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

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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 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. Based on observation, interview, and record review, the facility failed to store medications properly and maintain a clean medication cart for one of two medication carts and two Residents (R24 and R48) of six residents reviewed for medication storage. Findings include:Resident #24 (R24) On 3/23/26 at 11:27 AM, an observation was made of R24 in his room. R24 had a bottle of fluticasone propionate solution nasal spray sitting on top of his nightstand. Resident #48 (R48) On 3/23/26 at 11:21 AM, an observation was made of R48 in her room. R48 had a fluticasone furoate/vilanterol inhaler new inhaler on her bedside table. R48 was asked how long she had the inhaler and replied, It is new. I think it has been about two months. During an interview on 3/23/26 at 12:15 PM, with Registered Nurse (RN) G who was asked about medications left at the bedside and replied, My bad. I left them sitting in there. I went to circle back. I just did not make it back yet. On 3/23/26 at 12:25 PM, an audit was made of medication cart on Wharf unit and was found to be out of compliance with debris in the second drawer and two medications found loose. The two loose medications were identified as famotidine 20 milligrams (mg) and bethanechol chloride 25 mg. Inside the top right small drawer was a medication in medication cup without a label identifying who or what it was. During an interview with RN D on 3/23/25 at 12:28 PM who was asked about the medication cup with the pill inside and replied, I got it ready and she was unavailable to administer. I should have put her name on the medication cup and what it was. I am currently training another nurse and that could have caused an error. RN D was asked about cleaning medication carts and replied, The nightshift nurses are responsible for cleaning medication carts. RN D was asked if she was aware of the small handheld cordless vacuum in the medication room and replied, Yes, I guess maybe I should clean the cart out. An interview was conducted on 3/23/26 at 12:45 PM, with the Director of Nursing (DON) regarding medication storage and replied, (R24) does not have an order for that medication, no care plan or assessed to self-administer medications. (R48) does not have an order for that medication to be left at the bedside. Medications should not be left at the bedside. Medication carts should be cleaned regularly, and no loose pills should be left or debris. Medications should be administered and returned back to the cart such as inhalers, nasal sprays, and insulins. On 3/24/26 at 11:45 AM, an observation was made of the medication cart on Cedar unit and was found to be unlocked and unattended by a nurse. At 11:50 AM, on 3/24/26 Certified Nurse Aide (CNA) K came walking down the unit on Cedar and was asked if he had seen RN F and if nurses usually let medication carts unlocked and unattended and replied, (RN F) was down on the Wharf unit. Nurses do not leave their medication carts unlocked to my knowledge, but that is a big no, no in my book. On 3/24/26 at 12:00 PM, an observation was made of RN F heading down to the Cedar unit. RN F was asked if she normally leaves her medication cart unlocked and unattended and replied slowly, No, I am sorry. 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 cart on Wharf being unlocked and unattended and replied, The problem has been addressed and taken care of. Review of policy titled, Medication Storage, dated 1/30/24, read in part Policy: It is the policy of this facility to ensure all medications housed on our premises will be (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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	stored according to the manufacture's recommendations and sufficient to ensure proper sanitation, temperature, light, ventilation, moisture control, segregation, and security. Policy Explanation and Compliance Guidelines: 1. General Guidelines: a. All drugs and biologicals will be stored in locked compartments (i.e., medication carts. 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.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on interview and record review, the facility failed to ensure a recapitulation of stay and the Long-Term Care Ombudsman were notified of a resident's discharge from the facility for one Residents (#74) of two residents reviewed for discharge practices.Findings include: Resident #74 (R74)Review of R74 Electronic Medical Record (EMR) revealed the resident was discharged from the facility on December 31, 2025, in police custody. Review of R74's EMR indicated there was not a recapitulation (a summary of the main points of the resident's treatments) of stay completed. Review of the documentation provided to the Long-Term Care Ombudsman in December 2025 indicated they were not notified of the resident's discharge from the facility. On 3/24/26 at 12:10 PM, an interview was conducted with the Nursing Home Administrator (NHA), when asked what discharges are expected to be on the Ombudsman list, he stated I have always been told emergency transfers only.On 3/24/26 at approximately 2:30 PM, during an interview with the Director of Nursing (DON) when asked if a recapitulation of stay was completed for R74, the DON stated the facility had a call with fellow department heads from sister facility's regarding R74's discharge, but there was never a recapitulation of stay completed.Review of the facility's policy titled Transfer and Discharge (including AMA) last revised on 10/30/23 indicated in part: .7. Emergency Transfers/Discharges-initiated by the facility for medical reasons, or for immediate safety and welfare of a resident.h. Document assessment findings and other relevant information regarding the transfer in the medical record.k. Social Services Director, or designee, shall provide notice of transfer to a representative of the State Long-Term Care Ombudsman via monthly list.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to perform Activity of Daily Living (ADL) care (finger and toenail trimming services) for one resident (R12) of one resident reviewed for ADL care. Findings include: Review of R12's Electronic Medical Record (EMR) revealed admission to the facility on 1/28/25 with diagnosis of malignant neoplasm of brain. R12's Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 3/15, indicative of severe cognitive impairment. On 03/23/2026 at approximately 11:50 AM, R12 was observed sitting in her room. An interview was attempted with R12, but she was unable to answer questions appropriately. It was observed that R12 was not wearing any socks or shoes at the time of the interview, and R12's fingernails and toenails appeared to be very long. On 03/24/2026 at 1:07 PM, R12 was observed to be walking down the hallway returning her lunch tray. R12 was not wearing any socks or shoes and had visibly long fingernails and toenails with debris noted underneath the nails. An interview was conducted with Certified Nurse Aide (CNA) B on R12's nails. CNA B stated that R12 receives hospice services who are supposed to trim R12's nails. However, the staff from hospice have not been routinely coming to the facility. CNA B confirmed that R12's fingernails and toenails were approximately a quarter inch in length. On 3/24/26 at approximately 1:30 PM, an interview was conducted with the Nursing Home Administrator (NHA) and Assistant Nursing Home Administrator/Registered Nurse (RN) E regarding R12's nail length. The NHA confirmed that the hospice staff that was to routinely come to the facility was replaced and they would investigate R12's nails further. On 3/24/26 at 2:22 PM, an interview was conducted with Assistant Nursing Home Administrator (NHA)/RN E who confirmed that R12's nail length for both finger and toenails are extremely long and were attempted to be trimmed but will need an order for podiatry to assess R12's nails. Review of R12's Care Plans read, in part, Resident has an ADL self-care performance deficit related to malignant neoplasm of the brain, epilepsy, communication deficit .Trim resident's fingernails and toenails biweekly and PRN (as needed) date initiated: 2/26/25 .

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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.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide restorative therapy services per the resident care plan for one Resident (R63) of one resident reviewed for restorative therapy. Findings include: Revealed admission to the facility on [DATE] with diagnoses including cerebral infarction. R63's 2/27/26 Minimum Data Set (MDS) assessment revealed a Brief Interview for Mental Status (BIMS) score of 6/15 indicative of moderate cognitive impairment. In Section O of the 2/27/26 MDS assessment, R63 received four days of Passive Range of Motion (PROM) and three days of splint or brace assistance.On 3/23/26 at 11:50 AM, R63 was observed sleeping in her bed with a hospital gown. It was observed that a wool therapy carrot (a specialized orthosis designed to position severely contracted hands) was on R63's bedside table. Residents' left hand noted to be severely contracted with no open space or view of R63's fingernails.On 3/24/26 at 9:51 AM, R63 was observed laying in bed, finishing her breakfast and drinking her coffee. An interview was conducted with R63 who asked why she was at the facility. It was noted that a wool therapy carrot was sitting on her bedside table. R63 was observed to only use her right hand for eating and drinking, with her left hand showing a severe contracture.On 3/25/26 at 9:25 AM, an interview was conducted with Therapy Director M regarding R63's contracture restorative therapy services. Therapy Director M stated that R63 was discharged from restorative therapy on 3/5/26 and was never placed back on until last night (3/24/26). Therapy Director M explained that R63 was discharged from restorative therapy so she could be evaluated from the therapy department for her contracture but was not picked up by therapy services. Therapy Director M confirmed that R63 should have been placed back on restorative therapy and had not received any range of motion or splint assistant services since 3/5/26.On 3/25/26 at 9:51 AM, an interview was conducted with Restorative Aide N regarding R63's contracture and restorative therapy services. Restorative Aide N stated that she had a meeting with the Director of Nursing (DON) on 3/4/26 and discussed discharging R63 from restorative so therapy could evaluate and possible treat R63's left hand. Restorative Aide N stated that the next time she came to work with R63, she was unable to pull her medical records, indicating that she was not on restorative therapy services, and therefore, did not perform any PROM or splint assistance. Restorative Aide N stated that R63 is willing to participate in restorative therapy services with her, but it does take timeReview of R63's Progress Notes dated 3/3/26 and written by Occupational Therapist (OT) O read, in part, OT screen completed for L (left) hand contractures. Pt (patient) does not tolerate any passive movement of L fingers, unable to place washcloth or any other object in between fingers and palm.therapy indicated Y/N (Yes/No): (left blank) If therapy indicated, specify discipline(s) PT, OT and/or ST (Physical Therapy, Occupational Therapy, Speech Therapy): (left blank).Review of R63's Care Plans read, in part, Resident would benefit from a restorative rang of motion program related to contracture, decreased strength in lower extremities, decreased strength in upper extremities, hemiplegia, limitation in range of motion.interventions: observed for changes in ROM and report to nurse and Physician/Therapy as appropriate, passive range of motion to left lower extremities and left upper extremities in all planes 1 set of 20 reps.Provide range of motion program LUE/LLE (Left Upper Extremity/Left Lower Extremity) ROM Supine 3x (times) a week x 20 minutes to tolerance.

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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.