STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235243	A. Building B. Wing	10/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Gtc	2950 Lafranier Road Traverse City, MI 49686

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 0627 Level of Harm - Actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235243	A. Building B. Wing	10/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Gtc	2950 Lafranier Road Traverse City, MI 49686

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 0627 Level of Harm - Actual harm Residents Affected - Few	This deficient practice pertains to Intake 2646261.Based on interview and record review, the facility failed to ensure a safe community discharge for one Resident (#1) of three residents reviewed for transfer and/or discharge. This deficient practice resulted in the need for repeated emergency room visits for Resident #1 due to the inability to care for a colostomy (a surgical procedure that creates an opening in the abdominal wall to divert fecal matter from the colon to the outside of the body) and infection of the colostomy site. Findings include:Resident #1 (R1)Review of R1's electronic medical record (EMR) revealed initial admission to the facility on 9/20/25 with diagnoses including aftercare following surgery on the digestive system, perforation of the intestine, and colostomy status. Review of R1's discharge Minimum Data Set (MDS) assessment, dated 10/6/25, revealed a Brief Interview for Mental Status (BIMS) score of 13, indicative of intact cognition.Review of an intake submitted by Physician Assistant (PA) A to the State Agency (SA) on 10/20/25 read, in part: I am the primary care provider for [R1]. She was hospitalized .from 9/12/2025 through 9/20/2025 and was discharged . for subacute rehab following her bowel perforation which required surgery on 9/12/2025 unfortunately with end colostomy. [R1]. has poor family support as she only has 1 living relative nearby who works full-time. She went to subacute rehabilitation 9/20/2025 and was discharged home. During the time she was there [at the facility], she had staples in place which were supposed to be removed on day 10-14 postop (post-operative), this was not done. I saw the patient [on] 10/10/2025 and had to send her to the emergency department as she was 28 days postop with staples still in place. They [facility] also made no effort to get her a follow-up with the surgeon, she had no scheduled appointment with the surgery office after she left the facility, and [R1] is not able to do these things on her own. [R1] has now been back in the ER (emergency room) 3 separate times because of complications from being discharged home too early. [R1] cannot ambulate independently.and had spilled her [colostomy] bag all over the floor multiple times.On 10/22/25 at 11:01 AM, a telephone interview was conducted with PA A who verified she evaluated R1 on 10/10/25 in an outpatient clinic. PA A stated, When she [R1] came into the office, I saw she still had staples that needed to be removed because the facility hadn't scheduled a follow-up appointment with the surgeon . I ended up sending her to the ER to have them removed. PA A noted 10/10/25 was 28 days after the initial surgery while R1 was directed to follow-up with the surgeon within 10-14 days. PA A stated she wanted the ER to rule out infection at the incision because the area appeared red and inflamed. PA A stated R1's colostomy was not attached and leaking stool and R1 reported she was unable to secure the leak.Review of an Emergency Department Triage Document, dated 10/10/25, read, in part: Chief Complaint: Sent from post op followup [sic]; sx (symptoms) to see with staple removal. Review of an Emergency Department Triage Document, dated 10/13/25, read, in part: Chief Complaint: c/o (complains of) lightheadedness. Cold, shaking. home health care says [wound] looks infected.Review of a Wound/Skin/Ostomy Care Note in the Emergency Medicine Department, dated 10/13/25, read, in part: .[R1] with colostomy placement 3 weeks ago and discharged to SAR (subacute rehabilitation). Now home a week. I changed the 2-piece appliance that was dated for 11 days ago.Peristomal skin with mild partial thickness contact dermatitis (a condition in which the skin becomes red, sore, or inflamed).Review of a report titled, Emergency/UC [Urgent Care] Documents, dated 10/13/25, read, in part: .This is a.female.with end colostomy. since being home she has had some difficulties. She notes she cannot really empty her ostomy bag and she has only done it once and made a mess. she has had some dehiscence from her wound. Patient presents secondary to abdominal pain, shaking, lightheaded, need for help with ostomy care. Patient lives alone. seems like she is needing increased support in the home setting.her wound culture is growing.E.coli (a type of bacterium commonly found in the intestines of humans), Augmentin would be adequate coverage. Disposition: discharged to Home.Review of a document titled, Misc. [Miscellaneous] Patient Care Documents, dated 10/16/25, revealed additional results of the wound culture collected on 10/13/25 from R1's abdominal wall contained Staphylococcus aureus (a bacterial human pathogen).Review of a Transition of Care document, dated 10/16/25, written by PA A, read, in part: .I saw the patient [R1] in follow-up on 10/10/25 and she still had her staples in place (28 days later), had no idea how to manage her ostomy.and essentially had no one available to available to help her at home. She did go directly to the ER that same day and get her staples removed. She then went to the emergency department on 10/13/25 with essential failure to thrive.they [ER] did collect a wound culture; it shows Staphylococcus aureus. I had a long discussion with the patient today [10/16/25] and I think she is unsafe to be living at home and needs to consider going in for placement. Essentially, she

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235243	A. Building B. Wing	10/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Gtc	2950 Lafranier Road Traverse City, MI 49686

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. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235243	A. Building B. Wing	10/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Gtc	2950 Lafranier Road Traverse City, MI 49686

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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This deficient practice pertains to Intakes 2646261 and 2647525.Based on interview and record review, the facility failed to coordinate post-surgical care and follow established bowel protocol for two Residents (#1 and #2) of three residents review for quality of care.Findings include:Resident #1 (R1)Review of R1's electronic medical record (EMR) revealed initial admission to the facility on 9/20/25 with diagnoses including aftercare following surgery on the digestive system, perforation of the intestine, and colostomy status (a surgical procedure that creates an opening in the abdominal wall to divert feces from the colon to the outside of the body). Review of R1's discharge Minimum Data Set (MDS) assessment, dated 10/6/25, revealed a Brief Interview for Mental Status (BIMS) score of 13, indicative of intact cognition.Review of an intake submitted by Physician Assistant (PA) A to the State Agency (SA) on 10/20/25 read, in part: I am the primary care provider for [R1]. She was hospitalized .from 9/12/2025 through 9/20/2025 and was discharged . for subacute rehab following her bowel perforation which required surgery on 9/12/2025 unfortunately with end colostomy.During the time she was there [at the facility], she had staples in place which were supposed to be removed on day 10-14 postop (post-operative), this was not done. I saw the patient 10/10/2025 and had to send her to the emergency department as she was 28 days postop with staples still in place. They [facility] also made no effort to get her a follow-up with the surgeon, she had no scheduled appointment with the surgery office after she left the facility, and [R1] is not able to do these things on her own.Review of a document titled, Hospital Summary, dated 9/20/25, read, in part: .Discharge Recommendations: Follow up in clinic in 1-2 weeks.On 10/23/25 at 10:25 AM, an interview was conducted with Scheduler F who stated the facility protocol for new admissions is to review discharge instructions from the hospital, ascertain the correct doctor to follow up with, and call and schedule the appointment. Scheduler F explained it is preferential for the facility to schedule follow-up appointments to ensure facility transportation is available. When asked, Is there any time a resident would be expected to schedule their own follow-up appointments? Scheduler F replied, No. When Scheduler F was asked if a follow-up appointment was scheduled for R1, she stated she called the surgeon's office to schedule an appointment, and they directed her to remove the staples in-house [in the facility]. Scheduler F stated she did not have documentation she made the call to the surgeon's office, but she informed former Unit Manager/Registered Nurse (UM/RN) I of the directive. Scheduler F was unsure if R1's staples ever were removed.On 10/23/25 at 10:27 AM, an interview was conducted with Registered Nurse (RN) H at R1's surgeon's office. RN H stated the office had no record of a call from the facility to schedule a follow-up appointment.On 10/23/25 at 11:30 AM, a telephone interview was conducted with former UM/RN I who stated she never received a report from Scheduler F which indicated R1's staples were to be removed in the facility.Review of R1's EMR revealed the following physician's order, initiated 10/1/25, 11 days after her initial admission: Monitor abd (abdominal) surgical site for complications every shift.On 10/23/25 at 11:43 AM, an interview was conducted with UM/RN B regarding the management of R1's abdominal staples. UM/RN B stated she never received a report to remove R1's staples but had been, watching them and they were, looking good. UM/RN B stated she was waiting for R1's follow-up appointment to be scheduled but did not indicate why she did not check-in with Scheduler F after 14 days had elapsed. UM/RN B confirmed post-operative surgical site checks should occur daily but was unsure why R1's physician order for surgical site monitoring started on 10/1/25, 11 days after her initial admission. Prior to 10/1/25, UM/RN B stated daily monitoring was completed visually and not documented unless an issue was observed.On 10/23/25 at 11:24 AM, an interview was conducted with Social Services Director (SSD) J who verified she was responsible for ensuring follow-up appointments were scheduled for residents upon discharge from the facility. When asked if all follow-up appointments were scheduled for R1, SSD J stated she was only aware of the need to see her primary care physician.Review of R1's EMR revealed the following the following entries: New Follow Up Note on 10/6/25 at 9:32 PM by Nurse Practitioner (NP) C: 10-2. They [family] are also concerned about post-op follow up. They did not have the information or recall that they were to make a post-up appt [appointment] (in) 10-14 days. Today is day 13. New Follow Up Note on 10/6/25 at 9:32 PM by NP C: 10/4 - Surgical site midline abdomen still has staples, with skin healing around staples and patient reports wanting to scratch. New Follow Up Note on 10/6/25 at 9:32 PM by NP C: 10/6- Discharge planned for later this afternoon.Patient still needs post-op follow up and staple removal from abdominal incision.On 10/22/25 at 11:01 AM, a telephone interview was conducted with PA A who verified she evaluated R1 on 10/10/25 in an outpatient

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235243	A. Building B. Wing	10/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Gtc	2950 Lafranier Road Traverse City, MI 49686

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 0880 Level of Harm - Actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235243	A. Building B. Wing	10/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Gtc	2950 Lafranier Road Traverse City, MI 49686

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 0880 Level of Harm - Actual harm Residents Affected - Some	This deficient practice pertains to Intake 2647525.Based on interview and record review, the facility failed to implement infection control measures and ensure comprehensive infection surveillance to prevent the transmission of scabies (a highly contagious skin condition caused by parasitic itch mites that burrow into the skin). This deficient practice resulted in transmission of scabies with associated physical discomfort for six Residents (#2, #3, #4, #5, #6, #7) of twenty residents reviewed for infection control.Findings include:Resident #2 (R2)Review of R2's EMR revealed initial admission to the facility on 7/13/20 with diagnoses including anoxic brain damage and cognitive communication deficit.On 10/22/25 at 1:44 PM, a telephone interview was conducted with Family Member (FM) K regarding R2's care at the facility. FM K stated R2 had two recent dermatology appointments in which R2 was diagnosed with a scabies infection. FM K voiced concerns regarding the facility's efforts in preventing the spread of the infection.Review of R2's Dermatology Visit Note, dated 9/3/25, read, in part: Chief Complaints: Follow-Up Rash. Location : trunk.Rash type: itchy, red, and bleeding.Since the Last Visit the Rash is: spreading and worse. Impression/Plan: Scabies - Will presumptively treat for scabies given clinical appearance, degree of pruritus and nursing home residency. Plan: Counseling. Scabies is an infestation of mites that is very contagious. Household contacts should be treated. Plan: Prescription. Permethrin 5% topical cream.apply full tube of cream to entire body, from neck to toes at bedtime. Repeat one week later.Review of R2's EMR revealed the following physician's order, initiated 9/4/25: Permethrin External Cream 5 % (Permethrin). Apply to entire body topically one time only for [sic] apply full tube of cream to entire body, from neck to toes until 09/05/2025 21:00 [9:00 PM]. Leave on for 8hrs (hours), then wash off. Change all bedding. Repeat x1 wk (week) AND Apply to entire body topically one time only for [sic] apply full tube of cream to entire body, from neck to toes until 09/11/2025 21:00 Leave on for 8hrs, then wash off. Change all bedding.A review of the facility's monthly infection surveillance for September 2025 with Assistant Director of Nursing (ADON) H on 10/23/25 at 12:15 PM revealed no documentation of R2's treatment for scabies, implementation of transmission-based precautions to prevent spread of the infection or monitoring of other residents for signs and symptoms of the infection. When ADON H was asked why these elements were not recorded as part of the infection control program, she replied R2 was being treated prophylactically, and it wasn't an active infection or confirmed diagnosis. ADON H acknowledged the CDC (Centers for Disease Control and Prevention) guidelines recommended implementation of contact precautions for 24 hours after initiation of therapy for scabies, but it was not put into effect due to the prophylactic nature of R2's medicinal treatment. Review of R2's Dermatology Visit Note, dated 10/8/25, read, in part: Chief Complaint: follow up Rash. Impression/Plan: Crusted Scabies - enact scabies protocols according to facility/state Michigan guidelines. Linear burrows.and crusting distributed on the right radial dorsal hand, arms, legs, and trunk. Status: inadequately controlled. Expectations: scabies is an infestation of mites that is very contagious. Household contacts should be treated. Contaminated clothing should be isolated x 72 hours and washed and dried on high heat. Plan: Scabies Prep. A Scabies prep was performed on the right radial dorsal hand, showing mites.On 10/23/25 at 1:33 PM, a telephone interview was conducted with the Director of Nursing (DON) regarding the facility's response to R2's dermatology appointment on 10/8/25 which indicated crusted scabies. The DON stated the facility conducted skin assessments on all residents and identified 19 residents who presented with a rash of unknown etiology who were subsequently treated with a scabicidal.Resident #3 (R3)Review of R3's EMR revealed an Interdisciplinary Progress Note, dated 10/14/25 at 12:18 PM, which read, in part: .nursing - permethrin cream for suspected scabies.On 10/24/25 at 9:00 AM, an interview was conducted with R3 who confirmed she had an extensive rash on her chest and arms which required treatment. R3 stated the rash, itched terribly and remained, though not as bad.Resident #4 (R4)Review of R4's EMR revealed a Progress Note, dated 10/14/25 at 8:00 AM, which read, in part: .Resident exposed to confirmed scabies case; presenting with pruritic rash consistent with scabies infestation.Resident #5 (R5)Review of R5's EMR revealed a Progress Note, dated 10/14/25 at 8:00 AM, which read, in part: .Resident exposed to confirmed scabies case; presenting with pruritic rash consistent with scabies infestation.Resident #6 (R6)Review of R6's EMR revealed the following entries:Progress Note, 10/16/25 at 8:00 AM: .Chief complaint: rash is spreading. Pt [patient] seen for the above hydrocortisone was ineffective, the rash has spread to his opposite arm and down his abdomen. He complains of severe itch, especially at night. Suspect scabies, recent in outbreak in facility New Follow Up Note, 10/23/25 at 1:06 PM: .he states he is only uncomfortable due to his full body