STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235495	A. Building B. Wing	01/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Marshall	879 East Michigan Ave Marshall, MI 49068

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake: 2672585Based on observations/interviews/record review, the facility failed to protect the resident's (R2's) right to be free from verbal abuse and physical abuse by a resident.Findings Included:Resident #2 (R2)Review of the medical record revealed R2 was admitted to the facility 11/19/2024 with diagnoses that included pseudobulbar effect (a neurological condition causing sudden uncontrollable episodes of laughing or crying), cognitive impairment, severe intellectual disabilities (significant limitations in mental ability), bipolar disorder, social phobia, hypertension, gastro-esophageal reflux disease, depression, dysphagia, hypothyroidism (low thyroid hormone), obesity, and conversion disorder with seizures or convulsions (a condition where psychological stress or trauma manifest as real physical symptoms affecting movement). The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/25/2025 that could not be completed because resident is rarely/never understood.Resident #6 (R6)Review of the medical record revealed R6 was admitted to the facility 03/31/2025 with diagnoses that included hypothyroidism (low thyroid hormone), hyperlipidemia (high fat content in blood), adult failure to thrive, Alzheimer's Disease, low back pain, anemia (low number of red blood cells), constipation, insomnia, depression, weight loss, dementia, vitamin D deficiency, cognitive communication deficit, and morbid obesity. The most recent Minimum Data Set (MDS), with an Assessment Reference Date of 12/02/2025, revealed a Brief Interview of Mental Status (BIMS) of 3 (severe cognitive impairment) out of 15.Review of facility incident report, dated 11/05/2025 at 05:00 p.m., revealed resident (R6) approached in dining room other resident (R2) who was shouting. Other resident (R2) upset resident (R6). Resident (R6) yelled at other resident and started to hit her (R2) in the face multiple times. Left a scratch on another resident's (R2) nose. Staff member approached the situation and redirected resident (R6) to another room. Resident description of the incident report revealed, Resident (R6) sated that other resident (R2) was yelling at her and that's why she hit her.During a telephone interview on 12/29/2025 at 02:33 p.m. Certified Nursing Aide (CNA) C explained that on 11/05/2025 at approximately 5:00 p.m. she had entered the dining room to report off to another certified nursing aide. CNA C explained that while she was talking to the other employee she observed R6 standing beside R2. CNA C explained she then heard R2 starting to yell. CNA C explained that then she witnessed R6 grab R2 by her sweatshirt and then observed R6 hit R2 three to four times on her forehead. CNA C explained that she separated R6 from R2. CNA C explained that she knew R6 had a history of altercations with other residents. CNA C explained that she believed that R6 was not to be left unattended in the dining room and R6 should not be next to other residents while in the dining room. CNA C could not explain that she did not see any other staff member observing R6 in the dining room at the time of the incident.During observation and attempted interview on 12/30/2025 at 08:21 a.m. R6 was observed walking in hall. Observed staff member assist R6 into her room. R6 was asked questions regarding incident with R2. She explained that (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	she recalled pushing someone away from herself but did not recall ever hitting another resident.During observation and attempted interview on 12/30/2025 at 08:26 a.m. R2 was observed lying down in bed. R2 could not be understood when asked questions regarding the incident with R6.Review of R6's facility incident reports revealed the following: 05/25/25 physical aggression-accusation of physical aggression toward another resident, 06/22/2025-physical aggression with another resident in dining room, 6/26/2025-altercation in dining room with another resident grabbing and hitting, 07/20/2025-slapped another resident in the dining room, 08/22/2025- threw plastic coke bottle at another resident in the dining room. 10/26/2025 hit roommate.Review of R6's plan of care revealed at problem statement which stated: Resident has behaviors related to dementia with behavioral disturbances as evidenced by: physical aggressive (yelling and hitting) toward staff, resistant to care, refusing medication, cusses at staff, refuses showers, physical aggressive (yelling and hitting) towards other residents, wandering into residents room, refusing showers. Problem statement revealed last revision 11/06/2025. Interventions reviewed and revealed 1:1 care until infection ruled out, date initiated 6/27/2025 and resolved 07/08/2025. Interventions also included frequent checks on resident, date initiated 07/08/2025, revised 11/03/2025, and resolved 11/03/2025. Further review of R6's plan of care did not include any interventions to prevent altercations in the facility dining room.In an interview on 12/30/2025 at 08:35 a.m. Nursing Home Administrator (NHA) A explained that R6 was sent to the hospital following the altercation on 11/05/2025 and was sent to a Geropsychiatric Unit until R6 returned to the facility on [DATE]. NHA A confirmed that R6 had had previous alterations with other residents while in the dining room. NHA A could not verbalize or present evidence of interventions in R6's plan of care which revealed actions that the facility had taken after each altercation. NHA A could not verbalize or present evidence in R'6's plan of care of interventions that would have been in place prior to the incident on 11/05/2025. NHA A could not verbalize or provide documentation of interventions that were in place to prevent R6's behaviors and potential physical altercations between other residents.Review of facility policy entitled Abuse, Neglect and Exploitation, with an implementation date 07/28/2020 and last revision date of 01/20/2024, revealed section entitled III Prevention of Abuse, Neglect and Exploitation- D. The identification, ongoing assessment, care planning for appropriate interventions, and monitoring of residents with needs and behaviors which might lead to conflict or neglect.

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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 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** This citation pertains to intake: 2642660 Based on observation, interview, and record review the facility failed to ensure that Nursing staff followed professional standards for medication administration for one resident (#1) out of three residents reviewed for medication administration. Findings Included:Resident #1 (R1)Review of the medical record revealed R1 was admitted to the facility 02/19/2025 with diagnoses that included depression, thyroiditis (inflammation of the thyroid gland), gastro-esophageal reflux, osteoporosis (weak and brittle bones), dementia, hypercholesterolemia (high cholesterol), sleep apnea, insomnia, chronic pain, dysphagia, and (difficulty swallowing). The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/25/2025, did not have a Brief Interview for Mental Status (BIMS) conducted.Resident #7 (R7) Review of the medical record revealed R7 was admitted to the facility 02/07/2025 with diagnoses that included chronic respiratory failure, type 2 diabetes, depression, pain in right hip, post-traumatic stress disorder (PTSD), hypercholesterolemia (high cholesterol), anxiety, adjustment disorder, mild cognitive impairment, dementia, dysphagia (difficulty swallowing), hypertension, and cognitive communication deficit. The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 09/30/2025, revealed a Brief interview for Mental Status (BIMS) of 12 (moderate cognitive impairment) out of 15. During a telephone interview on 12/20/2025 at 10:24 a.m. R1 Family member G explained that R1 had received a different resident's medication. R1 Family member G explained that R1 had received insulin and a medication for high blood pressure. R1 Family member G could not list all the wrong medication that had been provided. During observation and interview on 01/06/2025 at 10:21 a.m. R1 was observed lying down in bed. R1 explained that she remembers getting the wrong medication but could not remember the medication or the date that the incident occurred. R1 explained that there was no negative outcome related to receiving the wrong medication. Review of facility medication incident report and provided investigation revealed that on 10/07/2025 at 08:00 a.m. R1 received medication that was not prescribed to her. The incident report stated, wrong medication given to resident, including insulin. (name of Physician Assistant) notified immediately. All medications were reviewed and plan of care established. Resident BS (blood sugar) will be monitored throughout the day along with VS (vital signs). Morning medications held per PA. The medication that was given to R1 was ordered for R7. Review of the investigation provided revealed R1 had received the following medications: Farxia 10mg (milligrams), Hydrochlorothiazide 25mg, Furosemide 20mg, Loaratadine 10mg, Multivitamin adult tab, Potassium Chloride 10 meq (milliequivalent), Tylenol 650mg, Lantus 22 units subcutaneous, and Metoprolol Tartrate 25mg. Review of R1 medical record revealed a program note written by Physician assistant, dated 10/7/2025, which stated [AGE] year old female is seen per nursing report due to reported medication administration error. Nursing staff reports that resident received another residents morning medications. Reviewed medication list that they received which includes the following Farxiga 10mg (milligrams), furosemide 20mg, de hydrochlorothiazide 25mg, Loratadine 10mg, Potassium 10 meq (milliequivalent), metoprolol tartrate 25mg, Lantus 22 units, Tylenol 650mg, and multivitamin. Resident is seen in her room and appears in no acute distress. Vitals are stable and she states that she is feeling well at this time. Advised nursing staff to monitor blood pressure and vitals signs every 6 hours, as well as blood glucose levels every 6 hours.Review of R1's blood sugar levels revealed: Review of blood sugars revealed 10/07/2025 11:58a.m. 126mg/dl (milligrams/deciliter), 10/07/2025 5:26 p.m. 150mg/dl, 10/08/2025 at 00:57 a.m. 218mg/dl, and 10/08/2025 123mg/dl.Review of R1's MAR for October revealed all 0800 medication was held to include Alendronate sodium oral tablet 10mg (milligrams), cholecalciferol tablet 1000 unit give 2 tablet by (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	mouth, Duloxetine HLC oral capsule 60mg, fenofibrate oral tablet 48mg, hydrochlorothiazide 25mg, Losartan potassium oral tablet 50mg. and clonidine HCL 0.2mg, famotidine 20mg. In an interview on 01/06/2026 at 09:04 a.m. Nursing Home Administrator (NHA) A explained that Registered Nurse (RN) H had pulled the medication for R7. NHA A explained that once the medication was pulled from the medication cart RN H gave the medication to Licensed Practical Nurse (LPN) I, who was on orientation, and instructed LPN I to go give the medication to R7. NHA A explained that LPN I went and provided the medication to R1 instead of R7.In an interview on 01/06/2025 at 09:21 a.m. Regional Clinical Consultant F explained that the route cause of the incident was that Licensed Practical Nurse LPN I did not pull the medication herself. Regional Clinical Consultant F explained that Registered Nurse (RN) H pulled the medication from the medication cart. Regional Clinical Consultant F explained that professional practice dictates that the person pulling the medication should be the one providing the medication to the resident. Regional Clinical Consultant F explained that those professional standards were not followed in this incident. Regional Clinical Consultant F also explained that LPN I did not follow the 5 rights while administering R1's medication. Regional Clinical Consultant F explained 5 rights for safe medication administration is widely recognized in healthcare as a standard checklist to reduce medication errors. 5 rights include: right patient/resident, right medication, right dose, right time, and right route. On 01/06/2026 at 09:41 a.m. Registered Nurse (RN) H explained that on 10/07/2025 he was the nurse preceptor (nurse providing orientation a new nurse) for Licensed Practical Nurse (LPN) I. RN H explained that LPN I did not have access to the facility computerized medical record system called PointClickCare(PCC), which would have allowed LPN I to have access to a resident's Medication Administration Record (MAR). RN H explained that because LPN I did not have access to a resident MAR to verify and obtain medication for residents that he removed and documented the administration of the medication for R7. RN H explained that he then provided R7's medication to LPN I to administer to R7. RN H explained that he did not observed LPN I give R7's medication to R1 but was notified after the fact. On 01/06/2025 at 10:45 a.m. in a telephone interview Licensed Practical Nurse (LPN) I explained that she was working on 10/07/2025. LPN I explained that she was being trained by Registered Nurse H on 10/07/2025. LPN I explained that she did not have access to PointClickCare (PCC) and residents Medication Administration Record (MAR). LPN I explained that RN H pulled the medication and documented it as give for R7. LPN I explained that RN H then provided her with R7's medication for administration but that she gave the medication to R1. LPN I explained that she did not follow the 5 rights of medication administration and therefore administered R7's medication to R1 by accident. LPN I explained that she immediately identified the error and took action as explained on R1's incident report.

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. This citation pertains to Intake: 2644057Based on observation, interview, and record review the facility failed to prevent the development of pressure ulcers for one resident (#4) out of three residents with pressure ulcers reviewed, resulting in the development of two unstageable pressure ulcers and one stage 3 pressure ulcer. Findings Included:Resident #4 (R4)Review of the medical record revealed R4 was admitted to the facility 05/03/2025/ with diagnoses that included chronic obstructive pulmonary disease (COPD), chondrocostal junction syndrome (inflammation and pain where ribs connect to cartilage), obesity, anxiety, mild neurocognitive disorder (a stage where there's a noticeable decline in memory), neuromuscular dysfunction of bladder (nerve damage between brain and bladder causing urinary incontinence, retention, urgency, or a weak stream), depression, anemia (low red blood cell count), hypothyroidism (low thyroid hormone), insomnia, hypertension, sleep apnea, gastro-esophageal reflux, and osteoarthritis (degenerative joint disease). The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/06/2025, revealed a Brief Interview for Mental Status (BIMS) of 15 (cognitively intact) out of 15. Section M-Skin condition of the MDS, with the same ARD, revealed R4 had one stage 3 pressure ulcer present on upon admission and one unstageable pressure ulcer that was not present on admission. Review of R4's medical record revealed the following pressure ulcers:Unstageable right heel wound (caused by brace) facility acquired. Original acquired date of 12/15/2025 with measurements 4.6 cm (centimeters) in length by 1.6 centimeters in width. Most recent measurements 12/29/2025, 2.5 cm in length and 3.0 cm in width.Unstageable right heel superior facility acquired. Original acquired date of 12/08/2025 with measurement 2.9cm in length by 1.9cm in width and 0.1 cm in depth. Most recent measurement , now stage 3 pressure ulcer, 12/29/2025 6.5cm in length by 3.0cm in width and 0.3 cm in depth. Unstageable right medial malleolus facility acquired. Originally acquired date of 12/08/2025 with measurements of 1.4cm length by 0.8cm in width. Most recent measurements, 12/29/2025 5cm in length by 3.8 cm in width. Review of R4's medical record revealed treatment orders that included: Right heel: (medial cleanse with wound wash, pat dry, apply calcium alginate to wound bed and cover with bordered gauze dressing. In the morning every Monday (Mon), Wednesday(Wed), Friday(Fri) for wound care. Start date of 12/15/2025. Order was still in place as of 12/29/2025. Review of Treatment Record revealed treatment was not completed 12/15/2025, 12/19/2025, 12/24/25.Right heel: cleanse with wound wash, pat dry. Apply betadine to areas of dark/redness. Cover with bordered gauze dressing. In morning every Mon, Wed, Fri for wound care. Start date of 11/05/2025 and still in place as of 12/29/2025. Review of Treatment Record revealed treatment was not completed 12/10/2025, 12/15/2025, 12/19/2025, 12/24/2025.Right heel: cleanse with wound wash, pat dry. Apply calcium alginate to wound bed that is open, cover with silicone super absorbent dressing. In the morning every Mon, Wed, Fri for wound care. Start date of 12/17/2025 and still in place as of 12/29/2025. Review of Treatment Record revealed treatment was not completed 12/19/2025 and 12/24/2025.Right medial malleolus: cleanse with wound wash, pat dry. Apply iodine to area and cover with bordered gauze dressing. In the morning every Mon, Wed, Fri for wound care. Start Date of 12/15/2025 and still in place 12/29/2025. Review of Treatment Record revealed treatment was not completed 12/15/2025, 12/19/2025 and 12/24/2025.Right medial malleolus: clean with wound wash, pat dry apply iodine to wound bed and cover with bordered gauze. In morning every Mon, Wed, Fri for wound care. Start date of 12/15/2025 and still in place 12/29/2025. Review of Treatment Record revealed treatment was not completed 12/15/2025, 12/19/2025 and 12/24/2025.Right medial malleolus: cleanse with wound wash, pat dry. Apply medihoney to calcium alginate and then apply to wound bed. Cover with bordered gauze dressing. In the morning every Mon, Wed, Fri for wound care. Start date of 12/17/2025 and still in place 12/29/2025. Review of (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Treatment Record revealed treatment was not completed 12/19/2025 and 12/24/2025In an interview on 12/29/2025 at 11:06 a.m. Wound Nurse (WN) E explained that she was responsible for the oversight of pressure wounds at the facility. WN E explained that R4 had a pressure wound to her right heel, a pressure wound to her right medial malleolus, and her right heel superior. WN E was asked to explain why there were three different orders for R4's right heel. After review of the right heel orders WN E explained that some of the orders should have been deleted but WN E could not explain which orders were correct at this time. WN E was asked to explain why there were three different orders for the R4's right medial malleolus. After review of the right medial malleolus orders WN E explained that some of the orders should have been deleted. WN E could not explain which orders were correct at this time. WN E was asked to review the R4's Treatments Records for December of 2025. WN E was asked to explain why the treatments were not completed to the right heel and the right medial malleolus, as ordered, on the dates listed above. WN E could not provide an explanation as to why the treatments had not been completed. During observation and interview on 12/29/2025 at 12:35 p.m. R4 was observed lying down in the bed. An alternating air mattress was observed to be in use and R4's right foot was elevated on a pillow. R4 explained that she had several pressure wounds to her right foot and that they were caused by a boot that she had to wear when she first arrived at the facility. R4 explained that she currently does not wear the boot. On 12/29/2025 at 01:40 p.m. R4 was observed lying down in bed. Wound Nurse (WN) E was observed explaining to R4 that she would be changing her wound dressing to her right boot. WN E removed the right heel dressing which was dated 12/26/2025. The wound was observed to have eschar tissue and WN E informed this surveyor that the right heel was an unstageable wound. WN E was observed to measure the right heel and found it to me 2.5 centimeters (cm) in length x 3cm in width and had no depth. wipe the wound with wound wash. The right heel wound was cleansed with wound wash and betadine was applied. WN E was then observed to place a boarder gauze over the right heel wound. WN E was observed to removed R4's right superior heel dressing, dated 12/26/2025, the dressing was observed to have a large amount of yellowish/greenish drainage and a foul odor was present. The wound was cleansed with wound wash. WN E then was observed to measure the right superior heel wound and found to be 6.5cm in length x 3cm in width x0.3cm in depth. WN E explained that the right superior heel wound was now classified as a stage 3 pressure ulcer. The wound bed was observed to be pink with granulation tissue present. WN E applied calcium alginate and medihoney. WN E was then observed to place a boarder gauze over the right superior heel wound. WN E was then observed to remove the right medial malleolus dressing, dated 12/26/2025. The wound site was observed with slough tissue in the wound bed and appeared to be unstageable. WN E was observed to cleanse the right medial malleolus wound site with wound wash. WN E was observed to measure the right medial malleolus wound site and was observed to be 5.0cm in length x 3.8cm in width and no depth. WN E was observed to apply calcium alginate and boarder gauze. WN E was observed to use appropriate infection control standards during all dressing changes. R4 rated her pain as between 7 and 9 out of a possible 10at the conclusion of the dressing changes.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake: 2642660Based on observation, interview, and record review the facility failed to prevent significant medication errors for one resident (#1) out of three residents reviewed for medication errors. Findings Included:Resident #1 (R1)Review of the medical record revealed R1 was admitted to the facility 02/19/2025 with diagnoses that included depression, thyroiditis (inflammation of the thyroid gland), gastro-esophageal reflux, osteoporosis (weak and brittle bones), dementia, hypercholesterolemia (high cholesterol), sleep apnea, insomnia, chronic pain, dysphagia, and (difficulty swallowing). The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/25/2025, did not have a Brief Interview for Mental Status (BIMS) conducted.Resident #7 (R7) Review of the medical record revealed R7 was admitted to the facility 02/07/2025 with diagnoses that included chronic respiratory failure, type 2 diabetes, depression, pain in right hip, post-traumatic stress disorder (PTSD), hypercholesterolemia (high cholesterol), anxiety, adjustment disorder, mild cognitive impairment, dementia, dysphagia (difficulty swallowing), hypertension, and cognitive communication deficit. The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 09/30/2025, revealed a Brief interview for Mental Status (BIMS) of 12 (moderate cognitive impairment) out of 15. During a telephone interview on 12/20/2025 at 10:24 a.m. R1 Family member G explained that R1 had received a different resident's medication. R1 Family member G explained that R1 had received insulin and a medication for high blood pressure. R1 Family member G could not list all the wrong medication that had been provided. During observation and interview on 01/06/2025 at 10:21 a.m. R1 was observed lying down in bed. R1 explained that she remembers getting the wrong medication but could not remember the medication or the date that the incident occurred. R1 explained that there was no negative outcome related to receiving the wrong medication. Review of facility medication incident report and provided investigation revealed that on 10/07/2025 at 08:00 a.m. R1 received medication that was not prescribed to her. The incident report stated, wrong medication given to resident, including insulin. (name of Physician Assistant) notified immediately. All medications were reviewed and plan of care established. Resident BS (blood sugar) will be monitored throughout the day along with VS (vital signs). Morning medications held per PA. The medication that was given to R1 was ordered for R7. Review of the investigation provided revealed R1 had received the following medications: Farxia 10mg (milligrams), Hydrochlorothiazide 25mg, Furosemide 20mg, Loaratadine 10mg, Multivitamin adult tab, Potassium Chloride 10 meq (milliequivalent), Tylenol 650mg, Lantus 22 units subcutaneous, and Metoprolol Tartrate 25mg. Review of R1 medical record revealed a program note written by Physician assistant, dated 10/7/2025, which stated [AGE] year old female is seen per nursing report due to reported medication administration error. Nursing staff reports that resident received another residents morning medications. Reviewed medication list that they received which includes the following Farxiga 10mg (milligrams), furosemide 20mg, de hydrochlorothiazide 25mg, Loratadine 10mg, Potassium 10 meq (milliequivalent), metoprolol tartrate 25mg, Lantus 22 units, Tylenol 650mg, and multivitamin. Resident is seen in her room and appears in no acute distress. Vitals are stable and she states that she is feeling well at this time. Advised nursing staff to monitor blood pressure and vitals signs every 6 hours, as well as blood glucose levels every 6 hours.Review of R1's blood sugar levels revealed: Review of blood sugars revealed 10/07/2025 11:58a.m. 126mg/dl (milligrams/deciliter), 10/07/2025 5:26 p.m. 150mg/dl, 10/08/2025 at 00:57 a.m. 218mg/dl, and 10/08/2025 123mg/dl.Review of R1's MAR for October revealed all 0800 medication was held to include Alendronate sodium oral tablet 10mg (milligrams), cholecalciferol tablet 1000 unit give 2 tablet by mouth, Duloxetine HLC oral capsule 60mg, fenofibrate oral tablet 48mg, (continued on next page)

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	hydrochlorothiazide 25mg, Losartan potassium oral tablet 50mg. and clonidine HCL 0.2mg, famotidine 20mg. In an interview on 01/06/2026 at 09:04 a.m. Nursing Home Administrator (NHA) A explained that Registered Nurse (RN) H had pulled the medication for R7. NHA A explained that once the medication was pulled from the medication cart RN H gave the medication to Licensed Practical Nurse (LPN) I, who was on orientation, and instructed LPN I to go give the medication to R7. NHA A explained that LPN I went and provided the medication to R1 instead of R7.In an interview on 01/06/2025 at 09:21 a.m. Regional Clinical Consultant F explained that the route cause of the incident was that Licensed Practical Nurse LPN I did not pull the medication herself. Regional Clinical Consultant F explained that Registered Nurse (RN) H pulled the medication from the medication cart. Regional Clinical Consultant F explained that professional practice dictates that the person pulling the medication should be the one providing the medication to the resident. Regional Clinical Consultant F explained that those professional standards were not followed in this incident. Regional Clinical Consultant F also explained that LPN I did not follow the 5 rights while administering R1's medication. Regional Clinical Consultant F explained 5 rights for safe medication administration is widely recognized in healthcare as a standard checklist to reduce medication errors. 5 rights include: right patient/resident, right medication, right dose, right time, and right route. On 01/06/2026 at 09:41 a.m. Registered Nurse (RN) H explained that on 10/07/2025 he was the nurse preceptor (nurse providing orientation a new nurse) for Licensed Practical Nurse (LPN) I. RN H explained that LPN I did not have access to the facility computerized medical record system called PointClickCare(PCC), which would have allowed LPN I to have access to a resident's Medication Administration Record (MAR). RN H explained that because LPN I did not have access to a resident MAR to verify and obtain medication for residents that he removed and documented the administration of the medication for R7. RN H explained that he then provided R7's medication to LPN I to administer to R7. RN H explained that he did not observed LPN I give R7's medication to R1 but was notified after the fact. On 01/06/2025 at 10:45 a.m. in a telephone interview Licensed Practical Nurse (LPN) I explained that she was working on 10/07/2025. LPN I explained that she was being trained by Registered Nurse H on 10/07/2025. LPN I explained that she did not have access to PointClickCare (PCC) and residents Medication Administration Record (MAR). LPN I explained that RN H pulled the medication and documented it as give for R7. LPN I explained that RN H then provided her with R7's medication for administration but that she gave the medication to R1. LPN I explained that she did not follow the 5 rights of medication administration and therefore administered R7's medication to R1 by accident. LPN I explained that she immediately identified the error and took action as explained on R1's incident report.