STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235209	A. Building B. Wing	03/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Leelanau	124 West 4th Street Suttons Bay, MI 49682

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 - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on interview and record review, the facility failed to observe the consumption of medication for one Resident (R6) of one resident reviewed for quality of care. This deficient practice resulted in R6 consuming acetic acid with medications. Findings include:This citation pertains to intake 2788510 Resident #6 (R6) Review of a complaint received on 2/25/26 filed with the State Agency (SA) read in part, Complainant states a nurse.gave him his fluid, Acidic Acid, on 02/22/26, in a regular cup and didn't tell him what it was so he drank it. The acidic acid was for flushing out his catheter . On 3/23/26 at 4:00 PM, an interview was conducted with Registered Nurse (RN) G about R6 and receiving acetic acid and replied, (R6) was very upset about the situation and that is why I got called to talk with him and calm him down. What happened was (RN F) was training and brought in (R6's) medication including oral pills, a glass of water, and a glass of acetic acid in the same glass the water was in, so both glasses were identical with clear fluid. (RN F) forgot something and left (R6) with the medication and the glasses of clear fluid. (R6) took his medication after (RN F) left his room. (R6) took his medication with the acetic acid and not the water because he was not instructed on which glass was which and neither was labeled. The acetic acid was not even drawn up in a sterile manner. We are supposed to use the syringe we are flushing with or a sterile collection cup. On 3/24/26 at 9:45 AM, an interview was conducted with RN D who was orienting RN F on the day of the incident with R6. RN D stated, I got the acetic acid ready and (RN F) prepared (R6's) medications. I was not aware that she had gotten water for his medications. (RN F) did not even tell me what happened and I was unaware that (R6) drank his acetic acid flush with his medication. RN D was asked if she had witnessed RN F perform an indwelling catheter flush while RN F was on orientation and replied, No, I just explained the procedure to her. I did not know she was going to leave all the stuff in the room with him. During an interview on 3/24/26 at 12:05 PM with R6 in his room, R6 proceeded to tell this surveyor about the day of the incident when he drank acetic acid with his medications. R6 stated, (RN F) came into my room and gave me two glasses with clear liquid and set them on my bedside table on the right side of my bed with a cup of medications. (RN F) then left the room without witnessing me taking my medications. While I was taking my medications, I quickly became aware that what I was drinking was not water. I threw it out after that. I was told she forgot something and left my room to go get it. I became upset after that. (RN F) returned to my room after that and I told her to get out and not to return. She makes mistakes all the time. Once she brought me the wrong meds. I don't want her helping me. I don't trust her. They better keep her away from me. On 3/24/26 at 12:30 PM, an interview was conducted with the Director of Nursing (DON) who was asked if she was aware of the incident with RN F and R6 and replied, Yes, I did some reeducation with (RN F) and other staff. Review of RN Fs nursing competencies on 3/24/26 at 1:00 PM, revealed that RN F lacked any check off for flushing urinary catheters. Review of RN Fs personnel file revealed that RN F was on an extended orientation process.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, interview, and record review, the facility failed to ensure accurate and standards of practice of medication administration for two Residents (R47 and R59) of four residents reviewed for medication administration with 4 errors out of 29 opportunities resulting in a medication error rate of 14%. Findings include:Resident #47 (R47)On 3/24/26 at 8:06 AM, an observation was made of Registered Nurse (RN) F during a medication pass with R47. RN F prepared R47's medications and went to administer the medications to R47 in her room which included oral pills and subcutaneous insulin. R47 asked RN F if her diuretic was within the medication cup and RN F replied, Yes. R47 asked RN F to remove the medication from the cup, and she would take it after her appointment when she later returned to the facility. RN F left R47's room and returned to her medication cart. RN F opened her medication cart to visually see what the diuretic looked like and proceeded to look through R47's pills unable to identify the diuretic in R47's medication cup. While RN F went through R47's medication cup she touched three pills with her bare hands. RN F then returned to R47's room and administered R47 her medications including the diuretic without R47 knowing the medication was still in the cup. RN F was interviewed on 3/24/26 at 8:06 AM, during the preparation of R47's medications and asked where R47's nasal spray fluticasone propionate suspension was and replied, I am not sure. I guess I will have to go get a new one from back-up supply. During R47's medication preparation on 3/24/26 at 8:06 AM, RN F failed to clean the hub of the insulin lispro pen and primed the pen with two units of insulin holding the pen horizontal and not vertical. During the administration of R47's insulin lispro RN F held the injection site for two seconds and when RN F pulled R47's insulin pen away from her skin there was a drop of blood that immediately appeared from the injection site. (Error #1) On 3/24/26 at 8:30 AM, this surveyor performed a medication reconciliation of R47's medication administration record and identified the following errors:R47's diuretic (bumetanide) was signed out as being held and was given. (Error #2)R47's nasal spray was omitted and not given. (Error #3) An observation was made of the Cedar medication cart on 3/24/26 at 8:45 AM and lacked R47's nasal spray. On 3/24/26 at 9:15 AM, an interview was conducted with RN F who was asked if she replaced and dispensed R47's nasal spray and replied, No, I did not. I have to strike that out. On 3/24/26 at 9:30 AM, an interview was conducted with the Director of Nursing (DON) who was asked about medication administration and what her expectations were and replied, To follow the five or six rights of medication administration. Double check the orders while preparing medications. The DON agreed RN F improperly primed and prepared the insulin pen and failed to hold the insulin injection site for ten seconds. The DON stated, Medications should not be touched with bare hands. Resident #59 (R59)During a medication preparation for R59 on 3/25/26 at 7:50 AM, an observation was made of RN J preparing medications for R59. During medication preparation RN J dispensed one enteric coated aspirin 81 milligrams (mg) for R59 in a medication cup along with R59's other medications. RN J finished preparing R59's medications and was going to dispense R59's medications. RN J was asked if he had the correct aspirin type and went to double check the order. RN J replied, No, I do not. I need to replace the aspirin with a chewable form. (Error #4) On 3/25/26 at 8:50 AM, an interview was conducted with the Regional Director of Operations (RDO) L who was made aware of the medication administration error rate who replied, Yes, we knew this was going to be an issue because of yesterday. Review of policy titled, Medication Administration, dated 1/17/23, read in part Policy: Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infections. Policy Explanation and Compliance Guidelines.1. Keep medication carts clean, organized, and stocked with adequate supplies.11. Compare medication source with MAR to verify resident name, medication name, form, dose, route, and time of administration.b. Administer within 60 minutes prior to or after scheduled time unless otherwise ordered by physician. c. If other than PO route, administer in accordance with facility policy (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	for the relevant route of administration (i.e., injection, eye, ear, rectal, etc.).17. Sign MAR after administrated.20. Correct any discrepancies and report to nurse manager. Review of insulin lispro pen instructions obtained from website: https://pi.lilly.com/insulin-lispro-kwikpen-us-ifu.pdf, date retrieved 3/26/26, read in part .Preparing your pen.Step 1.wipe the rubber seal with an alcohol swab.Priming your pen.Step 7 Hold your pen with the needle pointing up.Giving your injection.Step 11 Insert the needle into your skin. Push the dose knob all the way in. Continue to hold the dose knob in and slowly count to 5 before removing the needle.