STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235490	A. Building B. Wing	02/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Mt. Pleasant	1524 Portbella Road Mt. Pleasant, MI 48858

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Citation pertains to intake #2676090Based on interview and record review, the facility failed to notify the medical provider of a new open wound for one resident (R103) of 4 residents reviewed for notifications when one resident (R103) developed an open wound. Findings include:Review of the Electronic Medical Record (EMR) admission Record reflected R103 admitted to the facility 12/10/2024 with pertinent diagnosis that included Diabetes Mellitus.Review of the EMR Progress Notes for R103 revealed an entry dated 1/13/2026 at 4:55 PM that a new wound, diabetic foot ulcer was identified on the left lateral mid foot of the Resident. The documentation reflected Wound acquired in-house which was measured and dressed. The entry did not reflect that the physician was notified of the new wound or its characteristics.On 2/9/2026 at 3:32 PM an interview was conducted with Unit Manager (UM) D in the conference room. UM D acknowledged that the medical record did not contain information that the medical provider had been notified of the new wound identified on 1/13/2026. UM D reported that mid- level providers will review the photographs but acknowledged that that no Medical Providers had charted that they had reviewed any photographs. The policy provided by the facility titled Notification of Changes last revised 1/1/22 was reviewed. The policy reflected 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, The policy further reiterates a need to notify the physician by defining circumstances requiring notification which include . 1. B. Potential to require physician intervention, and 3. New treatment. Review of the undated job description for Registered Nurse (RN) provided by the facility reflected Summary: Plans, coordinates and provides total nursing care for residents and provides supervision to clinical staff members. The job description reflected Essential Functions: which included: Reports and records pertinent observations and reactions regarding residents,Review of the job description for Licensed Practical/Vocational Nurse (LPN) provided by the facility was also reviewed. This job description holds this same Essential Function expectation of recording and reporting.As of survey exit on 2/10/2026 no additional information had been provided by the facility.

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. This citation pertains to intake #s 2676090 and 2658540Based on interview and record review, the facility failed to revise the comprehensive care plan and formulate goals and interventions when one facility Resident (R103) developed an open wound of four residents reviewed for care plans. Findings include:Review of the Electronic Medical Record (EMR) reflected R103 admitted to the facility 12/10/2024 with pertinent diagnosis that included Diabetes Mellitus.Review of the EMR Progress Notes for R103 revealed an entry dated 1/13/2026 at 4:55 PM that a new wound, diabetic foot ulcer was identified on the left lateral mid foot of the Resident. The documentation reflected Wound acquired in-house which was measured and a dressing applied.Review of the Care Plan for R103 reflected that a nursing Care Plan for the new wound identified on 1/13/26 was not formulated until after the survey was initiated on 2/9/2026. This indicated that, prior to 2/9/2026, nursing had not revised the comprehensive Care Plan to formulate goals/ benchmarks for care or devised nursing interventions for the new wound.On 2/9/2026 at 3:32 PM an interview was conducted with Unit Manager (UM) D in the conference room. During this interview UM D reported that R103 did have a Care Plan for the new wound but acknowledged the Care Plan was not initiated until 2/9/2026.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. This citation pertains to intake #2685190Based on observation, interview and record review, the facility failed to consistently ensure the readiness of the nurse's emergency crash cart. Findings include:On 2/10/2026 at 10:30 AM a review of the emergency crash cart was conducted with RN I. RN I reported that the emergency equipment was checked daily by night shift nursing. RN I reported the checks included an inspection for outdated supplies and to ensure the readiness of the Automatic External Defibrillator (AED - a portable life-saving device used to analyze for an abnormal heart rhythm and deliver an electric shock to restore normal heart rhythm). The document accompanying the emergency cart titled Crash Cart Daily Check Off Log was reviewed. The document listed twenty- eight items to be checked daily with a Nurse Initials box for nurses to verify the readiness of the emergency cart. Review of the checklists for November 2025 through February 9, 2026, revealed 62 days the cart readiness had not been verified as ready by nursing. The Daily Check Log's included 10 periods of 3 to 5 days without checks. Additionally, the review reflected one gap of 11 days (November 7- 17/2025) and another gap of 8 days (January 20-27/2026) during which the readiness of the cart and AED device had not been verified by a nurse.Review of the undated job description for Registered Nurse (RN) provided by the facility reflected Summary: Plans, coordinates and provides total nursing care for residents and provides supervision to clinical staff members. The job description reflected Essential Functions: that included: Ensures that supplies are utilized economically and that equipment is clean and maintained in a safe manner,Assures that inventory and supplies are maintained on the unit. Assists with or institutes emergency measures for sudden adverse developments in residents,Review of the undated job description for ‘Licensed Practical/Vocational Nurse (LPN) provided by the facility was also reviewed. This job description includes many of the same Essential Functions of the RN but with an expectation of practice within the scope of an LPN.As of survey exit on 2/10/2026 no additional information had been provided by the facility.

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Obtain a doctor's order to admit a resident and ensure the resident is under a doctor's care. 710 Physician servicesThis citation pertains to intake #s 2638540 2724503, 2676090Based on interview and record review, the facility failed to ensure the medical provider adequately supervised the care of one Resident (R103) of four residents reviewed for physician services. Findings include:Review of the Electronic Medical Record (EMR) admission record reflected R103 admitted to the facility 12/10/2024 with pertinent diagnosis that included Diabetes Mellitus.Review of the EMR Progress Notes for R103 revealed an entry dated 1/13/2026 at 4:55 PM of a new wound, diabetic foot ulcer on the left lateral mid foot. The documentation reflected Wound acquired in-house which was measured and dressed. The entry did not reflect the medical provider was notified of the new wound or its characteristics.Review of the medical record Physicians Orders for R103 reflected a new ordered treatment of left foot pressure injury-betadine and white border gauze in the morning with a start date of 1/14/2026.Review of the EMR Progress Notes for R103 reflected documentation by the Medical Provider of encounters with the Resident on 1/16/2026 at 8:00 AM, 1/21/2026 at 8:00 AM, and 2/3/2026 at 8:00 AM. The documentation of these encounters reflected the Medical Provider addressed constipation and left thumb pain. However, the documentation did not reflect a physical assessment by the Medical Provider of the new wound or an acknowledgement of the new condition. Review of the Care Plan for R103 reflected that a nursing Care Plan for the new wound identified on 1/13/2026 was not formulated until after the survey was initiated on 2/9/2026. This indicated that, prior to 2/9/2026, the Medical Provider and nursing had not collaborated to formulate a comprehensive care plan for the new wound.On 2/9/2026 at 3:32 PM an interview was conducted with Unit Manager (UM) D in the conference room. UM D was informed that no documentation was in the EMR that the Medical Provider had evaluated the new wound on the left foot of R103. UM D reported that mid- level providers will review the photographs but acknowledged that no Medical Providers had charted that they had reviewed any photographs. UM D was informed that the Progress Notes reflected three Medical Provider encounters with R103, but no physical assessment or documentation of the left foot wound was located. UM D was unable to provide any additional information or documentation.As of survey exit on 2/10/2026 no additional information had been provided by the facility.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. This citation pertains to intake# 2685190Based on observation, interview, and record review, the facility failed to store medication and biologicals in accordance with manufacturer's recommendations.Findings include:On 2/10/2026 at 9:35 AM a review of the C Hall medication cart was conducted with Registered Nurse (RN) H. During the review an in use, opened and undated insulin pen was identified. RN H reported she did not know when the insulin pen had been placed in service and acknowledged this date should be evident as this device has a shortened use life after placed into service. On 2/10/2026 at 9:45 AM a review of the wet medication room was conducted with RN H. During the review two undated and opened vials of Purified Protein Derivative (PPD) solution were discovered in the medication refrigerator. RN H reported these medications should have been dated by nursing when the vials were placed in service.Review of the manufacturer's product information sheet for PPD solution reflected A vial of (PPD solution) which has been entered and in use for 30 days should be discarded. This indicated that the date a vial has been placed in service must be known to nurses so a discard date, in accordance with manufacturer's recommendation, can be calculated.The policy provided by the facility titled Medication Storage last revised 1/30/2024 was reviewed. The policy reflected It is the policy of this facility to ensure all medication housed on our premise will be stored according to manufacturer's recommendations and sufficient to ensure proper sanitation, temperature, light, ventilation, moisture control, segregation, and security.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake #s 2638540 and 2676090Based on interview and record review, the facility failed to ensure clear and concise documentation in the Electronic Medical Record for one Resident (R103) of three residents reviewed for medical record accuracy. Findings include:Review of the Electronic Medical Record (EMR) admission record reflected R103 admitted to the facility 12/10/2024 with pertinent diagnosis that included Diabetes Mellitus. Review of the Minimum Data Set (MDS) dated [DATE] reflected a Brief Interview for Mental Status (BIMS) (a tool used to determine a resident's cognitive status) score of 15 out of 15 which reflected the Resident was cognitively intact. Review of the EMR Progress Notes for R103 revealed an entry dated 1/13/2026 at 4:55 PM that a new wound, diabetic foot ulcer was identified on the left lateral mid foot of the Resident. The documentation reflected Wound acquired in-house which was measured and dressed. The Treatment Administration Record (TAR) for R103 for January and February 2026 were reviewed. The TARs reflected a treatment described as left foot pressure injury-betadine and white border gauze in the morning with a start date of 1/14/2026 at 7:00 AM. The TAR revealed that between 1/14/2026 and 2/9 /2026 there was no documentation by nursing (initials) this was completed for 11 of the past 27 days the treatment was in place. (1/17, 1/21,1/23, 1/26, 1/27, 1/30, 2/1, 2/4, 2/6, 2/8, 2/9/2026). Review of the Progress Notes for R103 did not reflect documentation by nurses why the treatments were not performed as ordered or documentation that the Medical Provider was notified or aware of interruption or rejection of care by the Resident.Review of the Care Plan for R103 reflected that a nursing Care Plan for the new wound identified on 1/13/26 was not formulated until after the survey was initiated on 2/9/2026. This indicated that, prior to 2/9/2026, nursing had not updated the medical record to include a revised Care Plan for the new wound.On 2/9/2026 at 3:32 PM an interview was conducted with Unit Manager (UM) D in the conference room. UM D reported that R103 would dictate when and who does his care. UM D acknowledged the undocumented dressing changes on the TARs and reported he assumed the Resident had refused or had asked staff to delay treatment to a more convenient time. UM D acknowledged that the medical record did not contain information on why nursing had not performed, delayed, or documented the treatments. On 2/9/2026 at approximately 4:10 PM the Director of Nursing (DON) was informed of the un-initialed TARs for the daily dressing changes and that no nursing notes had been entered that might have provided data on why the ordered treatments were refused, delayed or were, in fact, completed. The DON reported R103 would delay care or only allow specific staff to provide care. The DON could not provide information that the Medical Provider had been informed by nursing through documentation of the delay or refusal of ordered treatments or documentation that the Resident had been educated on the potential effects of treatment delays or refusals. The DON reported she absolutely expected nursing to document when ordered care is or is not completed. Review of the undated job description for Registered Nurse (RN) provided by the facility reflected Summary: Plans, coordinates and provides total nursing care for residents and provides supervision to clinical staff members. The job description reflected Essential Functions: to include: Initiates and leads team conferences in the development of individual nursing care plans, Assesses and documents the resident's condition and nursing needs, Accurately and promptly implements physician's orders, Administers medications, starts IVs (intra venous access) and performs treatments for assigned residents and documents that treatment as required (by) company, and local, state, and federal rules and regulations. Reports and records pertinent observations and reactions regarding residents,Review of the job description for Licensed Practical/Vocational Nurse (LPN) provided by the facility was also reviewed. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	This job description holds the same Essential Functions implementation and documentation of care of the RN but with an expectation of practice within the scope of an LPN.As of survey exit on 2/10/2026 no additional information had been provided by the facility on the nursing care of R103 or of the duties and expectations of nursing.