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	01/08/2026

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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to complete annual PASARR (Pre-admission Screening and Annual Resident Review/3877) assessments for four residents (R6, R28, R32 and R61) of four residents reviewed for PASARR assessments.Findings include:Resident 6On 1/06/26 at 10:15 AM, R6 was observed sitting in a chair in their room. When asked about their care, R6 was not able to answer questions.On 1/06/26 the medical record for R6 was reviewed and revealed the following: R6 was initially admitted to the facility on [DATE] and after a brief hospitalization was readmitted [DATE] with diagnoses including Vascular Dementia, Mood Affective Disorder and Adjust Disorder with Disturbance of Conduct. A review of R6's MDS (Minimum Data Set) assessment revealed a BIMS (Brief Interview for Mental Status) assessment score of 3/15 indicating severely impaired cognition.On 1/07/26 further review of R6's medical record revealed a PASARR assessment dated [DATE] for a 30-day hospital exempted discharge. There was no updated PASARR noted in the record. Resident 28On 1/06/26 at 11:25 AM, R28 was observed resting in bed awake. On 1/06/26 the medical record for R28 was reviewed and revealed the following: R28 was initially admitted to the facility on [DATE] and after a brief hospitalization was readmitted [DATE] with diagnoses including Dementia.A review of R6's MDS (Minimum Data Set) assessment revealed a BIMS (Brief Interview for Mental Status) assessment score of 8/15 indicating moderately impaired cognition.On 1/07/26 further review of R28's medical record revealed a PASARR (3877) assessment dated [DATE] with no mental diagnoses reported. There was no updated PASARR or 3878 noted in the record acknowledging diagnosis of Dementia.Resident 32On 1/06/26 at 11:25 AM, R32 was observed resting in bed awake. Resident 32 appeared confused and stuttered trying to answer questions. On 1/06/26 the medical record for R32 was reviewed and revealed the following: R32 was initially admitted to the facility on [DATE] and after a brief hospitalization was readmitted [DATE] with diagnoses including Dementia. A review of R32's MDS (Minimum Data Set) assessment revealed a BIMS score (Brief Interview for Mental Status) assessment score of 5/15 indicating severely impaired cognition. On 1/07/26 further review of R32's medical record revealed a PASARR (3877) assessment dated [DATE] with no mental diagnoses reported on the form. There was no updated PASARR or 3878 noted in the record acknowledging diagnosis of Dementia.Resident 61On 1/06/26 at 3:05 PM, R61 was observed sitting in the chair in the dining room. R61 just nodded their head when asked if they had any concerns about their care. On 1/06/26 the medical record for R61 was reviewed and revealed the following: R61 was initially admitted to the facility on [DATE] with diagnoses including Dementia, and Alzheimer's Disease. A review of R61's MDS (Minimum Data Set) assessment revealed a BIMS (Brief Interview for Mental Status) assessment score of 3/15 indicating severely impaired cognition.On 1/07/26 further review of R61's medical record revealed a PASARR (3877) assessment dated [DATE]. There was no updated PASARR or 3878 noted in the record acknowledging diagnosis of Dementia.On 1/08/26 at 10:45 AM, the Social Services Coordinator (SSC) H was interviewed in regard to PASARR assessments. The SSC H stated resident's PASARR updates were missed (not completed). When asked what their expectation for updating Pre-admission (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Screening and Annual Resident Reviews, they said, residents are assessed appropriately per policy. On 1/08/26 at 2:28 PM, the Director of Nursing (DON) was interviewed. The DON stated they were unaware of the PASARR assessments not being up to date. The DON stated that their expectation is that residents will be assessed and updated as needed per the policy.A review of the PASRR - Preadmission Screen and Resident Review policy dated 10/30/23 revealed, A facility must coordinate assessments with the pre-admission screening and resident review program under Medicaid in part 483, subpart C to the maximum extent practicable to avoid duplicative testing and efforts.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one (R8) of three residents reviewed for medication administration received the correct dose of a medication and consumed all medications provided. Findings include:Review of the medical record revealed a physician's order dated 9/25/25 for Potassium Chloride ER Tablet Extended Release 20 MEQ (milliequivalents), Give 3 tablet by mouth three times a day for supplement.Further review of the medical record revealed R8 was admitted to the facility on [DATE] with the following relevant diagnoses: Essential Hypertension, Lymphedema, Chronic Venous insufficiency and Peripheral Vascular Disease and was cognitively intact. On 1/7/26 at 7:56 AM, during an observation with Licensed Practical Nurse (LPN) A, the nurse was observed to prepare and administer medications to R8. While preparing the medication for administration, LPN A revealed R8 usually only takes one of three prescribed Potassium 20 MEQ tablets and proceeded to put one tablet into a medicine cup. R8 was not offered or asked if they would be willing to take the full prescribed dose. LPN A prepared the remainder of the medications for R8 and entered the residents' room, handing them a medicine cup with several tablets, including a narcotic. The resident set the cup on the bedside table while they obtained soda from a cooler next to their chair. R8 opened the soda, retrieved the medicine cup and remove a tablet. While still taking their medications, LPN A left the room returning to the medication cart. LPN A did not observe the resident consume any part of the medication in the cup.LPN A then documented on the Medication Administration Record (MAR) that R8 took their medications, including 3 tablets of Potassium (which only one was consumed). LPN A did not put a note in the MAR to indicate R8 did not take the full dose and did not notify the physician. On 1/7/26 at 1:54 PM, the Unit Manager (UM) F was interviewed regarding expectations regarding medication administration. UM F indicated the nurse should watch the resident consume/swallow the medication before leaving the room. UM F further indicated when part of or all of a dose of medication is refused, the nurse would document in the MAR exactly what the resident took and any other pertinent information such as education and notify the physician/nurse practitioner. On 1/8/26 at 3:00 PM, the Director of Nursing (DON) was interviewed regarding expectations regarding medication administration. The DON revealed the nurse is to ensure the resident consumes/swallows the medication and then documents in the MAR the correct doses consumed. Communication should be documented with the Physician/Nurse Practitioner when the full dose is not taken. On 1/7/26 at 2:10 PM, an interview with Nurse Practitioner (NP) G revealed they and the physician were aware of R8's medication non-compliance. NP G further revealed R8 sometimes does take all prescribed medication but often picks and chooses what they will take. NP G further revealed she reviews the MAR and did not realize full doses were not always given though were documented as given. A review of the policy titled, Medication Administration, revised 1/17/2003 revealed, 15. Observe resident consumption of medication.19. Report and document any adverse side effects or refusals.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to Intake 2704083. Based on observation, interview, and record review, the facility failed to provide showers for one resident (R66) of three reviewed for activities of daily living (ADLs). Findings include: A review of an Intake allegation noted, It was alleged the resident isn't provided with appropriate showers per preference.A review of R66's shower schedule noted, Bathing: Monday and Thursday dayshift.A review of R66's shower record for the last 30 days revealed, Thursday 12/11/25 documented as response not required (shower did not occur), Thursday 12/18/25 checked as one person assist, Monday 12/22/25 checked as one person assist, Thursday 12/25/25 response not required. Further review of R66's medical record revealed, was admitted to the facility on [DATE] with diagnosis of Paraplegia. A review of R66's Minimum Data Set (MDS) assessment dated [DATE] noted, R66 with an intact cognition and dependent of staff to complete activities of daily. The MDS noted R66's shower ability as Shower/bathe self: The ability to bathe self, including washing, rinsing, and drying self-partial/moderate assistance. A review of R66's care plan revealed, Focus: Resident has an Activities of Daily Living (ADL) self-care performance deficit related to Low Back pain, Paraplegia, Major Depressive disorder, Other Chronic Pain. Date Initiated: 09/20/2025. Goal: Resident's ADL needs will be met through next review. Date Initiated: 09/20/2025. Interventions: BATHING: 1 person assist Date Initiated: 12/23/2025. On 1/08/2026 at 2:52 PM, the Director of Nursing (DON) was asked to review R66's 30-day shower record and if there was any other documentation for R66's showers or refusals of showers. The DON explained, as a team they review shower documentation during the morning meeting and was not made aware of R66 currently refusing showers. After a review of R66's medical record the DON reported, she did not see any documentation regarding the refusals. The DON was asked the process for a resident that refuses a shower and explained, it should be charted under the task section by the Aide, then the Nurse would reapproach the resident, then the outcome is to be documented with a progress note. On 1/08/2026 at 3:22 PM, R66's call light was observed to be activated above the door. R66 reported the light was pressed because today is a shower day and a week ago was their last shower. On 1/08/2026 at 4:00 PM, the DON confirmed R66 is a morning shift shower on Monday and Thursday. The DON was asked why R66 shower was not documented as given for Monday 1/5/26. The DON reported they were not sure and will speak with the assigned Aide. A review of the facility's policy noted, Policy: The facility takes measures to minimize the loss of resident's functional abilities, including activities of daily living (ADLs). Activities of Daily Living include the ability to: 1. Bathe, dress, and groom Policy Explanation and Compliance Guidelines: 1. Conditions which may demonstrate unavoidable decline in ADLs include . 2. The facility provides maintenance and restorative program to assist residents in achieving and maintaining the highest practicable outcome based on their comprehensive assessment. 3. A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene .

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review, the facility failed to remove expired medications from two of three medication carts reviewed. Findings include:On 1/7/26 at 1:00 PM, an observation of the Station One, medication cart 2, was a bottle of Midodrine (used to treat low blood pressure), labeled for R17 filled on 11/1/24 with a use by date of 11/1/25. On 1/7/26 at 1:22 PM, an observation of the Station One, medication cart 1, was an over-the-counter brand of sinus severe tablets with an expiration date of 8/2024. An identifying label for a specific resident was not present. On 1/7/26 at 1:54 PM, an interview with Unit Manager (UM) F revealed medication should be in the medication carts secondary to being long past their expiration dates. On 1/8/26 at 2:10 PM, an interview with the Director of Nursing (DON) revealed expired medications are to be removed from the medication carts or medication storage area and returned to pharmacy or discarded.