

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235495	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/12/2026
NAME OF PROVIDER OR SUPPLIER Medilodge of Marshall		STREET ADDRESS, CITY, STATE, ZIP CODE 879 East Michigan Ave Marshall, MI 49068	

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)
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to Intake 2728065. Based on observation, interview, and record review, the facility failed to administer medications as ordered for one (R2) of three reviewed. Findings include: Review of the medical record revealed R2 was admitted to the facility on [DATE] with diagnoses that included necrotizing fasciitis, major depressive disorder with anxiety, and type 2 diabetes. The Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/18/25 revealed R2 scored 13 out of 15 (cognitively intact) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool). On 2/11/26 at 8:40 AM, R2 was observed sitting on the edge of their bed, eating breakfast. R2 reported they had concerns that their pain medications were occasionally administered late. Review of the Physician's Order dated 12/30/25 revealed an order for oxycodone (opioid pain medication) 10 milligrams (mg) every four hours. Review of the Medication Administration Record (MAR) revealed R2's oxycodone was scheduled to be administered every day at 12:00 AM, 4:00 AM, 8:00 AM, 12:00 PM, 4:00 PM, and 8:00 PM. Review of the Controlled Substance Records for R2's oxycodone 10 mg revealed the oxycodone was often signed out outside of the ordered 4 hours, which included but was not limited to the following: 1/18/26 at 9:58 PM and 1/19/26 at 12:16 AM (2 hours and 18 minutes between doses) 1/19/26 at 7:15 AM and 1/19/26 at 12:00 PM (4 hours and 45 minutes between doses) 1/19/26 at 12:25 AM and 1/20/26 at 5:15 AM (4 hours and 50 minutes between doses) 1/20/26 at 3:00 PM and 1/20/26 at 8:03 PM (5 hours and 3 minutes between doses) and 1/20/26 at 9:52 PM (1 hour and 49 minutes between doses) 1/24/26 4:07 AM and 1/24/26 at 9:00 AM (4 hours and 53 minutes between doses) 1/24/26 at 7:52 PM and 1/24/26 at 11:25 PM (2 hours and 33 minutes between doses) 1/26/26 at 4:30 AM and 1/26/26 at 9:15 AM (4 hours and 45 minutes between doses) 1/26/26 at 8:25 PM and 1/26/28 at 11:20 PM (2 hours and 55 minutes between doses) 1/27/26 at 11:17 PM and 1/28/26 at 4:45 AM (5 hours and 28 minutes between doses) 1/28/26 at 9:15 AM and 1/28/26 at 11:00 AM (1 hour and 45 minutes between doses) and 1/28/26 at 4:10 PM (5 hours and 10 minutes between doses) 2/3/26 at 4:47 AM and 2/3/26 at 7:56 AM (3 hours and 9 minutes between doses) 2/4/26 at 11:56 AM and 2/4/26 at 5:17 PM (5 hours and 21 minutes between doses) 2/10/26 at 5:00 AM and 2/10/26 at 7:01 AM (2 hours and 1 minute between doses) 2/10/26 at 3:30 PM and 2/10/26 at 8:41 PM (5 hours and 11 minutes between doses) 2/11/26 at 8:01 AM and 2/11/26 at 11:00 AM (2 hours and 59 minutes between doses) and 2/11/26 at 4:13 PM (5 hours and 13 minutes between doses) 2/12/26 at 5:00 AM and 2/12/26 at 7:01 AM (2 hours and 1 minute between doses) and 2/12/26 at 12:10 PM (5 hours and 9 minutes between doses) In an interview on 2/12/26 at 11:32 AM, Registered Nurse (RN) I nurses often work two halls and as a result, medications were administered late. In an interview on 2/12/26 at 3:11 PM, Director of Nursing (DON) B reported the Controlled Substance Records should reflect the time the nurse pulled the medication out of the medication cart for administration to the resident. DON B reported if a medication was ordered every 4 hours, it would be expected that staff signed it out every 4 hours for administration unless the resident refused the medication. DON B reviewed R2's Controlled Substance</p> <p>(continued on next page)</p>

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: Facility ID: 235495	If continuation sheet Page 1 of 2

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Records and agreed R2's oxycodone was signed out as administered outside of the ordered every 4 hours.</p>		