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	01/07/2026

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This deficient practice pertains to Intakes 2704447 and 2691458.Based on interview and record review, the facility failed to obtain informed consent prior to changing a code status for one Resident (#1) of five residents reviewed for resident rights.Findings include: Resident #1 (R1):Review of the Electronic Medical Record (EMR) revealed R1 was a [AGE] year-old male who admitted to the facility on [DATE] with diagnoses including malignant neoplasm (cancerous tumor) of the tonsil and lymph node, dysphagia (difficulty swallowing food or liquids), and pneumonitis (inflammation or swelling of the lung tissue). Further review of R1's EMR revealed a physician's advanced directive order, initiated 11/17/25, that read, Full Resuscitate (the complete medical effort to revive an individual from apparent death or unconsciousness). Review of R1's Brief Interview for Mental Status (BIMS) Examination, dated 11/22/25, revealed a score of 15, indicative of intact cognition. Review of a document titled, Advanced Directives Acknowledgements/CPR Consent signed by R1 on 11/17/25 read, in part: .CPR is an attempt to restart your heart and breathing. It could include pressing hard on your chest to try to restart your heart and placing a tube in your windpipe to connect to the breathing machine. Electric shock to your heart and medications to support your heart may be included . R1 selected, Resuscitation: in the event of a cardiac arrest I am requesting CPR.Review of an Interdisciplinary (IDT) Progress Note on 12/7/25 at 12:00 PM written by the NHA read, in part: .9:15 AM - [Certified Nursing Assistant (CNA) Z] entered [R1's] room to obtain vitals; noted resident with eyes and mouth open, resident was not responsive to touch or name. RN [Q] assessment included feeling for pulse, felt ankles, oral mucous dry, mottling from waist to feet and listened for respirations with stethoscope for 1 minute. 9:24 AM - RN Q notified NHA and DON [Director of Nursing] that [R1] is deceased and it was an irreversible death. 9:28 AM - RN M verified [R1's] code status was a full code. 9:30 AM - CPR initiated by RN M. 9:39 AM - CPR stopped. 9:47 AM - EMS [emergency medical services] and police arrived. 9:51 AM - Patient TOD [time of death] called by [acute care hospital] Physician.On 1/6/26 at 9:24 AM, a telephone interview was conducted with CNA Z who verified she was the primary nurse aide on duty for R1's unit on the morning of 12/7/25. CNA Z remembered she heard a code blue (an emergency code signaling a patient needs immediate resuscitation prompting trained staff to rush to the location to provide life-saving interventions) called on the overheard speakers for R1's room at approximately 9:30 AM. CNA Z indicated she assisted in the code with two other CNAs and three other nurses. CNA Z recalled RN Q came into the room in the middle of performing CPR and indicated R1's code status and changed to DNR [do not resuscitate] and life sustaining measures could be stopped. CNA Z said, I remembered everybody was so confused [how R1's code status changed]. Maybe we were missing something. Maybe [the DON] got a hold of the physician or something we were unaware of.Review of a witness statement written by RN M on 12/8/25 at 10:06 AM read, in part: At approximately 9:30 [AM on 12/7/25] I became aware that there was a (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
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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	patient who had died on A-North [hall]. I secured my Hall and my patients and I went to A North to talk to the nurse [RN Q], who said she had a death. I immediately asked for the code status and she said it was a DNR [do not resuscitate]. I noticed the chart she was reading was not the patient who died. I pointed that out and directed her to the patient's chart where it said full code where I directed her to immediately begin CPR call code blue and call 911. During CPR the pads were applied no shock was advised and CPR was continue[d] . shortly after that, [RN Q] came to the room on the phone and advised us we could stop CPR under order of a doctor. She had [the DON] on the phone. we noted the time and discontinued CPR.On 1/6/25 at 2:52 PM, a telephone interview was conducted with RN M who confirmed the events in his witness statement which included beginning life sustaining efforts on R1 on the morning of 12/7/25. RN M stated shortly after beginning bag-valve-mask (BVM) ventilation (a handheld device used to provide manual positive pressure ventilation to individuals who can't breathe adequately on their own), RN Q entered R1's room with a phone to her ear and said to stop CPR. RN M stated he was hesitant to stop so he questioned RN Q as to who was on the other end of the phone and she replied, [the DON]. RN M verified CPR stopped at that point.On 1/5/26 at 1:50 PM, an interview was conducted with Licensed Practical Nurse (LPN) O who verified she was working on the morning of 12/7/25 and responded to the code blue for R1. LPN O stated upon her arrival to the scene she took over compression when RN Q walked into the room and said, Stop, stop, stop! [performing CPR]. LPN O stated RN Q was questioned on who told them to stop the code and she replied, [the DON]. LPN O stated RN Q was the charge nurse that morning and she therefore followed the orders of her direct supervisor [and stopped the code].On 1/6/25 at 7:48 AM, an interview was conducted with the DON who confirmed she received a call from RN Q on the morning of 12/7/25. The DON recollected RN Q stating that there was, a dead guy in room [ROOM NUMBER] and he's been dead for hours. The DON stated she informed RN Q if the resident was a full code to run the code and stop when EMS arrived or a physician order was received. The DON denied giving RN Q an order to stop life sustaining efforts on R1. When the DON asked if there was ever a situation in which life-sustaining measures are not expected to be called for a full code resident, she replied, A full code is a full code is a full code. I want to eliminate any grey area. I'd prefer they [staff] run it.On 1/6/25 at 9:02 AM, a telephone interview was conducted with RN Q who verified she had contacted the DON during the code blue on 12/7/25. RN Q stated during her phone call with the DON, she misunderstood and thought the DON said she had contacted a doctor and had received an order to stop CPR. RN Q stated it was not until after the events that she learned the DON told her she [RN Q] would have to get a physician's order or wait until EMS arrived before stopping CPR.On 1/6/25 at 9:44 AM, a follow-up telephone interview was conducted with RN Q who recalled in the middle of the code blue, she contacted an on-call provider to change R1's code status to a DNR [do not resuscitate]. When asked how R1's code status could be changed from a full-code to a DNR without his consent, RN Q replied, That's a good question, I don't know the answer to that.Review of R1's EMR revealed the following telehealth encounter note written by Physician Assistant (PA) BB, effective 12/7/25 at 8:00 AM and created 12/7/25 at 11:28 AM: .Notified by nursing staff resident [R1] passed away.CPR started, code status changes to DNR. On 1/6/26 at 2:00 PM, a telephone interview was conducted with PA BB who verified she had been contacted on the morning of 12/7/25 regarding R1's condition. PA BB stated RN Q asked her to change R1's code status to a DNR because, imminent death was suspected. When asked how R1's code status could be changed from a full code to a DNR without his consent, PA BB replied, Isn't it the same thing? I was just going based off what nursing staff told me.On 1/6/25 at 11:58 AM, an interview was conducted with Nurse Practitioner (NP) L regarding R1's sudden change in code status. NP L replied, That's impossible. NP L further (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	explained a code status changed required a signature of the declarant, a physician signature, and the signature of two witnesses.Review of Michigan Public's Health Code, Section 333.1053 read, in part: .MICHIGAN DO-NOT-RESUSCITATE PROCEDURE ACT. (1) Subject to section 5, an individual who is [AGE] years of age or older and of sound mind may execute a do-not-resuscitate order on his or her own behalf. A patient advocate of an individual who is [AGE] years of age or older may execute a do-not-resuscitate order on behalf of that individual. (2) An order executed under this section shall be on a form described in section 4. The order shall be dated and executed voluntarily and signed by each of the following persons: (a) The declarant, the declarant's patient advocate, or another person who, at the time of the signing, is in the presence of the declarant and acting pursuant to the directions of the declarant. (b) The declarant's attending physician. (c) Two witnesses [AGE] years of age or older, at least 1 of whom is not the declarant's spouse, parent, child, grandchild, sibling, or presumptive heir. (3) The names of all signatories shall be printed or typed below the corresponding signatures. A witness shall not sign an order unless the declarant or the declarant's patient advocate appears to the witness to be of sound mind and under no duress, fraud, or undue influence.

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This deficient practice pertains to Intakes 2704447 and 2691458.Based on interview and record review, the facility failed to perform timely emergency medical care and Cardiopulmonary Resuscitation (CPR) for one Resident (#1) of five residents reviewed for quality of care, resulting in the death of Resident #1.Findings include:The Immediate Jeopardy (IJ) began on 12/7/25 at 9:15 AM when Registered Nurse (RN) Q discovered R1 without pulse or respirations and failed to initiate emergency life-sustaining measures resulting in the death of R1 at 9:51 AM on 12/7/25 despite his designated full code status. The Nursing Home Administrator (NHA) was notified of the IJ on 1/6/26 at 12:27 PM. At that time, a written immediacy removal plan was requested from the facility. This surveyor confirmed by interview and record review the immediacy was removed on 1/7/26 at 11:51 AM, however, noncompliance remained at the potential for more than minimal harm due to sustained compliance which has not been verified by the State Agency (SA).Resident #1 (R1):Review of the Electronic Medical Record (EMR) revealed R1 was a [AGE] year-old male who admitted to the facility on [DATE] with diagnoses including malignant neoplasm (cancerous tumor) of the tonsil and lymph node, dysphagia (difficulty swallowing food or liquids), and pneumonitis (inflammation or swelling of the lung tissue). R1's EMR revealed a physician's advance directive order, initiated 11/17/25, that read, Full Resuscitate (the complete medical effort to revive an individual from apparent death or unconsciousness). Review of R1's Brief Interview for Mental Status (BIMS) Examination, dated 11/22/25, revealed a score of 15, indicative of intact cognition. Review of a document titled, Advanced Directives Acknowledgements/CPR Consent signed by R1 on 11/17/25 read, in part: .CPR is an attempt to restart your heart and breathing. It could include pressing hard on your chest to try to restart your heart and placing a tube in your windpipe to connect to the breathing machine. Electric shock to your heart and medications to support your heart may be included . R1 selected, Resuscitation: in the event of a cardiac arrest I am requesting CPR.Review of an Interdisciplinary (IDT) Progress Note on 12/7/25 at 12:00 PM written by the NHA read, in part: .9:15 AM - [Certified Nursing Assistant (CNA) Z] entered [R1's] room to obtain vitals; noted resident with eyes and mouth open, resident was not responsive to touch or name. RN [Q] assessment included feeling for pulse, felt ankles, oral mucous dry, mottling from waist to feet and listened for respirations with stethoscope for 1 minute. 9:24 AM - RN Q notified NHA and DON [Director of Nursing] that [R1] is deceased and it was an irreversible death. 9:28 AM - RN M verified [R1's] code status was a full code. 9:30 AM - CPR initiated by RN M. 9:39 AM - CPR stopped. 9:47 AM - EMS [emergency medical services] and police arrived. 9:51 AM - Patient TOD [time of death] called by [acute care hospital] Physician.On 1/6/26 at 9:24 AM, a telephone interview was conducted with CNA Z who verified she was the primary nurse aide on duty for R1's unit on the morning of 12/7/25. CNA Z stated at 9:15 AM on 12/7/25, she walked into R1's room to obtain his morning vitals and observed R1 lying in bed. CNA Z recalled as she walked closer to the bedside, it appeared as if R1 was not breathing. CNA Z stated after R1 did not respond to touch or his name, she immediately notified RN Q of an emergency, who was standing at the medication cart at the opposite end of the hallway. CNA Z reported after she called out to RN Q for help she replied, What is it? instead of making her way down the hall. CNA Z stated she ran down the hall and told RN Q that R1 was unresponsive in his bed. CNA Z recalled RN Q had many medications on the cart as pharmacy just made a delivery and approximated it took RN Q two minutes to put away the medications and walk to R1's room. CNA Z stated when RN Q arrived to R1's room she assessed his wrist pulse, his ankle pulse, stated, he's passed, and covered his entire body with a sheet. CNA Z stated they both walked out (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	of the room and RN Q indicated she would have to verify R1 was deceased with her stethoscope which was located back at the medication cart. CNA Z recalled RN Z returned to her medication cart and administered another resident their morning medications before returning to R1's room with a stethoscope. CNA Z stated upon arrival to R1's room, RN Q pulled back the sheet, listened to R1's heart, covered R1 back up with the sheet and walked out of the room. CNA Z remembered she was confused when approximately 15 minutes later [at 9:30 AM] she heard a code blue (an emergency code signaling a patient needs immediate resuscitation prompting trained staff to rush to the location to provide life-saving interventions) called on the overheard speakers for R1's room number after a nurse on the opposite unit [RN M] discovered R1's full-code designation. CNA Z indicated she assisted in the code by recording events and times throughout the code and recalled, Every nurse in the building was in that room [R1's] but her [RN Q]. CNA Z stated RN Q came into the room in the middle of performing CPR and indicated R1's code status had changed, and life sustaining measures could be stopped. CNA Z said, I remembered everybody was so confused [how R1's code status changed]. Maybe we were missing something. Maybe [the DON] got a hold of the physician or something we were unaware of. When asked if she was surprised by R1's sudden death, CNA Z said, I was very much so a shock this happened. he was supposed to be discharged that coming Friday [12/12/25].Review of a witness statement written by RN M on 12/8/25 at 10:06 AM read, in part: At approximately 9:30 [AM on 12/7/25] I became aware that there was a patient who had died on A-North [hall]. I remember it's striking me as odd that the CNA had such a [NAME] attitude about a patient death. When I became aware of it, I secured my Hall and my patients and I went to A North to talk to the nurse [RN Q], who said she had a death. I immediately asked for the code status and she said it was a DNR [do not resuscitate]. I noticed the chart she was reading was not the patient who died. I pointed that out and directed her to the patient's chart where it said full code where I directed her to immediately begin CPR call code blue and call 911. While she called the code blue and called 911 I grabbed the crash cart and went down to the patient's room when I opened the door I observe[d] the patient with a sheet draped completely over the body. I removed the sheet and checked response of of [sic] the patient. He [R1] was not responsive. He was pulseless and not breathing. During CPR the pads were applied no shock was advised and CPR was continue[d] . shortly after that, [RN Q] came to the room on the phone and advised us we could stop CPR under order of a doctor. She had [the DON] on the phone. we noted the time and discontinued CPR.On 1/6/25 at 2:52 PM, a telephone interview was conducted with RN M who confirmed the events in his witness statement written on 12/8/25. RN M recounted upon his initial arrival to the room, audible tones could be heard coming from R1's trachea. RN M verified R1 was pulseless and breathless upon arriving and when asked if R1 displayed signs of, irreversible death, RN M stated, Absolutely not. RN M further explained he did not witness mottling (patchy, web-like, or marbled discoloration of the skin), lividity (the purplish-red skin discoloration that occurs after death from blood settling in the lowest parts of the body due to gravity), or rigor mortis (muscle rigidity). When asked the temperature of R1's body upon assessment, RN M replied, I do not recall him being cold to the touch, and that's not something I would rely on in an emergency situation to indicate death anyway. RN M stated shortly after beginning bag-valve-mask (BVM) ventilation (a handheld device used to provide manual positive pressure ventilation to individuals who can't breathe adequately on their own), RN Q entered R1's room with a phone to her ear and said to stop CPR. RN M stated he was hesitant to stop so he questioned RN Q as to who was on the other end of the phone and she replied, [the DON]. RN M verified CPR stopped at that point.On 1/5/26 at 1:50 PM, an interview was conducted with Licensed Practical Nurse (LPN) O who verified she was working on the morning of 12/7/25. LPN O stated she heard the code blue (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	paged overhead and ran to the opposite side of the building where she saw RN Q sitting at the nurse's station on the phone. LPN O remembered asking RN Q where the emergency was to which she replied, Don't be too worried, I think he's been gone for a couple hours. LPN O stated upon her arrival to the scene there were two CNAs and three nurses in the room and she took over compression when RN Q walked into the room and said, Stop, stop, stop! LPN O stated RN Q was questioned on who told them to stop the code and she replied, [the DON]. LPN O stated RN Q was the charge nurse that morning and she therefore followed the orders of her direct supervisor [and stopped the code].On 1/7/26 at 8:43 AM, a follow-up interview was conducted with LPN O regarding her initial clinical assessment of R1. LPN O recalled R1 was gray in color but did not show signs of irreversible death including rigor mortis, lividity, or mottling of the lower extremities.On 1/6/25 at 7:48 AM, an interview was conducted with the DON who confirmed she received a call from RN Q on the morning of 12/7/25. The DON recollected RN Q stating that there was, a dead guy in room [ROOM NUMBER] and he's been dead for hours. When asked how RN Q knew the duration of R1's death, the DON guessed it was because RN Q indicated R1 was, cold. The DON stated she informed RN Q if the resident was a full code to run the code and stop when EMS arrived or a physician order was received. The DON denied giving RN Q an order to stop life sustaining efforts on R1. When the DON asked if there was ever a situation in which life-sustaining measures are not expected to be called for a full code resident, she replied, A full code is a full code is a full code. I want to eliminate any gray area. I'd prefer they [staff] run it.On 1/6/25 at 9:02 AM, a telephone interview was conducted with RN Q who verified she was alerted by CNA Z that R1 was unresponsive in his room on the morning of 12/7/25 at approximately 9:15 AM. RN Q stated, When I first got in there, he was obviously cold. I felt he was very cold and very dead. When asked the outcome of her clinical assessment, RN Q stated she recalled taking a wrist pulse which was absent. RN Q remembered leaving R1's room to retrieve her stethoscope. Upon returning, RN Q stated she listened for R1's apical pulse (the heartbeat heard at the apex of the heart) and pulled down the sheet where she observed mottling in R1's legs. When questioned, RN Q stated, I did not know his [R1's] code status. When asked if she would have called a code blue after the first assessment had she known R1's full code status, RN Q replied, Yes. RN Q stated during her phone call with the DON, she misunderstood and thought the DON said she had contacted a doctor and had received an order to stop CPR. RN Q stated it was not until after the events that she learned the DON told her she [RN Q] would have to get a physician's order or wait until EMS arrived before stopping CPR.On 1/6/25 at 9:44 AM, a follow-up telephone interview was conducted with RN Q who recalled in the middle of the code blue, she contacted an on-call provider to change R1's code status to a DNR [do not resuscitate]. When asked how R1's code status could be changed from a full code to a DNR without his consent, RN Q replied, That's a good question, I don't know the answer to that.Review of R1's EMR revealed the following telehealth encounter note written by Physician Assistant (PA) BB, effective 12/7/25 at 8:00 AM and created 12/7/25 at 11:28 AM: .Notified by nursing staff resident [R1] passed away.CPR started, code status changes to DNR. On 1/6/26 at 2:00 PM, a telephone interview was conducted with PA BB who verified she had been contacted on the morning of 12/7/25 regarding R1's condition. PA BB stated RN Q asked her to change R1's code status to a DNR because, imminent death was suspected. When asked how R1's code status could be changed from a full code to a DNR without his consent, PA BB replied, Isn't it the same thing? I was just going based off what nursing staff told me.On 1/6/25 at 11:58 AM, an interview was conducted with Nurse Practitioner (NP) L regarding R1's sudden change in code status. NP L replied, That's impossible. NP L further explained a code status change required a signature of the declarant, a physician signature, and the signature of two witnesses. In regard to R1's overall (continued on next page)

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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 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	health, NP L stated, I was very surprised he died. I wouldn't be surprised if he went back to the hospital, but I was surprised he died. When asked about emergency life-sustaining measures expectations for full code residents, NP L stated qualified facility staff are obligated to perform CPR until an order to stop is received from an on-site physician or med control (the physician oversight of EMS).On 1/6/25 at 9:25 AM, a telephone interview was conducted with CNA AA who verified she was working on R1's unit on the morning of 12/7/25. When asked how many minutes elapsed between finding R1 unresponsive and initiating CPR, CNA AA replied, Too many. and I'm a CPR instructor.On 1/6/25 at 11:04 AM, an interview was conducted with the Director of Rehabilitation (DOR) who stated R1 was progressing in therapies and planning to discharge soon. The DOR stated, I was surprised [R1] died.Review of R1's Physical Therapy Evaluation and Plan of Treatment, dated 11/18/25, read, in part: .Patient Goals: 1. To walk again and move to [State]. Potential for Achieving Rehab Goals: Patient demonstrates good rehab potential.Review of the facility policy titled, Cardiopulmonary Resuscitation (CPR) & Basic Life Support (BLS), reviewed 12/1/22, read, in part: The purpose of this policy is to provide guides for the initiation of Cardiopulmonary Resuscitation (CPR)/Basic Life Support (BLS) in victims of sudden cardiac arrest. Cardiac arrest is defined as inadequate cardiac contraction resulting in adequate blood flow; pulselessness. Procedures for administered CPR shall incorporate the steps covered in the American Heart Association, BLS training from the American Red Cross. The goal of early delivery of CPR is to try to maintain life until the emergency medical response team arrives to deliver Advanced Life Support (ALS). If a resident experiences a cardiac arrest or respiratory arrest and the resident does not show obvious clinical signs of irreversible death (e.g., rigor mortis, dependent lividity, decapitation, transection, or decomposition), facility staff must provide basic life support, including CPR, prior to the arrival of emergency medical services in accordance with the resident's advanced directives and any related physician order, such as code status. the licensed nurse or designed licensed personnel on each shift is response for coordination the rescue effort and directing other team members during the rescue effort until EMS has arrived.Review of the American Heart Association's 2025, Adult Basic Life Support Algorithm for Health Care Professionals, read, in part: .check for responsiveness.look for no breathing and check pulse.no breathing or only gasping, pulse not felt.start CPR.continue until ALS professionals take over or person starts to move.Review of Michigan Public's Health Code, Section 333.1053 read, in part: .MICHIGAN DO-NOT-RESUSCITATE PROCEDURE ACT. (1) Subject to section 5, an individual who is [AGE] years of age or older and of sound mind may execute a do-not-resuscitate order on his or her own behalf. A patient advocate of an individual who is [AGE] years of age or older may execute a do-not-resuscitate order on behalf of that individual. (2) An order executed under this section shall be on a form described in section 4. The order shall be dated and executed voluntarily and signed by each of the following persons: (a) The declarant, the declarant's patient advocate, or another person who, at the time of the signing, is in the presence of the declarant and acting pursuant to the directions of the declarant. (b) The declarant's attending physician. (c) Two witnesses [AGE] years of age or older, at least 1 of whom is not the declarant's spouse, parent, child, grandchild, sibling, or presumptive heir. (3) The names of all signatories shall be printed or typed below the corresponding signatures. A witness shall not sign an order unless the declarant or the declarant's patient advocate appears to the witness to be of sound mind and under no duress, fraud, or undue influence.The Immediate Jeopardy that began on 12/7/25 was removed on 1/7/26 at 11:51 AM when the facility took the following actions to remove the immediacy: Licensed Nurses are receiving education on the policy for CPR, including confirming code status in the medical record, assessing when to initiate CPR, when CPR can be stopped, and pronouncing death. (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	01/07/2026

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 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Education was initiated with licensed nurses on properly assessing prior to initiating CPR: -Check for pulse -Observe chest rise -Listen and feel for breathing -Observe skin and body findings Education was initiated with licensed nurses on Cardiopulmonary Resuscitation (CPR) & Basic Life Support (BLS) policy which identifies the following: -If the resident is a full code, facility staff must provide basic life support, including CPR, prior to the arrival of emergency medical services unless obvious clinical signs of irreversible death are present. -Clinical signs of irreversible death include rigor mortis, dependent lividity, decapitation, transection, or decomposition. -The licensed nurse on each shift is responsible for coordinating the rescue effort and directing other team members during the rescue effort until EMS has arrived. Education was initiated with licensed nurses that a resident may be declared dead by a Licensed Physician or Registered Nurse with physician authorization in accordance with state law per policy. Licensed nurses will be educated prior to working their next shift.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This deficient practice pertains to Intakes 2704447 and 2691458.Based on interview and record review, the facility failed to ensure medical records were accurately documented in accordance with professional standards and practices for one Resident (#1) of five residents reviewed for accurate medical records.Findings include:Resident #1 (R1):Review of the Electronic Medical Record (EMR) revealed R1 was a [AGE] year-old male who admitted to the facility on [DATE] with diagnoses including malignant neoplasm (cancerous tumor) of the tonsil and lymph node, dysphagia (difficulty swallowing food or liquids), and pneumonitis (inflammation or swelling of the lung tissue).Review of an Interdisciplinary (IDT) Progress Note on 12/7/25 at 12:00 PM written by the Nursing Home Administrator (NHA) read, in part: .9:15 AM - [Certified Nursing Assistant (CNA) Z] entered [R1's] room to obtain vitals; noted resident with eyes and mouth open, resident was not responsive to touch or name. RN [Q] assessment included feeling for pulse, felt ankles, oral mucous dry, mottling from waist to feet and listened for respirations with stethoscope for 1 minute. 9:24 AM - RN Q notified NHA and DON [Director of Nursing] that [R1] is deceased and it was an irreversible death.On 1/6/25 at 9:02 AM, a telephone interview was conducted with RN Q who verified she was the primary nurse responsible for R1's care on the morning of 12/7/25 and ultimately called a code blue. When asked if the event was documented in R1's medical chart, RN Q stated she remembered charting it in under some area in the EMR but was unsure of the exact location.Review of a report titled, # 1154 Code Blue, dated 12/7/25 at 9:30 AM read, in part: Resident: [R1]. Incident Location: Resident's Room. Person Preparing Report: [DON].On 1/6/25 at 10:10 AM, an interview was conducted with the DON regarding the code blue incident which occurred on 12/7/25. The DON stated she was not at the facility at the time of the incident and had not documented the report titled, # 1154 Code Blue but assumed it was RN Q's documentation. When asked why the incident was not documented under RN Q's own name, the DON surmised RN Q did not know how to open the appropriate assessment herself, therefore it was done for her by another staff member.On 1/6/25 at 10:15 AM, an interview was conducted with the NHA who stated all staff are required to document under their own name in the medical record.