STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235370	A. Building B. Wing	09/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of St. Clair	4220 S. Hospital Drive East China, MI 48054

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. (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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(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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to Intake: 2584046.Based on interview and record review, the facility failed to administer physician order medication in a timely manner for two (R900, R901) of two residents reviewed for medication administration. Findings include:R900A review of the Electronic Medical Record (EMR) revealed R900 was admitted to the facility on [DATE] with the following pertinent diagnoses: Right non-union intertrochanteric hip fracture after a fall, hypertension, hyperlipidemia (high cholesterol), legally blind, and anemia. Further review of the EMR revealed the resident was cognitively intact.On 9/4/25, a review of the August 2025 Medication Administration Record (MAR) revealed medications were administered later than one hour outside the window of one hour before and one hour after the designated scheduled time. The record revealed on the day shift (7:00 AM-3:30 PM) over a 10-day period (August 1 thru 10, 2025), R900's morning medication, which were due at 8:00 AM, was administered after 9:00 AM six of ten times. The medications included: Metoprolol (for blood pressure/rate control), Lisinopril (a blood pressure medication), Brimonidine Eye Drops (for Glaucoma), Iron (for anemia), Lysine (for cholesterol) in addition to over-the-counter medications such as Aspirin, Colace, Miralax, and Multivitamin. Further MAR review indicated one instance where a blood pressure medication was given at 0:40 AM on 8/8/25 when it should have been administered at 8:00 pm on 8/7/25.On 9/4/25, further review of the August MAR revealed medications on the afternoon shift (3:00 PM -11:30 PM) over the same 10-day period, revealed the 8:00 PM dose of medications; Metoprolol, Atorvastatin, and Brimonidine Eye Drops, and Aspirin were administered after 9:00 PM six of ten times. On 9/4/2025 at 11:52 AM, during an interview with R900 they confirmed their medications are late a lot. R900 further indicated they have reported this concern to their daughter.R901On 9/4/25, a review of the Electronic Medical Record (EMR) revealed R901 was admitted to the facility on [DATE] with the following pertinent diagnoses: Hypertension, Quadriparesis, Hyperlipidemia, Benign Prostatic Hypertrophy (BPH), and Major Depression. Further EMR review revealed R901 was cognitively intact.On 9/4/25, a review of the August 2025 Medication Administration Record (MAR) revealed medications were administered later than one hour outside the window of one hour before and one hour after the designated scheduled time. The MAR revealed on the day shift over a 10-day period (August 1 thru 10, 2025), R900's morning medication, due at 8:00 AM, was administered after 9:00 AM three of ten times. The medications included: Lisinopril (a blood pressure medication), Duloxetine (for Major Depression/Anxiety).Further review of August MAR revealed medications on the afternoon shift over the same 10-day period, revealed the evening dose of prescribed medications due at 8:00 PM, were administered after 9:00 PM nine of ten times. The medications included: Atorvastatin and Doxazosin. On 9/4/25 at 11:44 AM, in an interview with R901 they were asked about medication administration and said, they take care of me. At 1:50 PM, in an interview with Licensed Practical Nurse (LPN) B they were queried regarding late medications. LPN B stated sometimes nurses are late because residents may stop them or interrupt them requesting care or the nurse may be assigned to go to more than one unit, so their time can be limited, or administration may be taking longer. At 2:30 PM, an interview with the Director of Nursing (DON) was queried regarding their expectation regarding the timeliness of administration of medications. The DON revealed their expectation is that medications be administered one hour before to one hour after the scheduled time. They further revealed delays may occur such as being called to another room or part of the building and slow passing of medications secondary to resident requests.A review of the policy titled, Medication Administration, revised 1/17/2023, revealed . 11. Paragraph b: Administer within 60 minutes prior to or after scheduled time unless otherwise ordered by physician.