STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235300	A. Building B. Wing	05/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Taylor	23600 Northline Rd Taylor, MI 48180

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 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. This citation pertains to intake 3001431.Based on interview and record review the facility failed to ensure the physician was notified when medications were not administered as ordered for one resident (R902) out of three residents reviewed for medication administration, resulting in missed opportunities for physician intervention, alternative treatment considerations and the potential for further spread of the resident's infection.Findings include:Record review of electronic medical record (EMR) of R902 revealed admission into the facility on 3/14/26 and discharged from the facility on 3/15/26, with pertinent diagnoses of chronic osteomyelitis (infection of bone) of the left ankle and foot and Type 2 diabetes mellitus (metabolic disorder). Further review of EMR revealed that the resident was alert and oriented x 4 (person, place, time, and situation) upon admission to the facility.A phone interview was conducted with R902 on 5/15/26 at 10:17 AM. R902 reported that while at the facility the resident did not receive a dose of insulin or antibiotics that were prescribed. It was further reported that the resident left the facility and went back to the hospital the next morning so that antibiotics could be administered to decrease the risk of continued infection.Record review of Medication Administration Record (MAR) for March 2026 documented on 3/14/26 the following:Antibiotic- Cubicin Solution Reconstituted 500 MG (milligram) (Daptomycin) Use 500 mg intravenously every 24 hours for Osteomyelitis for 14 Days Administer 750mg in sodium chloride 0.8% -Start Date- 03/14/2026 1759. There was no documentation that the antibiotic was administered.Insulin- Glargine 100-15 unit at night shift for type 2 DM (type 2 diabetes mellitus) dated 3/14/26 9PM. 3/14/26 it was documented with number nine with nursing initials.Antibiotic- Piperacillin Sod- Tazobactam Sod Solution Reconstituted 4.0GM (grams). Use 4.5 gram intravenously every 6 hours for Infection for 14 Days. Start Date- 03/14/2026. There was no documentation that the1800 (6PM) dose was given and 0000 (12AM) dose documented the number nine with nursing initials.An interview was conducted on 5/15/26 at 11:00 AM with Director of Nursing (DON), it was reported that if there is no documentation on the MAR it was not given and if there is a nine you should refer to progress notes.Record review of progress notes documented on 3/15/26 at 3:54 AM, Did not arrive (antibiotics) from pharmacy. There was no documentation referring to why insulin dose was not given in the progress notes.An interview was conducted on 5/15/26 at 3:15 PM with Licensed Practical Nurse (LPN) A, it was reported that R902 did not receive the three prescribed antibiotics because they were not delivered from the pharmacy. It was further reported that the physician did not receive notification of the three missed doses of antibiotics or the insulin.On 5/15/26 at 3:30 PM a follow up interview was conducted with the DON. The DON reported that when prescribed medications are not available, the physician should be notified. This would give the physician an opportunity to assess the situation and provide further orders or alternative treatment recommendations. The DON reported that the insulin may not have been available in back up medications at that time.Record review of facility policy Medications Unavailable dated 1/31/24 documented the following: .4. Medications may be unavailable for a number of reasons. Staff should take immediate action when it is known that the medication is unavailable:a. Determine reasons for unavailability, length of time medication is unavailable, and what efforts have been attempted by the facility or pharmacy provider to obtain the medication.b. Notify physicians of inability to obtain (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medication upon notification or awareness that medication is not available. Obtain alternative treatment orders and/or specific orders for monitoring residents while medication is on hold.