STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235371	A. Building B. Wing	07/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Yale	90 Jean Street Yale, MI 48097

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 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 observation, interview, and record review, the facility failed to implement care plan interventions for heel boots, for one resident (R25) of two reviewed for positioning needs. Findings include: On 07/07/25 at 9:25 AM, and 04:18 PM, R25 was observed sleeping supine in bed, no heel boots on and heels not elevated off surface of the bed. No extra pillows or heels boots were observed at bedside. Review of the record for R25 revealed: R25 was admitted into the facility on [DATE]. Diagnoses included Muscle Weakness, High Blood Pressure, and Difficulty in Walking. A review of the Minimum Data Set (MDS) assessment dated [DATE] revealed: a Brief Interview for Mental Status (BIMS) score of 15/15; the need for substantial/maximal assistance for chair to bed transfer and toilet transfer; R25 was dependent on staff for lower body dressing putting and taking off footwear and R25 required partial/moderate assistant to roll left and right while in bed. Review of the at risk for impaired skin integrity care plan dated 06/04/25 documented Prevalon style off-loading boots (heel boots) to (bilateral lower extremities) BLE while in bed as tolerated. On 07/08/25 at 8:49 AM, R25 was observed to be in bed, laying on their back, with the head of the bed up slightly, and dressed in a hospital style gown. R25's heels rested on the bed surface without a device under the lower legs or heel boots. On 07/08/25 at 10:18 AM, 11:06 AM, 12:27 PM, 1:26 PM and 2:12 PM R25 was dressed in a t-shirt and shorts and laying on their back in a recliner. R25's feet hung off the end of the footrest at the level of the heel. No heel boots were in place. On 07/09/25 at 8:06 AM, R25 reported they would wear the heel boots in bed. On 07/09/25 at 08:06 AM, 9:07 AM, and 10:20 AM, R25 was observed sitting up in bed eating breakfast with no heel boots on and heels resting on the bed. At 8:06 AM, the daughter reported she has not seen the boots on R25's feet in a long time and family is there daily. (continued on next page)

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	On 07/09/25 at 10:04 AM, care was reviewed with Licensed Practical Nurse (LPN) G. LPN G identified an order for heel boots dated 04/12/25. LPN G reported the nurse who entered the order would be responsible for entering it into the care plan and the Kardex (Certified Nurse Assistant (CNA) guide for resident care). LPN G was unable to locate the intervention for heel boots in the care plan. CNA H was asked about the care of R25 and reported they had asked about changing the t-shirt and elevating the heels but was not asked about wearing the heel boots. Further review of the progress notes with LPN G revealed no documentation of refusal of care related to heel boots. The heel boots were observed in a closet in a plastic bag. On 07/09/25 at 10:43 AM, the Interim Director of Nursing (IDON) reported the nurse who writes the order for heel boots is responsible for entering it into the care plan which will trigger the Kardex for the CNAs to implement the intervention. The IDON reported refusals would be documented by the CNA and the nurse would be notified. Review of the Kardex revealed no intervention for heel boots, and review of the tasks in the electronic medical record (EMR) revealed no documentation by the CNA of refusal to wear the heel boots. A review of the policy, Comprehensive Care Plans, revised 6/30/22, revealed, 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) . 3. The comprehensive care plan will describe, at a minimum, the following: a. The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. b. Any services that would otherwise be furnished, but are not provided due to the resident's exercise of his or her right to refuse treatment .

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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 assess, monitor and control blood sugar levels (accu-cheks) for two residents (R54, R16) of three residents whose blood sugar monitoring was reviewed. Findings include: R54 On 07/07/2025 at 9:25 AM, R54 was observed walking in the hall. R54 indicated their blood sugars were out of control. R54 reported they did not discuss this with facility staff. A review of the medical record revealed R54 was admitted into the facility on [DATE] with readmissions after hospitalizations on 01/13/25, 01/17/25, and 03/14/25 secondary to complications from abdominal surgeries that included wound leaks, wound abscess, wound infection and ileus. Pertinent diagnoses include: Diabetes Mellitus and surgical complications. A Brief Interview for Mental Status (BIMS) dated 05/23/25 revealed a score of 13/15 which indicated little to no cognitive impairment. Further review of the medical record for R54 revealed sliding scale insulin coverage for blood sugar level checks were discontinued on 05/13/2025 based on pharmacy recommendations. Adjustments to long-acting insulin and short-acting insulin doses were made until 06/18/2025 based on glucose levels taken prior to meals. No adjustments were made to insulin doses after that date. Blood sugars taken after 06/18/25, continued to be high with the following results: 71 out of 82 blood glucose values were higher than 201(normal range 60-120). No sliding scale insulin was given or dosage adjustments in the long-acting dose or short- acting dose were not made. A review of the Physician Communication Book, revealed two communications related to R54. One was a note regarding a blood sugar of 400 on 06/02/2025, with no changes made. The second note dated 06/19/25 was related to blood work including a Hemoglobin A1C (an indication of blood sugar control over a 3 month period). The result for the A1C reported on 06/18/2025 was 11.1. (normal range equals less than 6.4), no changes were made to dosages of the long-acting or short-acting insulins. An interview with the Interim Director of Nursing (IDON) revealed the Nurse Practitioner was attempting to stop sliding scale coverage facility-wide based on a recommendation from the pharmacist and The Society for Post-Acute and Long-Term Care Medicine (AMDA). The IDON further revealed the expectationis that Nurse Practitioners and Physicians would be reviewing blood glucose levels and making adjustments in insulin orders as needed. The DON further indicated the expectation was that the nurse would report any trends of elevated blood sugars. A phone interview with Nurse Practitioner (NP) I revealed they could not recall whether the consistently elevated blood sugars were reported by the nurse. NP I further revealed they were not aware the blood sugar levels were still elevated. There was no indication of why blood sugar monitoring was discontinued. R16 On 07/07/25 at 8:08 AM, resident R16 was interviewed and indicated the nurses don't check my blood sugar or A1C. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/09/25 at 10:04 AM, Licensed Practical Nurse (LPN) G revealed they did not check R16's blood sugar this morning. LPN G revealed there was no order for it. LPN G reported blood sugars are not normally done on long-acting insulin. A review of the medical record for R16 revealed they were admitted to the facility on [DATE]. Pertinent diagnoses included Type 2 Diabetes, and Morbid Obesity . The Minimum Data Set (MDS) assessment dated [DATE] revealed intact cognition score of 15/15. A review of hospital discharge paperwork 04/15/25 revealed diabetes worsening, monitor glucose, tight glycemic control protocol. Discharge paperwork indicated to continue sliding scale insulin, and long-acting insulin. The discharge hospital note indicated R16's A1c on 4/10/25 was 8.2. The record review revealed on 04/15/25, the following diabetic orders were entered: by Nurse Practitioner (NP) I: Insulin Glargine Subcutaneous Solution (long-acting insulin) inject 5 units subcutaneously at bedtime. A review of the blood sugars from 04/15/25 through 4/30/25 were documented four times daily with the following summary of results: 42 blood sugars between 150-200 for an average of 184.78, seven blood sugars between 201-250 for an average of 225.71, there is one blood sugar at 253, and one blood sugar at 301, which indicated decreased blood sugar control. On 06/12/25 at 7:57 PM, a blood sugar was documented at 151. No other blood sugar readings were documented for the month of June. No blood sugars were documented for the months of May or July 2025. Review of the progress note for R16 dated 05/16/25, 05/19/25, 05/19/25, 06/09/25, and 06/16/25 revealed NP I documented the following: Uses Insulin Glargine 5 units at bedtime, sliding scale insulin coverage with meals. Continuing current therapy (blood sugar checks), will adjust dosage as needed to achieve optimal glycemic control monitor signs and symptoms hypo/hyperglycemia, notify provider of any acute changes. Review of the active physician orders revealed no accu-checks and no sliding scale insulin were ordered. Review of the active physician orders revealed no accu-checks and no sliding scale insulin were ordered Review of R16's impaired metabolic status related to diabetes care plan dated on 04/18/25 revealed the intervention to .monitor glucose levels . On 07/09/25 a policy was requested at 2:17 PM related to glucose monitoring. Administer replied via email at 3:01 PM, We do not have a policy for insulin sliding scale or diabetes/insulin order.