STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235331	A. Building B. Wing	05/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Howell	1333 W Grand River Howell, MI 48843

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 - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30675 This citatoin pertains to intake #MI00152841. Based on interview, and record review, the facility failed to ensure a resident was free from significant medication errors for one (R803) of four residents reviewed for medication administration, resulting in a significant change in condition and hospitalization when R803 received R801's medications. Findings include: Review of a complaint reported to the State Agency included allegations that a male resident received a heavy dose of his roommate's medication during the midnight shift and was sent to the hospital the next morning, foaming at the mouth. Review of R803's clinical record revealed the resident was admitted into the facility on [DATE] and discharged to the hospital on 4/26/25. As of this review, R803 had not returned to the facility. Diagnoses included: ischemic cardiomyopathy, permanent atrial fibrillation, ASHD (Atheriosclerotic Heart Disease) of native coronary artery without angina pectoris, CHF(congestive heart failure) pulmonary hypertension, type 2 DM (Diabetes Mellitis) with unspecified complications, nondisplaced fracture of greater trochanter of left femur, acute kidney failure, presence of coronary angioplasty implant and graft, and bradycardia. Review of the progress notes revealed following the administration of another resident's medications, R803 had a significant change in condition and changes in vital signs in which the resident was transferred to the hospital for further treatment. The progress notes included: An entry on 4/26/25 at 12:10 AM by Licensed Practical Nurse (LPN) 'G' read, Gave res (resident) wrong medication. Realized immediately when given. Notified Dr [Name of Nurse Practitioner/NP 'D'], Nurse on call DON (Director of Nursing) with no reply .No adverse reaction at this time.No change mental status.VS (Vital Signs) within normal limits.B/p (Blood Pressure) 132/68 hr (Heart Rate) 78 resp (respirations) 18 bs (blood sugar) 172 temp (temperature) 98.4.No s/s (signs/symptoms) of distress or discomfort at this time. (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 0760 Level of Harm - Actual harm Residents Affected - Few	An entry on 4/26/25 at 6:26 AM by LPN 'H' read, Resident got wrong medication last shift. In bed very lethargic. HOB (Head of Bed) elevated. 2400 (12:00 AM) (BP) 134/ 82 (O2) 96% .(Resp) 16 (Blood Sugar Level) AC 190. 0200 (2:00 AM) .(O2)93% (Resp) 18 (BP) 110/52 (HR) 64 (Blood Sugar Level) AC 136. Remains lethargic. Breathing unlabored. 0300 (3:00 AM) .(O2) 93% (Resp) 18 (BP) 81/55 (HR) 79 (Blood Sugar Level) AC 142 Continues to open eyes and that is about it. Chat easy sent to doctor about lethargic and BP drop. No new orders. 0400 (4:00 AM) .(O2) 92% (Resp) 18 (BP) 109/47 (HR) 93 (Blood Sugar Level) AC 134. HR. ranging from 79 to 100. Continues to snore and open when touched. 0430 (4:30 AM) chat easy sent with new VS (Vital Signs) and changes. No new orders. 0600 (6:00 AM) .(O2) 93% (Resp) 18 (BP) 122/61 (HR) 82 (Blood Sugar Level) AC 151. Did open mouth for TSH RX (Thyroid Medication). Continues to bed lethargic. 0625 (6:25 AM) chat easy sent and updated doctor. Improved BP and HR more stable. An entry created on 4/26/25 at 6:55 AM by Nurse Practitioner (NP 'D') for 4/25/25 documented an asynchronous - telehealth note that read, .Nurse called and report that she gave the resident was given wrong medication. These are medication that was given to the resident that does not belong to him: Divalproex Sodium 250mg (Milligrams - an anticonvulsant medication), levetiracetam 1000mg (an anticonvulsant medication), Metformin 1500mg (a diabetic medication), Clonazepam (a benzodiazepine medication), and cloZAPine Oral Tablet 200 MG (an antipsychotic medication), Lacosamide Oral Tablet 50 MG (an anticonvulsant medication). Resident doing well and Vital signs: BP (Blood Pressure) 128/62, P (Pulse) 86, O2 sat (Oxygen Saturation) 96% RA (Room Air), BS (Blood Sugar) 123, 20. Advise nurse not to give resident his Trazodone but can give Xarelto and Atorvastatin. Advise nurse to monitor vitals q (every) 2 hours and report any medical issue. Will update rounding provider. (There was no further documentation after this entry from the rounding provider and this entry did not identify/address the significant BP results reported by nursing staff.) An entry on 4/26/25 at 9:07 AM by Registered Nurse (RN 'I') read, Resident being monitored after medication error last night. Resident unresponsive to stimuli, and has increased secretions/ gurgling in throat. On call provider notified of changes and agreed to send to ER (emergency room) for further evaluation. A late entry on 4/28/25 at 7:49 AM for 4/28/25 at 7:40 AM by Nurse 'J' (Nurse on-call on 4/25/25) read, Late entry for 4/25/25: Contacted by floor nurse That <sic> she had given medications to this patient in error. Instructed to contact the on-call provider for further orders. This writer made DON aware and was instructed to have the floor follow up with on call provider. See floor nurse's note and on call provider's note for further information. On 5/28/25 at 11:25 AM, an interview was conducted with the Director of Nursing (DON). The DON was asked to provide any documentation and facility investigation regarding R803's medication error incident. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	On 5/28/25 at 11:35 AM, a phone interview was conducted with LPN 'G'. When asked to recall the events regarding R803's medication error, LPN 'G' reported they worked contingent but had been working at the facility for [AGE] years as a manager. They reported they had been assigned to the south unit, which was a memory care unit. They also had to take rooms that were on the north unit and a few rooms on the Tulip wing (outside of the secured unit). LPN 'G' recalled R803 was a newer admission to the facility and they had gone to the room with R801's (roommate of R803) medications in a cup in their hands and R801 was getting up so they tried to put him back into the bed. While doing that, R803 was also getting up and they set the medication cup down on R803's tray table and when they got both residents back into bed, LPN 'G' gave R803 his medications. I had to set the medications down to get them back in bed and accidentally gave R803 the medications for R801. As soon as they did it they knew and immediately called the physician and the Assistant Director of Nursing (ADON). LPN 'G' reported following this incident, the ADON was working with them about completing paperwork and training, but due to family emergency the ADON had been off since then. LPN 'G' reported the midnight nurse (LPN 'H') was there and reported it, the on-call said to monitor and call him back at 4:00 AM. LPN 'G' reported he seemed fine throughout the night and think when first shift came in they heard he was lethargic. LPN 'G' further reported the incident occurred on Friday and they were in the facility that Monday with the ADON. LPN 'G' also reported they were sure R803 received all of R801 they had prepared since they were all crushed in the medicine cup. On 5/28/25 at 12:35 PM, an interview was conducted with the DON. When asked about the medication error incident, the DON reported the facility had identified a Past Non-Compliance (PNC) regarding this incident and would provide documentation for review. The DON reported since the incident, the facility now looked at the 24 hour reports everyday and if the floor nurses reported medication errors, they were to report it to them directly and each medication error was looked into. During the onsite survey, past noncompliance (PNC) was cited after the facility implemented actions to correct the noncompliance which included: Element 1: Resident [Name of R803] is no longer in the facility. Element 2: The Director of Nursing/designee reviewed the last 7 days of Progress Notes for changes in condition being documented appropriately and timely and with proper notification. Any concerns were immediately addressed. Completed on 5/9/2025. Element 3: The Medication Administration policy and the Provision of Quality of Care policy was reviewed by the QAPI (Quality Assurance Performance Improvement) committed and deemed appropriate on 5/2/2025. The DON/Designee has re-educated all current nursing staff on Medication Administration policy by 5/14/225. Any current nursing staff member not re-educated by 5/14/2025 will be re-educated prior to their next scheduled shift. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	The DON/Designee has re-educated the IDT (Interdisciplinary) team on the Provision of Quality of Care policy by 5/19/2025. Any IDT team member or rehab staff member not re-educated prior to 5/19/2025, will be re-educated prior to their next working shift. IDT team will review in clinical morning meeting daily, Monday - Friday, to review the 24 Hour Report and identify all changes in condition for timely follow up. During the day, the Unit Managers will view medication records to validate accuracy. Element 4: The DON/Designee will audit all changes in condition daily, Monday - Friday, to ensure appropriate interventions are placed timely. The DON/Designee will audit 10 medication records twice a week to ensure accuracy. Audits will continue daily x4 weeks then weekly thereafter until substantial compliance is achieved and the audits are discontinued by the QAPI committee. The Director of Nursing is responsible to maintain compliance. The facility was able to demonstrate monitoring of the corrective action and maintained compliance.