buttock wound care was observed. R13's left buttock pressure ulcer was measured to be 2.63 cm long, 3.17 cm wide, and 2.5 cm deep.In an interview on 8/6/2025 at 1:48 PM, Wound RN M reviewed wound documentation and reported R13's left buttock pressure ulcer was identified by the admission nurse on 7/7/2025 but it was not assessed or measured until 7/10/2025. Wound picture and documentation from 7/10/2025 were reviewed and R13's pressure ulcer measurement was documented as 4.3 cm long, 2.8 cm wide, and depth was documented as not applicable. Wound picture and documentation from 7/16/2025 were reviewed and R13's pressure ulcer measurement was documented as 2.9 cm long, 2.7 cm wide, and 0.1 cm deep. The pictures reviewed for this pressure ulcer taken on both 7/10/2025 and 7/16/2025 clearly showed depth to the wound that was not documented in the wound measurements. Wound RN M was not able to explain why R13's wound was not assessed and measured upon her admission to the facility on 7/7/2025 or why wound documentation from 7/10/2025 and 7/16/2025 did not accurately reflect the depth of her pressure ulcer.In an interview on 8/7/2025 at 10:02 AM, RN Unit Manager J reported R13 refused to allow her left buttock pressure ulcer to be assessed on 7/7/2025 when she was completing the admission assessment. RN Unit Manager J reported she did not document this refusal, and she did not discuss this refusal with staff or otherwise arrange for timely completion of this wound assessment. RN Unit Manager J reported she expected the wound measurement to be completed the next day during wound rounds.In an interview on 8/7/2025 at 9:15 AM, the Director of Nursing (DON) reported R13 refused to allow her pressure ulcer to be measured upon admission to the facility on 7/7/2025 but could not find any documentation of this refusal. The DON reported the refusal should have been documented in the medical record and the wound assessment and measurements should have been completed as soon as possible after the initial refusal. The DON reported the wound measurements from 7/10/2025 and 7/16/2025 that showed no depth to the wound were believed to be inaccurate, but she could not find any documentation as to the true depth of the wound on these dates. The DON reported the facility was piloting a new way of taking wound pictures in the electronic medical record and she believed technical issues caused the wound depth to inaccurately populate on those dates.Review of R13's Nutrition Data Collection/Evaluation documented by Registered Dietician (RD) K on 7/10/2025 revealed R13 was documented to have no skin issues.In an interview on 8/7/2025 at 10:04 AM, RD K reported she was not aware of R13's pressure ulcer when she completed her evaluation on 7/10/2025 because the ulcer had not yet been documented under skin and wound in the electronic medical record. RD K reported she would have ordered Pro-Stat (a nutrition drink with extra protein) to promote healing at that time had she been aware of R13's skin issues. Review of facility policy/procedure Pressure Ulcer/Skin Breakdown- Clinical Protocol, revised 3/20/2024, revealed .Based on the comprehensive assessment of a resident, a resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers. and a resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice to promote healing. an admission evaluation helps identify. residents with existing (pressure ulcers). Initial Screen. Complete the. admission skin assessment upon admission to the facility. All (pressure ulcers) . are measured and documented. The (inter-disciplinary team) will review each pressure ulcer weekly for progress and changes.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to provide safe wheelchair transport for 1 resident (R40) of 1 resident reviewed for accident hazards. Findings include:Review of an admission Record revealed R40 admitted to the facility on [DATE] with pertinent diagnoses which included dementia and anxiety.Review of a current activities of daily living Care Plan intervention for R40, with a revision date of 7/21/2025, revealed she used a low scoot wheelchair for locomotion.In an observation on 8/5/2025 at 10:20 AM in the hallway outside R40's room, a Certified Nursing Assistant (CNA) pushed R40 down the hallway and into her room to provide resident care. R40's legs were hanging freely and not on foot pedals, and one foot was dragging on the ground. A few minutes later, CNA P exited R40's room and pushed R40 quickly back down the hallway in her wheelchair, with both feet dragging on the ground.In an interview on 85/2025 at 2:11 PM, CNA O reported residents should not be pushed in wheelchairs with their feet hanging down. CNA O reported footrests should be used to prevent accidents from feet getting tangled up in the chair.In an observation on 8/5/2025 at 2:37 PM in the hallway outside R40's room, CNA P pushed R40 down the hallway and into the dining are for an activity. R40's legs were hanging down and dragging on the floor.In an interview on 8/5/2025 at 2:47 PM, the Director of Nursing (DON) reported staff are expected to use foot pedals when pushing residents in wheelchairs if the resident is unable to use their feet to move the wheelchair to prevent accidents and injuries from feet getting tangled under the wheelchair.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to provide tube feeding according to standards of care for resident (R19) of two residents reviewed for tube feedings.Findings include:Review of R19's admission record dated 8/7/24 revealed she was admitted to the facility on [DATE] with diagnoses that included malignant neoplasm of brain, epilepsy, gastrostomy status, dysphagia oropharyngeal, (difficulty swallowing) and weakness.R19 was observed in bed on 8/5/25 at 11:22 AM. R19's eyes were closed, and she did not respond to calling her name. R19 had a feeding tube pump next to her bed and a bottle of tube feed was connected to the pump. The tube feeding bottle was connected to the feeding tube and food was visible in the tube. The tube feeding bottle contained approximately 850 ml of the 1000 ml (full bottle). A water bag was also connected to the pump. The tube feeding bottle and water bag were not labeled with resident name or date or time started.During an interview with Licensed Practical Nurse (LPN) I on 8/5/25 at 11:25 AM, LPN I was asked about R19's tube feeding. LPN I said night shift hung the tube feeding and the water bag. LPN I said she turned it off at 8:00 AM. LPN I was asked if the tube feeding and water should be labeled. LPN I said they should be labeled with the resident name, date, and time started. LPN I said she would dispose the current supplies and report the concern.R19 was observed in the main dining room on 8/6/25 at 1:50 PM with the tube feeding pump on a stand next to her. The pump was covered with a pillowcase. LPN G was asked about R19's tube feeding. LPN G removed the pillowcase, and the pump was observed to be running. It was set to infuse 303 ml over 1 hour and 127 ml had been received. The TF was labeled with R19's name and was dated 8/6/25. However, the water bag was dated 8/5/25 at 12:00 PM (more than 24 hours).Review of R19's Medication Administration Record (MAR) dated 8/5/25 revealed LPN I provided R19 tube feeding at 8:00 AM. LPN I had reported she turned the tube feeding off at 8:00 AM.During an interview with the Director of Nursing (DON) on 8/6/25 at 3:20 PM the DON was provided with the information of the tube feeding and water not being labeled on 8/5/25 and the water bottle in use after 24 hours of being open on 8/6/25. The Surveyor asked what the facility practice was as the facility policy did not cover the date, label or expiration date of supplies. The DON said she would investigate it.During an interview on 8/7/25 at 8:15 AM the DON said the tube feeding and water are to be labeled with the resident's name and open date. The tube feeding is to be disposed of after 48 hours and the water after 24 hours. The DON confirmed LPN I did do the 8:00 AM feeding on 8/5/25 when the tube feed and water bag were not dated or labeled and were in use. The DON confirmed that LPN G did not dispose of the water bag on 8/6/25 after 24 hours and continued to use an outdated water bag.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure timely replacement of respiratory equipment for 2 residents (R11 and R53) of 2 residents reviewed for respiratory concerns.Findings include:R11Review of an admission Record revealed R11 admitted to the facility on [DATE] with pertinent diagnoses which included congestive heart failure and chronic obstructive pulmonary disorder.In an observation on 8/5/2025 at 11:28 AM in R11's room, R11 was receiving oxygen therapy via a nasal cannula dated 7/16. In the corner of her room was a nebulizer machine with a nebulizer mask and tubing plugged into it dated 4/13. The nebulizer mask and tubing had begun to change to a yellowish color.In an observation on 8/7/2025 at 8:10 AM in R11's room, R11 was receiving oxygen therapy via a nasal cannula dated 7/16. In the corner of her room was a nebulizer machine with a nebulizer mask and tubing plugged into it dated 4/13, remaining unchanged from the previous observation.In an interview on 8/7/2025 at 8:15 AM, Registered Nurse (RN) N reported respiratory masks and tubing should be replaced weekly. RN N reported R11 received nebulizer treatments as needed and last received a treatment on 6/19/2025.R53Review of an admission Record revealed R53 admitted to the facility on [DATE] with pertinent diagnoses which included congestive heart failure and chronic obstructive pulmonary disorder.In an observation and interview on 8/5/2025 at 11:08 AM in R53's room, R53's wheelchair had a bag hanging on the back with a nasal cannula dated 6/18. R53 reported he used this oxygen cannula daily when out of his room.Review of facility policy/procedure Oxygen Administration, revised 10/26/2023, revealed .change oxygen tubing and mask/cannula weekly and as needed if it becomes soiled or contaminated. change nebulizer tubing and delivery devices every 72 hours.

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	08/07/2025

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 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. Based on interview and record review, the facility failed to ensure a Pharmacy Recommendation was acted upon for one resident (R3) of five residents reviewed for pharmacy recommendations. Findings include:Review of the Electronic Medical Record (EMR) reflected R3 admitted to the facility 7/10/24 with diagnoses that included Cerebral Infarction (stroke), Disorders of Electrolyte and Fluid Balance, and Gastrostomy (feeding tube).Review of the Pharmacy Recommendation dated 6/10/25 reflected, Note to Attending Physician/ Prescriber, Atorvastatin (a lipid lowering agent) Please add a lipid panel to the standing lab orders: (of) CBC (complete blood count), CMP (comprehensive metabolic panel), A1c every six months. The document reflected the physician had checked the agree box and signed on 6/12/25.Review of the EMR reflected since 6/10/25 R3 had three lab entry dates with results but a lipid panel had not been drawn. The EMR further reflected that a lipid panel had not been documented since admission and review of the Doctor's Orders did not reveal a pending order for a lipid panel. No other EMR documentation was identified that indicated a lipid panel was forthcoming.On 8/6/25 at approximately 2:00 PM an interview was conducted with the Director of Nursing (DON) regarding the Pharmacy Review of 6/10/25 for R3. The DON indicated a review would be conducted.On 8/7/25 a review of the Doctor's Orders for R3 revealed an order for lab work that included a lipid panel entered into the computer on 8/7/25.On 8/7/25 at 12:17 PM an interview and record review were conducted with the DON. The DON reported she had talked with the medical provider who indicated to the DON that she knew the lipid panel was out there. The DON provided EMR documentation dated 6/12/25 by a medical provider to Please add lipid panel to next standing order lab draw. However, prior to the lab order of 8/7/25 no documentation was identified in the EMR that indicated a lipid panel had been added.As of survey exit no additional information had been provided.