STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235286	A. Building B. Wing	08/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Cass City	4782 Hospital Drive Cass City, MI 48726

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to have an active and ongoing plan for reducing the risk of legionella and other opportunistic pathogens of the premise's plumbing. Findings include: On 08/26/2025 at approximately 1:00-1:30PM during the environmental tour with the Director of Maintenance D observed drain line to water softener sitting inside drain located in B hall. 08/26/2025 at approximately 1:00-1:30PM conducted interview with Director of Maintenance D on flushing water lines, he stated that the boiler is flushed, and it's done every month. On 08/26/2025 at approximately 1:00-2:00PM record review of legionella results showed legionella positive in C utility room, result was 0.8 CFU/mL on 3/14/25. When water was retested, legionella test results was negative on 5/15/25 for C utility hall. On 08/27/2025 at approximately 8:30-9:00AM during the housekeeping tour with the Housekeeping Manager E, observed a box with supplies stacked inside the basin of the utility sink in the janitor's closet between C and D hallways. When questioned on how often the utility sink is used, the Housekeeping Manager E stated housekeeping does not use this utility sink. On 08/27/2025 at 9:00-9:25AM observed the utility sink leaking from the atmospheric vacuum breaker in the janitor's closet located between C and D hallways. Conducted an interview with the Senior Maintenance Director F on the usage of the utility sink, and he claimed that housekeeping comes in and flushes the sink weekly. But when the surveyor mentioned the Housekeeping Manager E stated that this sink was not being used by housekeeping, he then claimed the Director of Maintenance D flushes it weekly. On 08/27/2025 at 9:00-9:25AM conducted interview with Director of Maintenance D and Senior Maintenance Director F on the utility sink located between C and D hallways. When asked about the usage of the utility sink, Director of Maintenance D answered that it's not in use and there was confusion on who flushes the sink weekly. The Senior Maintenance Director F stated that it is flushed weekly, but that there are no records on flushing. On 08/27/2025 10:47 AM observed a drinking fountain between A and B hallways. The water fountain would not turn on. Conducted interview with the Nursing Home Administrator on when the drinking fountain was shut off, and she stated she wasn't sure, but it's shut off due to an ongoing construction project. According to the 2008 Cross Connections Manual on water softeners, Typical water softener installations may pose a public health threat mainly due to the waste discharge piping being terminated in a floor drain or sewage piping system thereby creating a submerged inlet cross connection. According to Controlling Legionella in Potable Water Systems from the Centers of Disease Control and Prevention dated January 3rd, 2025, Eliminate dead legs, which are sections of no- or low-water flow. and Flush low-flow piping runs and dead legs at least weekly. Flush infrequently used fixtures regularly as needed to maintain water quality parameters within control limits. Record review of the facility's Water Management Program, it states Flush low-flow pipe runs, dead end legs and infrequently used fixtures weekly.

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to develop a comprehensive care plan for one resident (R31) of 16 residents reviewed for comprehensive care plans, resulting in the absence of a diabetic management care plan and the potential for unmet care needs. Findings include:R31 is [AGE] years old and admitted to the facility on [DATE] with diagnoses of type 2 diabetes mellitus, dementia, history of falling and delusional disorders. On 08/27/25 at 9:00AM, record review of the comprehensive minimum data set (MDS) dated [DATE], revealed that R31 had a diagnosis of diabetes mellitus. On 08/27/25 at 10:30AM, record review revealed an order for Lyumjev (Insulin) 2 units, subcutaneous prior to meals, hold if blood sugar (BS) is less than 120, call physician if more than 300, it is dated 10/17/24. On 08/27/25 at 10:33AM, record review of care plans revealed there was no care plan present for diabetic care of R31. On 08/28/2025 at 10:19AM, an interview was conducted with the Director of Nursing (DON). The DON was asked if R31 should have a care plan in place for diabetic management. The DON replied, yes, R31 should have one in the record. The DON stated, I'm not sure why there isn't one in the record, I will put it in right now. Review of the policy titled, Comprehensive Care Plans, revealed, Policy: It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing and mental and psychosocial needs that are identified in the resident's comprehensive assessment (minimum data set). Policy Explanation and Compliance Guidelines: 2. The comprehensive care plan will be developed within 7 days after the completion of the comprehensive MDS assessment. All care assessment area triggered by the MDS will be considered in developing a plan of care. Other factors identified by the interdisciplinary team, or in accordance with the resident's preferences, will also be addressed in the plan of care. The facility's rationale for deciding whether to proceed with care planning will be evidenced in the clinical record.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure appropriate measures were in place, assessed for effectiveness and the resident was monitored to prevent constipation for one resident (Resident #56) of 1 resident reviewed for constipation, resulting in Resident #56 experiencing discomfort, restlessness and adverse reactions after not having a bowel movement for 8 days. Findings include: Change of Condition Resident #56 A record review of the Face sheet and Minimum Data Set/MDS assessment indicated Resident #56 was initially admitted to the facility on [DATE], 4/4/2022 and readmitted on [DATE] with diagnoses: Heart disease, Epilepsy, dysphasia, Multiple sclerosis, neuromuscular dysfunction of the bladder, high blood pressure, muscle weakness, depression, constipation and acute bladder inflammation with bleeding (8/24/2025). The MDS assessment dated [DATE] revealed the resident had a memory problem and needed assistance with care. On 8/26/2025 at 11:03 AM, Resident #56 was observed lying in bed, he rubbed his abdomen and stated, Can't go and shook his head back and forth No. Resident #56 continued to rub his abdomen, and it appeared distended. Certified Nurse Aide G entered the room and talked to the resident he nodded his head and attempted to answer her questions. She said he had not been feeling well. Certified Nurse Aide G said he had been like that recently. While in the resident's room an X-ray technician arrived and said he was there to perform an X-ray of the resident's abdomen. A review of the Tasks documentation in the electronic medical record/emr for Bowel Elimination Description for 7/29/2025 to 8/26/2025. The documentation indicated Resident #56 had several long stretches with no Bowel movement/BM: On 8/7/2025 to 8/13/2025 the resident had no BM for 5 days and a small BM on 2 days (8/7/2025 and 8/12/2025). On 8/18/2025 to 8/25/2025 the resident had no BM for 8 days. A record review of the physician orders and Medication Administration Record/MAR indicated Resident #56 was receiving Hospice care and the resident had an order for daily Fleets enemas beginning 7/15/2025 to 8/13/2025 and 8/19/2025 to 8/26/2025. The resident had also received an enema on 8/14/2025 and 8/17/2025. There was an order for one Dulcolax suppository as needed for constipation dated 5/13/2025, but there was no documentation it was given in August 2025. A new order dated 8/26/2025 said to give 2 Dulcolax suppositories that day and it was documented as given (The resident had 2 large bowel movements after receiving the 2 suppositories). There was an order for Milk of Magnesia every 72 hours as needed for Constipation if no bowel movement for 3 days. It was provided once on 8/21/2025. A record review of the 8/26/2025 abdominal X-ray results for Resident #56 identified an ileus pattern and could not rule out an obstruction. Further review of the progress notes identified the following: 8/9/2025 at 8:00 AM, an encounter notes, Nurse reports pt (patient) has recent report of ileus type pattern of bowel, has been receiving nightly enemas. Pt is now on day 3 of no BM. Treatment: give MOM (Milk of Magnesia) and an enema or Dulcolax suppository. 8/12/2025 at 8:24 AM, a Nurses Note, Resident going on day 5 with out a BM. 8/13/2025 at 8:00 AM, a Provider Progress Note, . Patient has been bloated and has not passed bowel movement for the last 3-4 days. Upon examination, patient's abdomen is distended and he has active bowel sounds. 8/24/2025 at 5:33 PM, a Nurses Note, Resident declining, has not had a bowel movement in 7 days even with enemas. There was no prior documentation that the resident had not had a bowel movement day 4 through day 6. 8/26/2025 at 9:35 AM, a Nurses Note, Resident 8 day. Abdomen rigid and distended. ON 8/27/2025 at 9:59 AM, interviewed Certified Nurse Aide/CNA G in the resident's room, she said Resident #56 had a large bowel movement yesterday (8/26/2025) on days and afternoons after he had a suppository. The CNA was asked if the staff documented if a resident ha a bowel movement or not and she said they did. The CNA was asked what the staff do if the resident had not had a bowel movement for several days, and she said they would tell the nurse. On 8/27/2025 at 10:10 AM, Nurse H was interviewed she said she had cared for Resident #56 the day before on 8/26/2025 and that day 8/27/2025. Nurse H was asked if Resident #56 had constipation and she (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated, He was on our bowel list for not having a BM for 8 days. The Nurse said she had been off for several days and when she came back she was notified he was on day 8. She said she contacted the provider, and they ordered an abdominal X-ray on 8/26/2025. Nurse H was asked if the facility had a protocol for addressing a resident's constipation and she stated, After day 3 they get MOM, but Hospice may have gotten rid of that, then a suppository day 4 and an enema day 5. She said the instructions were on the Bowel list that the nurses receive each morning. She said Resident #56 was day 8 and should have received a suppository on day 4. She said for some residents' dietary would provide the residents with a bran mixture in the morning. A review of the Bowel Watch List dated 8/27/2025 indicated each hallway was listed with each resident. Beside each resident's name was a number for how many days without a BM. The majority had 0 next to their names, but one resident on another hall was noted with a 6, indicating 6 days without a BM. The list provided: L1- Monitor (no BM for 1 day); L2 Monitor/dietary will provide a bran muffin (no BM for 2 days); L3- 30 ml of MOM given on day shift (no BM for 3 days); L4- Dulcolax suppository on the night of identification no BM for 4 days); L5- Fleet enema on the night of identification (no BM for 5 days); L6- Call physician morning of identification (no BM for 6 days). Document interventions next to each resident when complete & initial. A review of the Care Plans for Resident #56 identified the following: (Resident #56) has episodes of bowel incontinence related to dementia, generalized weakness, impaired mobility, physical limitations, has supra-pubic cath in place, dated initiated 10/20/2023 and revised 10/27/2025 with Interventions including: (Resident #56) has a history of constipation, initiated power pudding along with PO (by mouth) medication to assist with irregularity, date initiated 2/26/2024; Administer medications as ordered, date initiated 10/20/2023. The interventions had not been updated since 2/26/2024. The residents' constipation had worsened.On 8/28/2025 at 10:30 AM, during an interview with the Director of Nursing/DON, she was asked about the facility bowel protocol. She said the dayshift nurses each received the bowel list in the morning to notify them if a resident had not had a bowel movement. She said the bowel protocol was also on the document and the nurses were to follow it. The DON was asked about Resident #56 being on the list on 8/26/2025 with no BM for 8 days and per the Medication Administration Record/MAR for August 2025 he did not receive MOM or a Dulcolax suppository until 8/26/2025, when he received 2 Dulcolax suppositories, per a new physician order. Reviewed the resident also had another long stretch of no BM August 7-13th. She said the residents had a history of constipation, but the nurses should follow the Bowel protocol. The DON was asked about the Bowel protocol as it waits until the resident has not had a bowel movement for 6 days prior to contacting the provider. Discussed the resident was supposed to receive an enema daily, but it was not working, and the nurses did not address the issue with the provider until the 8th day with no BM. She said they would have to work on that.

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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 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate colostomy, urostomy, or ileostomy care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure a comprehensive bowel elimination care plan, ensure documented assessments and changes for a colostomy (an opening in the abdomen through which stool from the colon can be discharged into a bag) for one resident (Resident #38) of one resident reviewed for colostomy (ostomy), resulting in a lack of overall documentation of the colostomy care with the likelihood of signs and symptoms of complications going unnoticed. Findings include: On 8/27/2025, at 8:15 AM, CNA A offered that when the ostomy bag needs changed, they let the nurses know and the nurses change it. On 8/27/2025, at 9:30 AM, a record review of Resident #38's electronic medical record revealed an admission on [DATE] with diagnoses that included Mild Intellectual Disabilities, Alzheimer's disease and Dementia. Resident #38 required assistance with all Activities of Daily Living. According to the most recent accepted quarterly Minimal Data set assessment revealed the resident had severely impaired cognition. A review of the care plan (the resident) has an alteration in elimination GI related to need for a Colostomy Date Initiated: 01/17/2025 . Goal Resident will have no signs of skin breakdown or irritation around stoma through the next review . Resident will have reduced complications related to their ostomy through the next review. Date Initiated: 01/17/2025 . Interventions . assist resident with colostomy care as needed. Date Initiated: 01/17/2025 Observe skin integrity at the stoma site and report signs of irritation, redness and/or rashes to Physician Date Initiated: 01/17/2025 Treatment to stoma site as ordered . Empty colostomy bag as needed . Observe stoma site for complications when colostomy appliance is changed . A review of the TREATMENT ADMINISTRATION RECORD 8/1/2025 - 8/31/2025 revealed colostomy- to be changed @ skin when coming off. As needed for bowel movement -Start Date- 08/17/2025 There was no documented colostomy changes. A review of the TREATMENT ADMINISTRATION RECORD for both July and June 2025 revealed no order to change the colostomy or order to assess the skin, stoma and stool consistency. A review of the physician orders revealed colostomy-to be changed @ skin when coming off. As needed for bowel movement . Start Date 8/17/2025 . A review of the following skin assessments and corresponding progress notes revealed Skin Assessment for the days of 8/24/20205 8/17/2025 8/10/2025 8/3/2025 . There were no documented assessments of the stoma, surrounding skin and stool consistency and/or color. On 8/27/2025, at 11:58 AM, the Director of Nursing (DON) was asked regarding Resident #38's ostomy care and how often it should be completed and the DON stated, every 7 days and prn (as needed). The DON was alerted there was no documentation of colostomy assessments and ostomy care every 7 days. The DON offered, they would look into and follow up. On 8/27/2025, at 1:34 PM, an observation of Resident #38's colostomy was conducted with Unit Manager (UM) B Resident #38 offered, the nurse changed it last night. The ostomy bag has liquid brown stool with the name [NAME]. The stoma appeared to be red in color and was unable to be completely visualized. UM B was asked where the nurses document the assessment of the stoma, surrounding skin and the changes of the ostomy appliance and UM B did not answer. A further review of Resident #38's electronic medical revealed a new physician order Order Date: 8/27/2025 . Change bag and flange every day shift every 7 day(s) for ostomy AND as needed. On 8/28/2025, at 11:18 AM, an observation along with Nurse C of the colostomy supplies for Resident #38 revealed a box of [NAME] appliances and a box of colostomy bags. There were no other colostomy supplies such as: stoma wipes, adhesive remover wipes, stoma powder /paste or deodorizer. Nurse C was asked if that was all the supplies and Nurse C stated, yes. According to National Institute of Health, A nurse assessing a colostomy should evaluate the stoma color and appearance, peristomal skin for irritation or breakdown, the pouching system for leaks, the ostomy output for consistency and abnormal changes, and the patient for symptoms like pain . A review of the facility provided Ostomy Care . Policy revealed it is the policy of this facility to ensure (continued on next page)

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F 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	that resident who require colostomy . services receive care consistent with professional standards of practice . The frequency of pouch changes and the products required for changing ostomy devices will be noted on the resident's person-centered care plan .

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure that dialysis communication forms were completed and included pre-dialysis and post-dialysis assessments and accurate identification of the dialysis access site for one resident (Resident #5) of 1 resident reviewed for dialysis services, resulting in the potential for a decline in condition and the inability for a prompt response to care needs.Findings include: Dialysis Resident #5 On 8/26/2025 at 9:33 AM, Resident #5 was observed in his room sitting in a wheelchair. He said he was getting ready to leave for dialysis. He said he goes on Tuesday, Thursday, and Saturday and leaves the facility about 9:00 AM. The resident showed his dialysis access site on his right chest. The dressing over the site was dated 8/20/25 and he said they would change it at the dialysis center. A record review of the Face sheet and electronic medical record, indicated Resident #5 was admitted to the facility on [DATE] with diagnoses: Diabetes, end stage kidney disease, dependence on renal dialysis, heart failure, COPD, post-polio syndrome, weakness, depression, and hypertension. The resident had a Brief Interview for Mental Status/BIMS score of 15/15 revealing full cognitive ability. The resident needed some assistance with care. A review of the physician orders for Resident #5 provided the following: Dialysis Tuesday, Thursday, Saturday, dated 7/23/2025; Monitor AV (arteriovenous) shunt site every shift for signs & symptoms of Infection/bleeding, dated 7/23/2025; Monitor new AV fistula site to left upper arm for bleeding, increased edema, or signs and symptoms of infection. Notify physician of changes, dated 8/18/2025. A review of Dialysis Communication Record for Resident #5 dated 8/26/2025 indicated the resident's dialysis access site was the Right chest CVC (central venous catheter). The physician orders identified an AV shunt, AV fistula in the left upper arm and the Communication record revealed right chest. There was a discrepancy with identifying the location of the dialysis access site. The nurses needed to the precise location to aid in assessing the resident for complications and adverse effects. Further review of the Dialysis Communication Records for Resident #5 indicated there were 2 assessment sections to be completed by the nurse. The first Pre dialysis section was for the facility to complete prior to the resident leaving for dialysis. The resident would take the form to the dialysis center and they would complete the 2nd section Dialysis and send the form back to the facility with the resident. Three of the 13 Dialysis Communication Record forms reviewed were missing assessment information such as vital signs, weights and on 8/12/2025 the facility assessment section was blank. There was nothing written for Vital signs: Blood pressure, pulse, respirations, temperature or weight, dialysis access site, pain or any problems. Further review of the 8/12/2025 Dialysis Communication Record for Resident #5, although blank on the top facility assessment section, the 2nd section completed by the Dialysis center revealed the following, Patient became unresponsive for < 1 minute d/t (due to) hypotension (low blood pressure); quickly returned baseline after intermittent fluid bolus. The resident had very low blood pressure and was administered IV fluids to elevate his blood pressure. A review of a progress note dated 8/12/2025 at 5:22 PM, Notes provided by dialysis while resident in care of dialysis center staff states resident experienced a brief unresponsive episode lasting less than 1 minute. States he quickly recovered following a few fluid boluses. Resident had not mentioned this.A review of the Care Plans for Resident #5 identified the following: (Resident #5) is at risk for infection related to dialysis port, initiated on 7/23/2025 and revised 7/31/2025, with Interventions including: Observe dialysis access site and report to Physician/NP/PA signs /symptoms bleeding or signs of infection: redness, swelling, local warmth, tenderness, date initiated 7/23/2025; Observe vital signs as indicated, date initiated 7/23/2025. The Care Plan did not provide a location of the dialysis port. On 8/28/2025 at 12:20 PM, during an interview with the Director of Nursing/DON, the resident's Dialysis Communication Record for 8/12/2025 was reviewed. The DON said the nurses should have completed the assessment information. Reviewed there was a discrepancy between the orders and Care Plan for location of the (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	dialysis access site. The DON was asked how the nurses would assess the resident if they did not correctly have this information, she said it would be fixed. A review of a facility policy titled, Care Planning Special Needs- Dialysis, date implemented 10/30/2020 and reviewed/revised 12/28/2023 provided, This facility will provide the necessary care and treatment, consistent with professional standards of practice, physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences, to meet the special medical, nursing, mental, and psychosocial needs of residents receiving dialysis. Comprehensive care plans will be developed. The care plan will reflect the coordination between the facility and the dialysis provider. Interventions will include, but not limited to: a. Documentation and monitoring of complications; b. Pre- and post-weights; c. Assessing, observing, and documenting care of access sites. f. Vital signs; g. Provision of medications on dialysis treatment days, such as which medications are: 1. Administered during dialysis; 2. Held prior to dialysis; 3. Given prior to dialysis; 4. Administered by dialysis staff. Nursing staff will provide a report to the dialysis provider regarding the resident's condition and treatment provisions each dialysis treatment day. The care plan will be reviewed routinely and as needed for effectiveness and revised as needed.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 follow physician-ordered medication administration parameters for two residents (R31, R49) of five residents reviewed for unnecessary medications, resulting in medications being administered outside of parameters. Findings include: Resident #49: A record review of the Face sheet and Minimum Data Set/MDS assessment for Resident #49 revealed an admission to the facility on 5/21/2024 with diagnoses: Diabetes, Heart failure, Cardiac pacemaker, history of repeated falls, COPD, high blood pressure, Dementia, weakness, hypothyroidism, depression, anxiety, peripheral vascular disease, arthritis and pain. The resident has a memory problem with a Brief Interview for Mental Status/BIMS score of 3/15 and needs assistance with care. A review of the physician orders for Resident #49 identified the following: Metoprolol Tartrate Oral Tablet: Give 50 mg by mouth two times a day for CHF (congestive heart failure), Hold dose if: SBP (systolic blood pressure/top number) <110 or heart rate less than 60,” start date 7/19/2025. A review of the Medication Administration Record/MAR for August 2025 indicated Metoprolol was administered 3 times to Resident #49 when his heart rate was lower than 60: on 8/11/2025 at 8:00 AM with heart rate of 59; 8/15/2025 at 8:00 AM with heart rate of 59 and 8/27/2025 with heart rate of 58. A physician order for Hydralazine HCl tablet 10 mg: Give 1 tablet by mouth three times a day for hypertension related to Essential (primary) hypertension, Hold if SBP is less than 120 mmhg,” start date 4/30/2025. A review of the Medication Administration Record/MAR for August 2025 indicated Hydralazine was administered on 8/18/2025 at 10:00 PM with a blood pressure of 118/58. A review of the progress notes for Resident #49 indicated there were no notes addressing the low blood pressures or heart rates or why the medications were not held as ordered. Although, on 2 of the dates the resident's pulse or blood pressure was low, the resident was yelling out “Help me” 8/18/2025 and yelling out for care 8/15/2025. A review of the Care Plans for Resident #49 identified the following: “(Resident #49) has an impaired cardiovascular status related to coronary artery disease, hypertension, CHF, Hyperlipidemia, (Pace Maker),” date initiated 6/28/2024 and revised 8/22/2024 with Interventions including: “Medications as ordered; observe for side effects and report to Physician/NP/PA,” date initiated 6/28/2024; “Observe vital signs as needed,” date initiated 6/28/2024. On 8/28/2025 at 12:25 PM, during an interview with the Director of Nursing/DON, the August 2025 MAR for Resident #49 was reviewed, the cardiac medication parameters to hold were not consistently followed. It was reviewed with the DON the progress notes did not explain why the medications were not held. The DON said the nurses should have followed the orders. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235286	A. Building B. Wing	08/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Cass City	4782 Hospital Drive Cass City, MI 48726

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 - Few	Resident #31: R31 is [AGE] years old and admitted to the facility on [DATE] with diagnoses of type 2 diabetes mellitus, dementia, history of falling and delusional disorder. On 08/27/25 at 9:00AM, record review of the comprehensive minimum data set (MDS) dated [DATE], revealed that R31 had a diagnosis of diabetes mellitus. On 08/27/2025 at 10:11AM, a review was completed of monthly medication regimen reviews performed by the pharmacy. It was revealed that on 10/12/24 there was a recommendation by the pharmacy to clarify blood sugar hold levels for an insulin order. This recommendation was completed on 10/17/24. On 08/27/25 at 10:30AM, record review revealed an order for Lyumjev (Insulin) 2 units, subcutaneous prior to meals, hold if blood sugar (BS) is less than 120, call physician if more than 300, it is dated 10/17/24. On 08/27/25 at 10:35AM, record review of the medication administration records from April 2025, May 2025, June 2025, July 2025 and August 2025 for the Lyumjev revealed that the insulin had been given outside of parameters on multiple dates: 4/11/25: BS of 109, administered 4/12/25: BS of 114, administered 4/21/25: BS of 117, administered 5/3/25: BS of 112, administered 5/3/25: BS of 117, administered 5/12/25: BS of 117, administered 5/19/25: BS of 114, administered 5/27/25: BS of 95, administered 6/3/25: BS of 107, administered 6/8/25: BS of 115, administered 6/22/25: BS of 114, administered 7/2/25: BS of 102, administered 7/26/25: BS of 100, administered 7/26/25: BS of 118, administered (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235286	A. Building B. Wing	08/28/2025

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	8/11/25: BS of 112, administered On 08/28/2025 at 10:19AM, an interview was conducted with the Director of Nursing (DON). The DON was asked if the nursing staff should be administering insulin outside of the parameters or holding it. The DON stated the nurses should be holding it and not administering it. The only time they should ever administer insulin outside of parameters is if the physician was notified and told them it was ok to give it. Review of the policy titled, Medication Administration, revealed: Policy: Medications are administered by licensed nurses, or other stuff 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. Policy Explanation and Compliance Guidelines: 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.