STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235473	A. Building B. Wing	05/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Shoreline	14900 Shore Line Drive Sterling Heights, MI 48313

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to Intakes 2999148 and 2996472.Based on observation, interview, and record review, the facility failed to transcribe and administer medications as ordered during a change in condition for one resident (R701) of three reviewed for change in condition, resulting in a delay in treatment and subsequent transfer to the hospital. Findings include:A summary of a complaint called into the State Agency revealed, [R701] was throwing up and having abdominal pain from hernia. The nursing home waited six hours to call EMS (Emergency Medical Services) . It was discovered [R701] had a perforated bowel. suffered for several hours crying out in pain and nothing was done at the nursing home other than giving [R701] Tylenol.A review of R701's medical record revealed, R701 was admitted to the facility on [DATE] readmitted [DATE] and discharged [DATE] with diagnoses of Ventral hernia without obstruction or gangrene, Morbid (severe) obesity, and Type II diabetes.A review of R701's progress note authored by Licensed Practical Nurse (LPN) A revealed, 4/21/2026 07:41 (7:41 AM) Nurses' Notes: Resident received asleep in bed. Resident awoke around 0300 (3:00 AM), verbalized c/o (complaint of) ABD (Abdomen) discomfort, reported one (1) episode of vomiting, stating [R701] ate spaghetti for dinner last night and it upset [R701's] stomach. Shortly after, resident had large loose BM (bowel movement). PRN (as needed) Tylenol admin. An hour later, resident notified writer that pain was back and hurts worse. Abdomen assessed, firm and distended, normal bowel sounds heard upon auscultation. VS (vital signs): 138/106, 109, 92% on r/a (room air), 20, 97.7. Physician and NP (Nurse Practitioner) notified, NP ordered Pepcid (a histamine-2 blocker used to treat and prevent heartburn, acid indigestion, by reducing stomach acid production), Pepto Bismol (an over-the-counter medication used to treat digestive issues, including nausea, heartburn, indigestion, upset stomach, and diarrhea) x1 (one time), stated she will be in to see resident this AM. Meds admin. LPN B notified of resident's status and NP plan to visit. Further review of R701's progress notes authored by LPN B, revealed, 4/21/2026 09:18 (9:18 AM) Nurses' Notes: Writer was called to resident room and before entering writer could hear resident vocalizing pain. Writer assessed resident and while looking at [R701] LLQ (Left lower quadrant) the hernia was pultruding from [R701's] abdomen. C/O (complaint of) pain 10/10, vitals 122/56, 100, 20, 95.6, 95%. Advised [Physician] of findings ordered to send out to hospital. DON (Director of Nursing) aware as well. A review of R701's SBAR (Situation, Background, Assessment, and Recommendation) assessment dated [DATE] 08:09 (8:09 AM), noted . Situation: ABD (abdominal) pain, distention. This started on 4/21/26. Since this started has it gotten: Worse. Things that make the condition or symptom worse are: increased pain. What do you think is going on with the resident? The resident appears to be in severe pain .On 5/7/26 at 1:00 PM, a call was made to LPN A, a voice message was unable to be made due to mailbox being full.On 5/7/26 at 12:42 PM, LPN B was asked about R701's transfer to the hospital and explained they got in the facility at 7:00 AM and could hear R701 yelling out from their room. LPN B explained they went to check on R701 and thought they would feel better if they were adjusted in bed. LPN B explained they pulled R701 up and as they pulled the resident up in the bed, they were observed to wince in pain and to grab their stomach. LPN B stated, they looked at R701's stomach and saw the resident's hernia protruding out and called the doctor. LPN B explained the (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	doctor reported their NP was coming in but if they were not in within a timely manner to send R701 out (to the hospital). LPN B continued to monitor R701, but because of how much pain the resident was in they called the doctor back and reported the resident should be transferred to the hospital, the doctor gave orders. LPN B then called 911 for R701 to be transferred to the hospital. LPN B explained EMS did not come right away but it was approximately 9:03 AM.A review of R701's April 2026, Medication Administration Record (MAR) revealed documentation of an as needed dose of Tylenol being administered on 4/21/26 at 4:00 AM. The MAR did not reveal the NP's one time order for the administration of the Pepcid or Pepto Bismol.R701's progress notes did not reveal monitoring of R701 by LPN A regarding the pain level status of R701 after the administration of Tylenol.On 5/7/26 at 2:03 PM, the assigned Certified Nursing Assistant (CNA) C was called, a voicemail was left.On 5/7/26 at 2:32 PM, R701's roommate at the time was asked about the day R701 was transferred out to the hospital. They reported that R701 had trouble and was in consistent pain with their hernias. They said R701 told them they had two, one the size of a football and the other the size of a baseball. That night R701's family came in to visit and gave R701 spaghetti, later that night is when R701 had some trouble.On 5/7/26 at 2:13 PM, the Director of Nursing (DON) was asked for the documentation of the administration of Pepcid and Pepto Bismol as ordered by the NP on 4/21/26. During the interview the DON looked in R701's medical chart, found the Tylenol was administered at 4am, but was unable to find the one-time order and documentation for the Pepcid and Pepto Bismol.The DON was later asked about the facility's process for a resident that is experiencing a change in condition. The DON explained the nurse is to call the physician to give the clinical report, if new orders are given, the nurse is to input them into the medical record, document with a nurse's note, and follow the orders. The DON confirmed LPN A wrote a note but did not follow through with the other orders.On 5/7/26 at 3:06 PM, the Nursing Home Administrator was asked about the incident with R701 and explained after the incident they completed a timeline of what happened with R701 and found the nurse (LPN A) did not transcribe the orders into R701's medical record.A review of the facility's policy titled Medication Orders dated 10/30/20 noted, Policy This facility shall use uniform guidelines for the ordering of medication. Policy Explanation and Compliance Guidelines: 2. Verbal orders should be received only by licensed nurses, or pharmacists, and confirmed in writing by the physician, on the next visit to the facility. 3. Each medication order should be documented with the date, time, and signature of the person receiving the order. A review of the facility's policy titled Notification of Changes dated, 10/30/2020 noted, Policy: The purpose of this policy is to ensure the facility promptly informs the resident, consults the resident's physician; and notifies, consistent with his or her authority, resident's representative when there is a change requiring notification .