

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  235600	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/14/2025
NAME OF PROVIDER OR SUPPLIER  Medilodge of Montrose Inc		STREET ADDRESS, CITY, STATE, ZIP CODE  9317 West Vienna Road Montrose, MI 48457	

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 - Actual harm  Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals.  (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 - Actual harm  Residents Affected - Few	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> This citation pertains to Intake Number 2580183. Based on interview and record review the facility failed to have diabetic supplies available to facility staff when Resident #108 had a hypoglycemic episode, resulting in a blood sugar of 52 and being placed on ventilator upon arrival to the Emergency Room. Findings Include: Resident #108: On [DATE] at approximately 11:00 AM, a review was conducted of Resident #108'S medical record and it revealed he admitted to the facility on [DATE] with diagnoses that included, Peripheral Vascular Disease, Heart Disease, Atrial Fibrillation, Diabetes Mellitus, Chronic Kidney Disease and Hypertension. Resident #108 was his own person and able to make his needs known to staff. Further review of his chart yielded the following: Progress Notes:[DATE] at 17:01: Resident in room comfortable in bed with call light in reach. Orders placed and verified.[DATE] at 04:30: A 22-gauge IV was inserted into the right forearm.[DATE] at 04:47: Albuterol Sulfate HFA Inhalation Aerosol Solution 108 (90 Base) MCG/ACT 2 puff inhale orally every 6 hours as needed for wheezing PRN Administration was: Effective.[DATE] at 5:23: Resident complained of SOB and wheezing earlier in the night. Resident had an order for a rescue inhaler and 2 puffs were given. Resident verbalized that it seemed to aid his breathing. No other signs of dyspnea noted during this time. A couple of hours later, nurse went in to perform wound dressings and found resident pale, frothing at the mouth with labored breathing, and had an altered level of consciousness. Resident had a blood sugar of 52. Crash cart was pulled out and resident was thrown on 3L of oxygen r/t O2 sats of 86. EMS ((Emergency Medical Services) was notified and came without a medic. On-call provider was notified of incident and well as on-call nurse. Resident had no family members listed on his profile to notify. He is his own person. Hospital Records:[DATE]- arrival time 5:23 AM .Pt (patient) arrives from (facility) after being found to have SPO2 at 70%. After calling EMS pt was also found to have glucose level of 41 by EMS and AMS (altered mental status). On arriving to ED (Emergency department), pt's HR (heart rate) of 22, afebrile, snoring and tachypenic of 26 somnolent, AxO 0, arousal to sternal rub. Given pt clinical status and inability to protect airway, was intubated. assessment/plan: Acute Respiratory Failure- GCS 6. metformin and Januvia for glycemic control. Discontinue insulin. High risk of hypoglycemia. July MAR (Medication Administration Record): Resident #108 is prescribed the current insulin regime to manage his diabetes: Lantus Solo Star 100 Unit/ML pen injector inject 17 unit subcutaneously at bedtime for diabetes. Humalog KwikPen 100 Unit/ML Solution pen-injector inject 3 unit subcutaneously with meals for diabetes. Insulin Lispro 100 Unit/ML solution Inject per sliding scale. If blood sugar is less than 70mg/dl or patient symptomatic, follow hypoglycemic protocol. There was no medications listed on the MAR as administered during the timeframe of Resident #108's critical incident. Medication Administration Audit Report: Resident #108 was administered insulin at the following times on evening of [DATE]: Insulin Lispro 100 Unit/ML per sliding scale- 1 unit at 16:29 Humalog KwikPen 100 Unit/ML - 3 units at 16:30 Lantus SoloStar 100 Unit/ML - 17 units at 19:43 Within approximately three hours Resident #108 administered 21 units of insulin. Blood Sugars:[DATE] 19:18: 332XXX[DATE] 22:03: 578XXX[DATE] 07:45: 313XXX[DATE] 12:53: 98XXX[DATE] 14:11: 188XXX[DATE]: 19:43 182.0 On [DATE] at 10:20 AM, Nurse Practitioner O stated Resident #108 was a new admission and they were not able to evaluate him prior to his readmission to the hospital. When an emergency occurs, the appropriate supplies should be available to facility staff. On [DATE] at 4:51 PM, Nurse T stated when she arrived for her shift Resident #108 had no diagnoses listed in his chart or emergency contacts. During the shift report there was nothing mentioned regarding shortness of breath or congestion. About 9:30 PM she first observed Resident #108, and he alert and oriented x4, pleasant demeanor with no complaints. A few hours later he had shortness of breath and she administered his rescue inhaler which provided him relief. At that time, he was still responding at his baseline. Some hours after administering his inhaler she found him foaming at the mouth, confused and decreased responsiveness which was a steep change in condition from a few hours prior. He would wake up to sternal rubs. His blood sugar low and they (Nurse T and two other nurses) were not able to administer medications to combat his hypoglycemia as there was no glucagon or IV dextrose on the crash carts. Nurse "T" stated another nurse went to the medication room as well but was unable to locate any. They started a line and ran saline until EMS arrived. Upon their arrival they did not have a medic but one did arrive about three or so minutes later and they worked on him outside of the facility. On [DATE] at 1:10 PM, Nurse N stated as she and another nurse were going into the medication room a code blue was paged from overhead on 700 unit. As she was enrolled in the unit she grabbed the</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> This Citation pertains to intake Number 2585749. Based on interview and record review, the facility failed to obtain a physician's order for urinary catheter per professional standards of practice for one resident (Resident #106), resulting in the potential for bladder injury, prolonged illness, and an indwelling catheter being left in place with no physician's order. Findings include: Resident #106: Record review of Resident #106's Minimum Data Set (MDS) dated [DATE] revealed that the resident had an indwelling urinary catheter. Medical diagnosis included: Atrial fibrillation, heart failure, renal insufficiency, wound infection, respiratory failure, cellulitis of lower limb, and lymphedema. Record review of Resident #106's 'Nursing admission Evaluation' assessment dated [DATE] revealed an indwelling catheter with clear yellow urine. Record review of Resident #106's physician order recap report for the month of January 2025 revealed that there was no physician's order for a urinary catheter ordered. Record review of Resident #106's nursing progress notes from January 9, 2025 through February 20th, 2025, noted upon discharge there was no mention urinary catheter care. Record review of Resident #106's January 2025 Medication Administration Record (MAR) and Treatment Administration Record (TAR) revealed there was no monitoring of urinary catheter, no order for when to change the urinary catheter, no order for a urinary catheter secured device. An interview and records review on 8/14/2025 at 11:28AM with the Director of Nursing (DON) regarding Resident #106's stay at the facility revealed the resident was admitted back on January 9, 2025, from the hospital setting. Record review of admission assessment had an indwelling catheter. Record review physician orders, no order for Foley catheter by physician, or for the urinary catheter to be discontinued. Record review of the MAR TAR for January &amp; February revealed there was no monitoring by nurses of the urinary catheter. Record review of care plans noted a catheter care plan started 1/9/2025. The DON stated that there should have been a physician order for the Foley catheter and monitoring on the treatment record by the nurses and to discontinue the urinary catheter would have to be done by a physician's order. Record review of the facility 'Physician Visits and Physician Delegation' policy dated 9/26/2024 revealed it is the policy of the facility to ensure the physician takes an active role in supervising the care of residents. (g.) A physician, physician assistant, nurse practitioner, or clinical nurse specialist must provide orders for residents' immediate care and needs. Record review of the facility 'Provisions of Quality Care' policy dated 1/1/2022 revealed that based on comprehensive assessments, the facility will ensure that residents receive treatment and care by qualified people in accordance with professional standards of practice. (4.) Qualified people will provide the care and treatment in accordance with professional standards of practice, the resident's care plan, and the resident's choices. Record review of Resident #106's transferred facility physician orders revealed that on 2/21/2025 to change indwelling Foley catheter (PRN) as needed clinically indicated with signs/symptoms of obstruction (leakage, increased sediment, etc.) infection, or if closed system was compromised.</p>		