

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235331	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/23/2026
NAME OF PROVIDER OR SUPPLIER Medilodge of Howell		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to Intake 2806339 and 2808113Based on record review and interview, the facility failed to reconcile and administer prescribed medication (Amoxicillin, an antibiotic) according to professional standards for one (R803) and ensure the accuracy of the administration of the drug Hizentra (a medication admitted under the skin to treat immune deficiency) for one (R808) out of three residents reviewed for medication administration. Findings include: A complaint was filed with the State Agency (SA) that alleged R808 had not received the physician ordered drug Hizentra (a drug used to treat diseases that affect the immune system) for months.</p> <p>A review of R808's clinical record revealed the resident was initially admitted to the facility on [DATE] and the last admission was on 11/27/25 with diagnoses that included: respiratory failure, common variable immunodeficiencies and Crohn's disease. Review of the residents Minimum Data Set (MDS) noted the resident was cognitively intact.</p> <p>Continued review of R808's clinical noted the following:</p> <p>2/28/25: Order: Hizentra.10 GM (Grams) /50 ML (milliliters).Inject 10 gram subcutaneously one time a day every 7 days related to common variable immunodeficiency unspecified.located in med room fridge. *This order was discontinued on 10/22/25 but a similar order (Hizentra 10 gram .every Monday for Chron's Disease was started on 10/27/25 and continued as a Monday order through 3/2/26. A new order changed administration date to once a week on Wednesdays starting on 3/11/26.</p> <p>R808's Medication Administration Report (MAR) for the months 10/25- 3/25 was reviewed and documented the administration of Hizentra as follows:</p> <p>October 2025: Received on 10/6/25, 10/13/25 and noted as not available on 10/20/25 and not given on 10/27/25.</p> <p>November 2025: Noted as administered on 11/3/25, 11/10/25 and not Administered on 11/17/25 based on hospitalization.</p> <p>December 2025: Noted as not available on 12/8/25, Noted as Administered by Nurse E on 12/15/25, Noted as not available on 12/22/25 and not available on 12/29/25.</p> <p>January 2026: Noted as not available on 1/6/26, 1/12/26, 1/19/26 and 1/26/26.</p> <p>February 2026: Noted as no available on 2/2/26, 2/9/26, 2/16/26 and administered by Nurse F on 2/23/26. (continued on next page)</p>

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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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>March 2026: Noted as not available on 3/2/26 and refused on 3/11/26 and noted as administered by Nurse F on 3/18/26.</p> <p>On 3/23/26 at approximately 9:43 AM, R808 was observed sitting on their bed. The resident was alert and able to answer questions asked. R808 reported that they had not received the drug Hizentra in months and was supposed to receive it one time per week. When asked if they could recall the last time they received the medication, R808 noted that they never received the drug following their return from the hospital in November 2025.</p> <p>On 3/23/26 at 11:50 AM, the Director of Nursing (DON) was interviewed regarding R808's order for Hizentra and why the resident was not receiving the medication. The DON noted that the medication came from a specialty pharmacy. The DON provided a copy of a letter sent to R808 from (name redacted) Infusion Pharmacy dated 3/13/26 that read: Dear (R808).Dr.referred you to.Infusion Pharmacy for your Hizentra therapy.we have not been able to reach you.we will close your case pending a return call.We look forward to helping you in any way we can. (Signed by Pharmacy Employee (PE) E).</p> <p>A phone interview was conducted with Pharmacy Employee (PE) E on 3/23/26 at approximately 2:15 PM. PE E reported that they were familiar with the resident but had not spoken to them since August 2025. When asked about the order for Hizentra, PE E stated the pharmacy would send a one-month supply of the medication (four doses) overnight to the facility as the medication needed to be stored in a refrigerator. PE E noted that the last monthly supply was sent to the facility on September 2, 2025, with a delivery date of September 3, 2025. PE E reported that have not received any calls from the facility after the last dose of medication was sent in September 2026.</p> <p>On 3/23/26 at approximately 12:28 PM, a phone interview was conducted with Nurse E. Nurse E was queried as to the Administration of Hizentra on 12/15/25 as noted in the MAR. Nurse E noted that they got the drug from the refrigerator in the medication room and the resident's name was on the box. Nurse E was asked if they had administered the medication before and/or after 12/15/25 and reported that they had but also noted that sometimes the medication was not available.</p> <p>On 3/23/26 at approximately 3:54 PM, a phone interview was conducted with Nurse F. Nurse F was asked as to the administration of the medication Hizentra as noted as not available on 2/9/26 but administered on 2/23/26 and 3/18/26. Nurse F could not recall the administration of the medication on 2/23/26 but noted the medication was obtained from the storage room refrigerator and administered on 3/18/26.</p> <p>On 3/23/26 at approximately 4:30 PM, an interview was conducted with the Administrator. Corporate staff were present during the interview. The Administrator was asked if the facility kept a record of the medication delivered by (name redacted) specialty pharmacy. They reported that they did not. The Administrator was asked if they could confirm Nurse E and F administered the medication as noted in the MAR as it was reported by the specialty pharmacy that the last four doses were delivered in September 2025, and notes also indicated the medication was not available the entire month of January 2026 and the first three weeks of February. The Administrator could not provide a clear answer and noted they were aware of the concern.</p> <p>The facility policy titled, Medication Administration (Revised 1/17/23) was reviewed and documented, in part: .Policy: Medications are administered by licensed nurses, or other staff who are legally authorized to do so.as ordered by the physician and in accordance with professional standards (continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>of practice, in a manner to prevent contamination or infection .</p> <p>Clinical record review revealed R803 was a long-term resident since August 2024 with a chronic medical history of cardiac and kidney disease. The Minimum Data Set (MDS) dated [DATE] did not document a (brief Interview of Mental Status) BIMS score, but &ndash; indicated R803 had moderate impaired cognitive skills.</p> <p>On 3/16/26 State Agency (SA) received an anonymous complaint alleging the facility failed to administer an antibiotic medication timely.</p> <p>On 3/1/26, R803 was transferred to the hospital and admitted into Intensive Care Unit (ICU) for severe sepsis (life threatening condition raised from the body's response to an infection) related to cellulitis (bacterial skin infection) of their left lower extremity.</p> <p>Record review of the Infectious Disease consultation dated 3/6/26 at 12:32 PM recommended at discharge for R803 to start, Amoxicillin 1 gram (GM) oral three times daily for four weeks, through 3/30/26.</p> <p>R803 was transferred back to the facility on 3/8/26. Record review of the After Visit Summary (AVS) dated 3/8/26, documented to start Amoxicillin 1,000 mg by mouth every eight hours.Last time this was given: March 8, 2026, 6:37 AM.</p> <p>Record review of the Medication Administration Record (MAR) for March 2026 did not reflect Amoxicillin was given by the facility until 3/11/26 at 22:00.</p> <p>R803 was transferred back to the facility on 3/8/26 and admitted under the care of Licensed Practical Nurse (LPN) C who was identified as the LPN who entered the admission medication orders. On 3/23/26 at 11:01 AM, LPN C was interviewed and explained the process of admitting residents once they returned from the hospital. LPN C concurred that they review the AVS (After Visit Summary) and discharge paperwork from the hospital, enter the orders into the computer, then place paperwork into a bin at the desk, where a Unit Manger will perform a second reconciliation. LPN C recalled R803's return from the hospital because it was their first resident admission at the facility.</p> <p>Further record review revealed the Amoxicillin order was not placed until 3/11/26 at 17:03 by Infection Control Unit Manger Registered Nurse (RN), B. RN B was interviewed on 3/23/26 at 11:34 AM, and acknowledged they were the RN who entered the order. Unable to recall exactly how this was conveyed to place the order, the record review of the discharge paperwork and AVS identified this medication should have been ordered and started on 3/8/26.</p> <p>Record review of the Physical Medicine and Rehabilitation (PMR) Provider note authored by Nurse Practitioner (NP) D on 3/11/26 at 11:50 AM, was the first documentation since admission from 3/8/26 that R803 was to be on Amoxicillin.</p> <p>On 3/23/26 at 11:49 AM, NP D was interviewed and disclosed while reviewing R803's discharge notes and AVS from 3/8/26 they had identified an order for Amoxicillin to continue 3/8/26. NP D reviewed, saw R803 had never started the medication, and then placed the order on 3/11/26.</p> <p>On 3/23/26 at 2:31 PM, the Director of Nursing (DON) and Assistant Director of Nursing (ADON) were (continued on next page)</p>		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	interviewed. The ADON explained the facility admission order process and said Nursing orders are reconciled by two nurses, then a third reconciliation is performed by a Nursing leader. The DON reviewed the orders for R803 on 3/8/26. Further record review revealed LPN C did in fact enter the Amoxicillin but had placed a start date of 4/1/26. The DON and ADON both concurred this medication was not ordered correctly, and the multiple reconciliations process of the admission medications were not performed accurately.		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to Intake #2808113. Based on observation, interview and record review the facility failed to ensure they obtained and administered a physician ordered medication for one (R808) out of three residents reviewed for medication administration. Findings include: A complaint was filed with the State Agency (SA) that alleged R808 had not received the physician ordered drug Hizentra (a drug used to treat diseases that affect the immune system) for months. The complainant further alleged that the failure to receive the drug resulted in a hospitalization stay in November 2025. In addition, the failure to obtain the medication put the resident at risk for viruses like COVID 19. A review of R808's clinical record revealed the resident was initially admitted to the facility on [DATE] and the last admission was on 11/27/25 with diagnoses that included: respiratory failure, common variable immunodeficiencies and Crohn's disease. Review of the residents Minimum Data Set (MDS) noted the resident was cognitively intact. Continued review of R808's clinical noted the following: 2/28/25: Order: Hizentra. 10 GM (Grams) /50 ML (milliliters). Inject 10 gram subcutaneously one time a day every 7 days related to common variable immunodeficiency unspecified. located in med room fridge. *This order was discontinued on 10/22/25 but a similar order (Hizentra 10 gram .every Monday for Chron's Disease was started on 10/27/25 and continued as a Monday order through 3/2/26. A new order changed administration date to once a week on Wednesdays starting on 3/11/26. R808's Medication Administration Report (MAR) for the months 10/25- 3/26 was reviewed and documented the administration of Hizentra as follows: October 2025: Received on 10/6/25, 10/13/25 and noted as not available on 10/20/25 and not given on 10/27/25. November 2025: Noted as administered on 11/3/25, 11/10/25 and not administered on 11/17/25 based on hospitalization. December 2025: Noted as not available on 12/8/25, Noted as administered by Nurse E on 12/15/25, Noted as not available on 12/22/25 and not available on 12/29/25. January 2026: Noted as not available on 1/6/26, 1/12/26, 1/19/26 and 1/26/26. February 2026: Noted as no available on 2/2/26, 2/9/26, 2/16/26 and administered by Nurse F on 2/23/26. March 2026: Noted as not available on 3/2/26 and refused on 3/11/26 and noted as administered by Nurse F on 3/18/26. On 3/23/26 at approximately 9:43 AM, R808 was observed sitting on their bed. The resident was alert and able to answer questions asked. R808 reported that they had not received the drug Hizentra in months and was supposed to receive it one time per week. R808 noted that they have an immune compromised disease and believed the medication would have helped to prevent them from getting COVID and the Flu over the last few months. R808 reported that they had an appointment scheduled with an outside physician on 3/24/26 and was hoping to get things straightened out. On 3/23/26 at 1:00 PM, the Director of Nursing (DON) was interviewed regarding R808's order for Hizentra and why the resident was not receiving the medication. The DON noted that the medication came from a specialty pharmacy. The DON provided a copy of a letter sent to R808 from (name redacted) Infusion Pharmacy dated 3/13/26 that read: Dear (R808). Dr. referred you to Infusion Pharmacy for your Hizentra therapy. We have not been able to reach you. We will close your case pending a return call. We look forward to helping you in any way we can. (Signed by Pharmacy Employee (PE) E). A phone interview was conducted with Pharmacy Employee (PE) E on 3/23/26 at approximately 2:15 PM. PE E reported that they were familiar with the resident but had not spoken to them since August 2025. When asked about the order for Hizentra, PE E stated the pharmacy would send a one-month supply of the medication (four doses) overnight to the facility as the medication needed to be stored in a refrigerator. PE E noted that the last monthly supply was sent to the facility on September 2, 2025, with a delivery date of September 3, 2025. PE E reported that have not received any calls from the facility after the last dose of medication was sent in September 2026. On 3/23/26 at approximately 2:30 PM, an interview was conducted with the Administrator. The Administrator was queried as to the failure to provide the physician ordered (continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>medication to the resident. The Administrator reported that they were aware of the concern, noted that medication should be provided as ordered and they were working on the problem. The facility policy titled, Medication Administration (Revised 1/17/23) was reviewed and documented, in part: .Policy: Medications are administered by licensed nurses, or other staff who are legally authorized to do so.as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection .</p>		