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	03/04/2026

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

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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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide the necessary treatment and services to prevent the development and promote the healing of pressure injuries for two Residents (#9 & #1) of three residents reviewed for wounds. This deficient practice resulted in the development of an unstageable pressure ulcer on the right foot of Resident (#9) and the deterioration of a left gluteus pressure injury from a stage three to an unstageable wound for Resident (#1).Findings include: Resident #1 (R1) Review of the Minimum Data Set (MDS) assessment, dated 1/6/2026, revealed R1 was admitted to the facility on [DATE] and had diagnoses including Parkinson's Disease, central cord syndrome (spinal cord damage), left side hemiparesis (weakness) and polyneuropathy. Further review of the MDS assessment revealed R1 required substantial/maximal assistance with bed mobility and transfers, was cognitively intact and exhibited no rejection of care behaviors during the assessment period. On 3/3/2026 at 7:35 a.m., R1 was observed in his room seated in a wheelchair watching television. It was noted during the observation, R1's lower legs, ankles and feet were swollen. R1 reported the swelling in his lower legs happened from sitting up in his wheelchair for long periods and it often improved upon laying down. When asked if he had any open wounds, R1 reported having a wound on his buttocks. R1 stated, I think it's from sitting too long and from my clothes, it was healed once. R1 reported he required assistance from staff and a mechanical lift to reposition and transfer due to spinal cord damage he obtained from a fall prior to being admitted to the facility. On 3/3/2026 at 11:35 a.m. R1 was observed in his room seated in a wheelchair watching television. R1 was asked if staff had been in to assist him to bed to reposition to which he reported he had been seated in his wheelchair since this Surveyor's previous observation at 7:35 a.m. It was noted four hours had lapsed between observations, indicating R1 was seated in his wheelchair for four hours without offloading pressure from his buttocks. During an interview on 3/3/2026 at 11:38 a.m., Certified Nursing Assistant (CNA) A reported R1 was very cooperative during care and did not have a history of declining interventions. CNA A was queried regarding R1's turning and repositioning schedule. CNA A reported R1 was assisted with transferring to lay down or sit in his recliner after meals. On 3/3/2026 at 12:43 p.m. R1 was observed seated in his wheelchair in the hall outside of the dining room. R1 was asked if he had been out of his chair since he was last observed in his room at 11:35 a.m. R1 reported he had remained in the chair then stated he would, probably after lunch, I'll go in the (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0686 Level of Harm - Actual harm Residents Affected - Few	recliner. It was noted that more than five hours had elapsed since R1 was initially observed seated in his wheelchair at 7:35 a.m. Review of the March 2026 point of care (POC) documentation titled, Turn and reposition per care plan and PRN [as needed], revealed CNA A documented R1 was turned and repositioned at 6:00 a.m., 8:00 a.m., 10:00 a.m. and 12:00 p.m. It was noted the documentation was contrary to R1's report and the continued observations of the Resident seated in his chair. On 3/3/2026 at 1:25 p.m., R1 was observed in the dining room seated in his wheelchair. During an interview on 3/3/3036 at 1:30 p.m. CNA A reported she planned on transferring R1 from the wheelchair to his recliner after lunch. When asked about R1's routine for offloading pressure from his buttocks, CNA A stated R1, Usually wakes up around 5:00 a.m. and nightshift gets him up. CNA A reported she provided catheter care to the resident every four hours. When asked about her documentation of turning and repositioning R1 this day at 8:00 a.m., 10:00 a.m. and 12:00 p.m., CNA A confirmed she did not reposition R1 every two hours and stated, We do lift him up, when I do catheter care, I use the sit-to-stand to lift him up. When asked to clarify, CNA A reported she used the sit-to-stand mechanical lift to assist the resident to stand while she performed catheter care every four hours then sat the resident back down in the wheelchair and counted the care as repositioning. Review of R1's wound evaluation, dated 2/25/2026 at 4:53 p.m. revealed the following: Left gluteus . Pressure ulcer/injury. Progress: Deteriorating: wound characteristics deteriorated . Stage 3 Pressure ulcer/injury – full thickness skin . Wound acquired in-house. Signs and symptoms of infection: non-healing wound . Further review revealed wound measurements as: length 2.56 cm (centimeters), width 4.07 cm, depth 1.1 cm, and an area 7.8 cm2 (centimeters squared). The description of the wound bed was assessed as being 90 percent (%) covered with slough (yellow, white or tan colored dead tissue) with 10% of the wound bed left without description. The peri-wound (area directly surrounding the wound) was assessed as having rolled edges (epibole, indicating stalled healing) and unattached. The tissue surrounding the wound was assessed as, fragile. Review of R1's wound evaluation, dated 2/18/2026 at 2:31 p.m., revealed the following: Left gluteus . Pressure ulcer/injury. Progress: Improving: overall wound characteristics improved . Stage 3 Pressure ulcer/injury – full thickness skin . Wound acquired in-house . Length (cm) 3.06. Width (cm) 1.97. Depth (cm) 1.6. Area (cm2) 4.41 . The wound bed assessment was documented as 90% granulation (red or pink healing tissue) and 10% slough with attached wound edges. No epibole was noted in the assessment. The surround tissue was documented as, fragile. In review of the wound evaluations it was noted R1's left gluteal wound increased in size from 2/18/2026 to 2/25/2026 as indicated by the increased size of the wound of 2.10 cm in width, 0.5 cm in depth and 3.39 cm2 in area and the wound bed progressing from 90% healing tissue to 90% covered with slough with epibole of the peri-wound area. Further review of R1's EMR, including all wound evaluations, revealed the wound was documented as a new wound on 12/8/2025. Review of the wound evaluation dated 12/8/2025 revealed the left gluteal wound was assessed as MASD (moisture-associated skin damage) with measurements of 2.9 cm length, 1.8 cm width, 0.2 cm depth and an area of 3.8 cm2. No description of the wound bed was included in the evaluation. Review of the left gluteal wound evaluation dated 12/22/2025 revealed (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	R1's was documented as an unstageable, pressure ulcer. Review of R1's comprehensive care plan revealed the following: Resident has an ADL [Activities of Daily Living] self-care performance deficit . Transfers: with 2 person assist and use of mechanical lift. Initiated: 12/22/2024. Resident has impaired skin integrity as evidenced by [history] of chronic MASD sacrococcygeal/glutes area . Assist resident with turning and repositioning upon rising and after meals/therapy, as HS [bedtime] and during care rounds at night. Dated Initiated 12/22/2024. Resident is at risk for impaired skin integrity related to wounds . Assist resident with turning and repositioning as needed. Dated Initiated: 12/22/2024. It was noted in review of R1's care plan, no new interventions were initiated after the Resident's left gluteal wound progressed from MASD to an unstageable pressure ulcer as documented on 12/22/2025. During an interview on 3/4/2026 at 10:30 a.m., Unit Manager/Registered Nurse (RN) D revealed R1's weekly wound evaluations were completed in the afternoons, and she would attempt to complete an evaluation later that day as R1, likes to wait until afternoon. RN D reported R1's most recent evaluation, dated 2/25/2026, revealed worsening of the wound from a healing Stage 3 wound to an unstageable (wound bed covered with necrotic tissue) due to nearly 100% of the would bed obscured. RN D was asked about R1's turning and repositioning scheduled to which she stated, We usually try to do after meals. He likes to be in his chair most of the time. Asked if the provision of catheter care constituted turning and repositioning to which she answered, Depends on how they do the care. RN reported resident lift with sit to stand while catheter care is provided may work as repositioning depending on how the resident was seated when placed back in the wheelchair. When asked if she was aware staff were documenting every two-hour repositioning, she stated they are supposed to be doing rounds every two hours and offering repositioning at that time. RN D reported all refusals by R1 to reposition should be documented in the EMR. During an interview on 3/4/2026 at 10:40 a.m. the Director of Nursing (DON) reported all refusals of care should be documented in the EMR. The DON stated if a resident refused at one time to turn/reposition or offload pressure that staff should still be approaching the Resident on a consistent basis to offer assistance and provide education related to the need to offload pressure from wounds. The DON reported refusals to turn and reposition should never be normalized as the refusal may only be situational and documentation of refusals was necessary to determine ongoing care planning. The DON confirmed the CNAs lifting R1 to stand during catheter care and immediately placing the Resident back in the chair seated on his buttocks did not constitute turning and repositioning or provide enough offloading to allow tissue to recover from the continued pressure of being seated in the wheelchair. Review of the facility policy titled, Pressure Injury Prevention and Management, last revised 3/20/2024, revealed the following: Interventions for Prevention and to Promote Healing . Evidence-based interventions for prevention will be implemented for all residents who are assessed at risk or who have a pressure injury present. Basic or routine care interventions could include, but are not limited to . redistribute pressure (such as repositioning, protection and/or offloading .) . (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of the National Pressure Injury Advisory Panel (NPIAP) guideline titled, Repositioning for Pressure Injury Prevention dated 2/25/2025 and accessed on 3/12/2026 (https://www.internationalguideline.com/repositioning), revealed the following: Extended periods of lying or sitting on a particular part of the body without redistributing the pressure leads to deformation of tissues and, ultimately if damage thresholds are exceeded, tissue damage in the form of a PI [pressure injury]. Repositioning and mobilization are essential preventive measures for reducing PI occurrence. The recommendations and good practice statements presented below are generally relevant to all individuals at risk of PIs . Good Practice Statement: It is good practice to reposition the individual in such a way that optimal offloading of pressure points and maximum redistribution of pressure are achieved . It is good practice to determine appropriate and individualized repositioning intervals based on a comprehensive assessment of the individual's: level of activity and mobility; ability to independently reposition; skin and tissue tolerance; . goals of care . It is good practice to assess for signs of early skin and tissue injury that may meal the individual requires more frequent repositioning or preferential positioning off damaged areas . Resident #9 (R9): Review of R9's Electronic Medical Record (EMR) revealed initial admission to the facility on 1/28/26 with diagnoses including paraplegia (an impairment in motor and/or sensory function of the lower extremities) and aftercare following surgery on the skin and subcutaneous tissue (the deepest layer of the skin, primarily composed of fat and loose connective tissue). Review of R9's acute care Discharge Summary on 1/27/26 read, in part: .Procedures and Treatments Provided: Left ischial (a bone located in the pelvis that bears weight while sitting or lying) pressure wound reconstruction with V-Y advancement flap (a reconstructive surgical technique used to repair skin defects by advancing a triangular island of tissue into a wound, with the donor site closed in a Y-configuration). Patient education: .[Brand Name] bed (a specialized air-fluidized therapy bed designed for advanced wound care) only. Review of a physician order, dated 2/5/26 at 20:48 [8:48 PM], read: Staff to monitor resident to ensure that his feet are not resting against the inner ridge of sand bed causing pressure areas - may use pillow or other appropriate device. Review of R9's EMR revealed the following entries: Skin Issue on 2/17/26 at 12:07 PM: .New skin Issue. Location: Right lateral [outside] foot. Issue type: Pressure ulcer / injury. Progress: New: new wound. Pressure ulcer staging: Unstageable pressure ulcer / injury. Wound acquired in-house. Length (cm) [centimeters]: 0.82 Width (cm): 0.98 Depth (cm): 0 Area (cm2): 0.61. Skin Issues Note: Resident is on a Sand bed and part of the air flow was and is not working properly. The air ring around the sand part of the bed was/is not filling with air and resident's right foot was leaning against it causing this wound, call to schedule repair made and is set for tomorrow. Pertinent Charting – Skin on 2/17/26 at 14:06 [2:06 PM]: Location of skin area being documented: right lateral foot. Resident is on a Sand bed and part of the air flow was and is not working properly. The air ring around the sand part of the bed was/is not filling with air and resident's (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	right foot was leaning against it causing this wound. On 3/4/26 at 12:55 PM, an interview was conducted with Unit Manager/Registered Nurse (RN) D regarding the development of the unstageable pressure injury to R9's right foot. RN D stated when she came into R9's room to complete wound treatments on 2/17/26, she noted his right foot was in contact with a malfunctioning deflated portion of a cushion made of a hard plastic surrounding the perimeter of the bed. RN D estimated the air flow had become compromised at some point during the night and R9's foot had been in contact with the inner edge of the sand bed for approximately 12 hours until it was discovered the next day which had ultimately caused the injury. This Surveyor attempted to contact R9 who was hospitalized on [DATE] for an unrelated concern; R9 was unavailable for interview.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to maintain best practices in the food service area resulting in the potential to spread food borne illness to all residents that consume food from the kitchen. Findings Include:On 3/2/2026 at 11:20 AM, the floor, sewage drain lines and floor drain under the three-compartment sink were observed soiled with dirt and food debris. On 3/2/2026 at 11:22 AM the drain line coming from the 2-compartment vegetable wash sink was observed soiled. On 3/2/2026 at 12:04 PM The floor under the hand sink was observed soiled. On 3/2/2026 at 12:05 PM, when asked who was responsible for cleaning of floors and equipment in the kitchen Dietary Director (DD) confirmed, that the dietary staff are responsible for these tasks, not the maintenance staff. According to the 2022 FDA Food Code section 6-501.12 Cleaning, Frequency and Restrictions. (A)PHYSICAL FACILITIES shall be cleaned as often as necessary to keep them clean. On 3/2/2026 at 12:08 PM 12 room trays were observed with uncovered cake on the Hall B North delivery speed rack. On 3/2/2026 at 12:26 PM during meal pass observed CNA K remove the lunch tray from the speed rack. The meal was covered with a protective lid and the cake was uncovered. CNA K took the tray into the resident's room. According to the 2022 FDA Food Code section 3-307 Preventing Contamination from Other Sources 3-307.11Miscellaneous Sources of Contamination. Food shall be protected from contamination that may result from a factor or source not specified under Subparts 3-301 -3-306. During lunch observations on 3/2/26 at 12:08 PM, a cart used to transport meal trays to residents eating in rooms was noted to be placed in the south hallway. When the cart was opened, it was observed that 12 chocolate cakes were not covered in plastic wrapping. Staff were observed to be transporting the uncovered chocolate cakes from the cart down the hallway to resident rooms. At 12:17 PM a second cart was observed to have 11 uncovered chocolate cakes. At 12:52 PM a third cart was observed with eight uncovered chocolate cakes.

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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 securely and discard expired medications in two of two medications rooms and two of three medication carts reviewed for medication storage.Findings include:On 3/3/26 at 12:30 PM, an observation was made of medication cart located on East Hall and was found to be out of compliance with the following 14 loose medications in the second and third drawers where a moderate amount of medication debris and paper backings were also noted:Lamotrigine 200 mg (milligrams) with imprinting of D 96 and scored on the back side and light blue in color shaped like a shield with six-sides,Klor-Con M20 20 mEq (milliequivalents) with imprint KC M20, white oblong,Haloperidol 10 mg (half tab) pill card was found to have full tabs, light green in color and oblong with imprint 08,Levetiracetam Extended Release 500 mg white oblong with imprint HH 172,Losartan Potassium 50 mg green oval with imprint E 46 (2 tabs found),One white round pill without any markings and unable to identify,Metoprolol Succinate Extended-Release 25 mg white oblong with imprint I 25,Amlodipine Besylate 5 mg white round with imprint C 127 (2 tabs found),Apixaban 5 mg pink oval with imprint 894 5,Amlodipine Besylate 5 mg with round with imprint V 21,Olanzapine 2.5 mg white oblong with imprint R 2.5 / 0163,Metoclopramide Hydrochloride 5 mg white round with imprint TV / 2204,Three insulin pens were dated after being opened, but lacked an expiration date.On 3/3/26 at 12:40 PM, an interview was conducted with Licensed Practical Nurse (LPN) N who was asked why there were so many loose pills in the medication cart and replied, I guess it is because the pill cards are so tightly packed in there. LPN N was asked how often the medication carts were cleaned out and replied, I am not sure, but night shift does that.On 3/3/26 at 12:45 PM, an observation was made of the medication storage room for East Hall which was found to be out of compliance. One opened vial of tuberculin purified protein derivative 1 ml (milliliter) with an opened date of 1/13/26 was in the storage area and had no expiration date written.On 3/3/26 at 12:50 PM an interview was conducted with LPN N who was asked how long the vial was good for after opening and if it should still be in the active medication storage supply and replied, It should only be kept for 30 days after opening and have an expiration date. The vial should not still be in the refrigerator and needs to be thrown away.On 3/3/26 at 1:00 PM, an observation was made of medication cart located on North Hall and was found to be out of compliance with the following 3 loose medications in the second and third drawers where a moderate amount of medication debris and paper backings were also noted:Carbidopa and Levodopa 25/100 mg yellow round tab with imprint APO 25/100,Amlodipine 2.5 mg white round with imprint 2.5,Levetiracetam 500 mg yellow oblong with imprint H 88.On 3/3/26 at 1:10 PM, an interview was conducted with Registered Nurse (RN) Q who was asked about loose pills in the medication cart and replied, The Unit Manager just looked in the medication cart, and I am not sure why the loose pills are still in there. RN Q stated, The cards are tight and that she did dispense the Levodopa/Carbidopa this morning.On 3/4/26 at 8:05 AM, an interview was conducted with the Director of Nursing (DON) and the Nursing Home Administrator (NHA) who both were asked about medication storage expectations and acknowledged that loose pills, clean medication carts, and expired medications were unacceptable. The DON stated, The medication carts and rooms are audited by the night shift nurse. The DON was asked if there was a check off sheet indicating the task was competed and dated and replied, I would have to check. No definitive documentation was provided by the close of survey indicating when the last cleaning or audit of the medication carts and storage was performed.Review of policy titled, Medication Storage, 1/30/24, read in part, Policy: It is the policy of this facility to ensure all medications housed on our premises will be stored according to the manufacturer's recommendations and sufficient to ensure proper sanitation, temperature, light, ventilation, moisture control, segregation, and security. Policy Explanation and Compliance Guidelines.7. Unused (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Medications: The pharmacy and all medication rooms are routinely inspected by the consultant pharmacist for discontinued, outdated, defective, or deteriorated medications with worn, illegible, or missing labels. These medications are destroyed in accordance with our Destruction of Unused Drugs Policy.Review of policy titled, Medication Administration, 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 infection. Policy Explanation and Compliance Guidelines: 1. Keep medication carts clean, organized, and stocked with adequate supplies.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake #2732400Based on observation, interview, and record review, the facility failed to:Provide Resident #49 (R49) sanitary catheter care,Provide a sanitary barrier and administration for medication,Implement and utilize enhanced barrier precautions (EBP) while performing Resident #12 (R12) high contact care administering medication via feeding tube,Maintain facility equipment in a sanitary manner, and;Ensure personal protective equipment (PPE) was stored in a sanitary manner.Findings include:On 3/3/2026 at 9:21 AM, the B Side Nurses Station soiled utility room hopper was observed soiled. The water was clean but observed the bowl with grime build up. Personal Protective Equipment (PPE) items including opened and closed boxes of gloves, face shields and face masks were observed stored on wire racks directly across from the bowl of the hopper. One closed box was within 10 inches of the bowl, and opened boxes were within 18 inches of the soiled hopper. This practice exposed all these items ot overspray from the hopper spray nozzle. On 3/3/2026 at 11:24 AM observed Registered Nurse (RN) M getting face shields and other PPE out of the Soiled Utility room to dispense to staff. Record review of the facilities policy – Personal Protective Equipment Revised 12/7/2023 stated Policy Explanation and Compliance Guidelines: 6. PPE Supply Management: a. The central supply clerk is responsible for ordering and maintaining adequate PPE supplies and stocking in appropriate facility locations to ensure access to staff who need them. Resident #49 (R49) On 3/2/26 at 12:43 PM, an interview was conducted with R49 who was asked if he had any recent urinary tract infection (UTI) and replied, Yes, I have had a few over the last couple of months. R49 was asked if the care assistance use PPE while providing cares and replied, They do not always wear a gown while performing catheter care. Review of R49's Minimum Date Set (MDS), dated [DATE], indicated that R49 had intact cognition. On 3/2/26 at 2:19 PM, a chart review was conducted for R49, which revealed a recent hospitalization on 12/12/25 and 1/13/26 for a UTI and a recent hospitalization on 2/19/26 for another UTI. During an observation on 3/3/26 at 9:40 AM, with Certified Nurse Aide (CNA) O who was performing catheter care on R49 the following occurred: CNA O gathered washcloths (four) and added warm water, CNA O came out of the bathroom and placed the washcloths over the right-side bedrail of R49's bed, CNA O wiped R49's peri area with the first washcloth then proceeded to remove the trash bag form R49's garbage can and remove a clear bag to add the dirty linens in (no visible soap residue was observed after using the first wash cloth, CNA O continued to clean R49's peri area with the other three washcloths, CNA O then removed the soiled brief from R49 and replaced it with a clean one, (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	CNA O did not change her gloves or use hand sanitizer during the entire process, CNA O knocked over R49's water bottle with a rubber straw on to the floor that had visible dirt and old French fries on the floor and placed it back on to R49's bedside table. An interview was conducted with CNA O on 3/3/26 at 9:53 AM, who was asked about hand hygiene and why she did not use a barrier for the washcloths or change her gloves while providing catheter care and replied, I don't know. I should have. I normally use a barrier. On 3/3/26 at 7:25 AM, an observation was made of Licensed Practical Nurse (LPN) N drawing up insulin for Resident #28 (R28). LPN N drew up R28's insulin lispro and placed it on the top of her medication cart without a barrier. On 3/3/26 at 7:28 AM, an observation was made of LPN N entering R28's room and placing the insulin syringe on the top of the dresser without a barrier. On 3/3/26 at 7:30 AM, an interview was conducted with LPN N regarding barriers to ensure medications were sanitary and replied, I forgot to place a barrier and should have. Resident #12 (R12) On 3/3/26 at 9:03 AM, an observation was made of LPN N administering medications to R12 via peg tube without wearing a gown. During an interview on 3/3/26 at 9:20 AM, LPN N was asked if she should have been wearing PPE during the administration of medication via feeding tube with R12 and replied, I forgot. I should have been wearing a gown. I did not mean to do that. It was an error on my part. Review of R12's physician order, dated 2/2/26, revealed an order to Use enhanced barriers while performing high-contact activity with the resident r/t (related to) Tube Feed. On 3/4/26 at 12:35 PM, an interview was conducted with R12 in her room who was asked if staff are consistently wearing PPE while providing care related to her tube feed and replied, No, they do not wear a gown while providing cares. Review of R12's MDS, dated [DATE], indicated that R12 had intact cognition. Resident #8 (R8) On 3/3/26 at 12:20 PM, an observation was made of LPN N dispensing an antianxiety medication for R8. LPN N touched the antianxiety medication with her bare hands and then administered the medication to R8. On 3/3/26 at 12:22 PM, an interview was conducted with LPN N who was asked why she touch the medication for R8 with her bare hands and did not give him a different medication and replied, I touched it because it was stuck in the packaging and I should have put gloves on. On 3/4/26 at 7:35 AM, during an interview, Registered Nurse (RN)/Unit Manger R was made aware of the breaches in infection control during cares between staff and residents and replied, I will let the (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	infection control nurse know and they can address this. On 3/4/26 at 12:05 PM, an interview was conducted with the Director of Nursing (DON) and the Nursing Home Administrator (NHA) who were both asked about infection control and resident cares. Both the NHA and the DON acknowledged errors and breaches with the above observations in staff to resident interactions. Review of policy, Personal Protective Equipment, dated 12/7/23, read in part Policy: This facility promotes appropriate use of personal protective equipment to prevent the transmission of pathogens to residents, visitors, and other staff.Policy Explanation and Compliance Guidelines: 1. All staff who have contact with residents and/or their environment must wear personal protective equipment as appropriate during resident care activities and at other times in which exposure to blood, body fluids, or potentially infectious materials is likely.4. Indications/considerations for PPE use.Change gloves and perform hand hygiene between clean and dirty tasks.

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. Based on observation, interview, and record review, the facility failed to ensure appropriate consents for restraints were in place for two Residents (#54 & #107) of three residents reviewed for restraints.Findings include:Resident #54 (R54)Review of R54's Electronic Medical Records (EMR) revealed admission to the facility on 7/11/25 with diagnoses including vascular dementia with anxiety and muscle weakness. R54's 1/23/26 Quarterly Minimum Data Set (MDS) assessment revealed a Brief Interview for Mental Status (BIMS) score of 2/15, indicating severe cognitive impairment.On 3/3/26 at 9:05 AM, R54 was observed sitting in a geri chair (a specialized recliner for limited mobility) in her room. An interview was attempted with R54, but she was unable to answer questions appropriately.A request to the Nursing Home Administrator for R54's consent was emailed on 3/3/26 at 12:16 PM.On 3/4/26 at 8:12 AM, review of R54's consent revealed it was electronically signed by the Designated Power of Attorney (DPOA) on 3/3/26.Review of R54's EMR revealed a Physical Restraint Elimination Review for the use of R54's geri chair began on 9/18/25 and was reviewed monthly, with the last completed assessment on 2/23/26.Review of R54's Physical Restraint Elimination Review dated 9/18/25 was marked for the following categories for the use of a geri chair restraint, Disoriented, Unable to follow directions, waits for needed assistance, no fears/anxieties expressed, not taking psychotropic medications, unsteady gait, unstable balance, non-ambulatory/uses wheelchair for assistance, non-weight bearing, no falls, requires assistance with ADL's (activities of daily living). R54's Physical Restraint Elimination Review read, in part, Resident utilizes geri chair for positioning and comfort . R107Review of R107's EMR revealed admission to the facility on 5/21/25 with diagnoses including Alzheimer's disease and history of falling. R107's 12/8/25 Quarterly MDS assessment revealed a BIMS score of 3/15, indicating severe cognitive impairment.On 3/3/26 at 11:45 AM, R107 was observed sitting in a geri chair out in the main hallway. R107 was currently sleeping.On 3/4/26 at 11:28 AM, R107 was observed sitting in a geri chair in the hallway. R107's head was reclined all the way back, with R107 attempting to lift her legs to lift herself out of the geri chair. A request to the Nursing Home Administrator for R54's consent was emailed on 3/4/26 at 8:25 AM.On 3/4/26 at 8:56 AM, review of R107's consent revealed it was electronically signed by the Designated Power of Attorney (DPOA) on 3/3/26.Review of R107's EMR revealed a Physical Restraint Elimination Review for the use of R107's geri chair began on 9/19/25 and was reviewed monthly, with the last completed assessment on 2/23/26.Review of R107's Physical Restraint Elimination Review dated 9/18/25 was marked for the following categories for the use of a geri chair restraint, Disoriented, Unable to follow directions, waits for needed assistance, no fears/anxieties expressed, not taking psychotropic medications, unsteady gait, unstable balance, non-ambulatory/uses wheelchair for assistance, non-weight bearing, no falls, requires assistance with ADL's (activities of daily living). R107's Physical Restraint Elimination Review read, in part, Resident utilizes geri chair for positioning and comfort . An interview with the Nursing Home Administrator (NHA) was conducted on 3/4/25 at 11:43 AM, The NHA stated that the facility did not feel geri chairs were being used as a restraint, despite labeling them as a restraint in both R107 and R54's EMR. The NHA agreed that consents should have been signed when the geri chairs were set into place in September 2025 for both residents. Review of the facility's Restraint Policy dated 10/26/23 read, in part, Restraints shall only be used for the safety and well-being of the resident(s) and only after other alternatives have been tried unsuccessfully.Restraints shall only be used upon the written order of a physician and after obtaining consent from the resident and/or representative (sponsor).

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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 the Long-Term Care Ombudsman was notified of a resident's discharge from the facility for two Residents (#7 & #12) of two residents reviewed for discharge practices.Findings include:Resident #7 (R7) Review of R7's Electronic Medical Record (EMR) revealed the resident was discharged from the facility on February 20, 2026, to an apartment. Review of the documentation provided to the Long-Term Care Ombudsman in February, indicated they were not notified of the resident's discharge from the facility. Resident #12 (R12)Review of R12's EMR indicated R12 was sent to the emergency department on February 28, 2026. Review of the documentation provided to the Long-Term Care Ombudsman in February, indicated they were not notified of the resident's discharge from the facility.On 3/3/2026 at 1:49 PM, an interview was conducted with the Nursing Home Administrator (NHA), she stated the Ombudsman notification had only to consist of emergent transfers that were discharged from the facility. Review of the facility's policy titled Transfer and Discharge (including AMA) indicated in part: .7. Emergency Transfers/Discharges.k. Social Services Director, or designee, shall provide notice of transfer to a representative of the State Long-Term Care Ombudsman via monthly list. There was not designation in the facility's policy to notify the Long-Term Care Ombudsman under .Anticipated Transfers or Discharges - initiated by the resident.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to monitor for acute illness and provide timely physician notification of change in condition for two Residents (#68 & #78) of five residents reviewed for hospitalization. This deficient practice resulted in delay of treatment and the potential for worsening of condition.Findings include: Resident #78 (R78) Review of R78's EMR revealed initial admission to the facility on 6/25/21 with diagnoses including presence of a tracheostomy (a surgical procedure which creates an opening through the neck to provide an alternative airway), presence of a gastrostomy (a surgical procedure that creates an opening through the abdominal wall directly into the stomach to insert a feeding tube), and chronic obstructive pulmonary disease (COPD). Review of R68's most recent MDS assessment, dated 1/7/26, revealed a BIMS score of 15, indicative of intact cognition. On 3/3/2026 at 7:55 AM, R78 was observed lying in bed. R78 acknowledged they were recently hospitalized but they were unable to provide specific clinical details. Review of R78's EMR revealed the following entries: Encounter Note on 12/26/25 at 8:00 AM: Situation: Hypotension [low blood pressure] persists – Midodrine [a medication used to treat low blood pressure] administered at 12:30 [PM], blood pressure taken just now showed 88/33. Nursing Evaluation Summary on 1/7/26 at 21:06 [9:06 PM]: 81 yo [year-old] alert and oriented man re-admitted .following extended hospital stay for UTI [urinary tract infection] and strept [sic] throat. Client has been long time enteral feeding patient [delivering nutrition via a feeding tube], NPO [nothing by mouth] as well as indwelling foley catheter and trach [tracheostomy]. Patient as well as [sic] 02 [supplement oxygen] dependent. Review of the facility census revealed R78 was hospitalized from [DATE] – 1/7/26. Further review of R78's EMR revealed no further monitoring after identification of a critically low blood pressure on 12/26/26 and no documentation outlining the clinical justification for R78's hospitalization on 12/28/26. Review of an Infectious Disease Progress Note from a local acute care hospital, dated 1/2/26 at 13:49 [1:49 PM], read, in part: [R78] is an 81 yo [year-old] man admitted to [hospital name] with 1-2 day history of sore throat, fevers, weakness, and hypotension. He was found to have streptococcal bacteremia [strep throat]. Review of R78's Hospital Summary from a local acute care hospital, dated 1/7/26 at 14:49 [2:49 PM], read, in part: .All diagnoses this visit: hypovolemic shock (a life-threatening, emergency condition caused by a severe, rapid loss of blood or bodily fluids), sepsis (a life-threatening condition which occurs when blood pressure drops to a dangerously low level after an infection), streptococcal bacteremia, chronic respiratory failure with hypoxia, COPD. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/4/26 at 12:30 PM, an interview was conducted with the DON regarding her expectation with monitoring, following up, and notifying the physician about changes in medical conditions. The DON stated the facility had already identified this as an area as an opportunity for improvement. The DON confirmed the EMR should reflect ongoing monitoring of a change in condition (including vitals), notification of a physician given a significant change in clinical status and ensuring transfer forms are completed when sending a resident out of the facility for further evaluation. The DON verified all three elements should have been included in R78's EMR prior to his 12/28/25 hospitalization. Resident #68 (R68) Review of the Minimum Data Set (MDS) assessment, dated 2/20/2026, revealed R68 was admitted to the facility on [DATE] and had admitting diagnoses including sarcoidosis (chronic abnormal collections of inflammatory cells in lungs, skin and lymph nodes) of the lung, pneumonia, and pneumothorax (abnormal collection of air in the lung space. Section C of the MDS revealed R68 scored 15 out of 15 on the Brief Interview for Mental Status, indicating he was cognitively intact. An observation on 3/3/2026 at 8:45 a.m. revealed R68 seated in a recliner in his room. R68 was noted to be receiving supplemental oxygen via a nasal cannula with tubing attached to a portable concentrator set to deliver 3L (liters)/minute. During an interview at the time of the observation, R68 reported he was recently hospitalized due to increased weakness and shortness of breath. Review of the electronic medical record (EMR) revealed R68 was transferred to the hospital on 2/17/2026 and returned to the facility on 2/21/2026. Review of R68's, Hospital Summary, dated and signed 2/21/2026 at 8:50 a.m., revealed the following: [R68} presents from [facility] with shortness of breath and hypotension [abnormally low blood pressure], found to have acute anemia [lack of sufficient red blood cells secondary to] . GI bleed. Acute blood loss anemia secondary to esophagitis with esophageal ulcer. Presented with Hgb [hemoglobin] of 7.1, decreased from 12 on 2/6 [2/06/2026]. Received a total of 2 units packed red blood cells . Review of R68's vital sign documentation, gleaned from the EMR, revealed a change in the Resident's condition occurred when his blood pressure dropped from 101/71 mmHg [millimeters Mercury] on 2/16/2026 at 9:04 a.m. to 70/43 mmHg on 2/16/2026 at 4:39 p.m. Review of the EMR revealed no documentation of physical assessment, manual blood pressure rechecks or physician notification by R68's attending nurse to correspond with the change in condition or any other documentation referencing the drop in the Resident's blood pressure on 2/16/2026 at 4:39 p.m. It was noted R68's blood pressure reading of 70/43 mmHg on 2/16/2026 at 4:39 p.m. was documented as completed by non-Certified Nursing Assistant (nCNA) B. Further review of the EMR revealed R68's next recorded blood pressure reading was 75/52 mmHG on 2/17/2026 at 3:23 a.m. and documented as completed by CNA E. Review of the EMR revealed no documentation of physical assessment, manual blood pressure rechecks or physician notification by R68's attending nurse or any documentation referencing the Resident's continued hypotension. During an interview on 3/4/2026 at 7:50 a.m., Registered Nurse (RN) C was asked what the process was for responding to a resident with a change in condition, such as a drop in blood pressure (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	indicating hypotension. RN C reported he had instructed the CNAs to report to him immediately of any abnormal vital signs, so he is able to follow up with an assessment of the resident to determine need for intervention and physician notification. RN C reported he was aware of R68's condition warranting transfer to the hospital on 2/17/2026. RN C reported he was assigned to the care of R68 for the day shift (6:00 a.m. – 6:00 p.m.) on 2/16/2026. During a record review at the time of the interview, RN C confirmed there was no documentation in reference to R68's blood pressure reading of 70/43 mmHG on 2/16/2026 at 4:39 p.m. RN C stated he was unsure if he worked a full shift that day as he did not remember R68's condition changing until he arrived the morning of 2/17/2026 at which time he obtained an order for midodrine (a medication to raise blood pressure). RN C was asked if CNA vital sign documentation required verification by licensed nursing staff to which he answered, yes, I would have had to sign-off on it. RN C did not remember being notified by nCNA B on 4/16/2026 of R68's blood pressure reading of 70/43 mmHg. During an interview and record review of R68's EMR on 3/4/2026 at 8:59 a.m., the Director of Nursing (DON) confirmed there was no documentation on 2/16/2026 in reference to the Resident's drop in blood pressure from 101/71 mmHg on 2/16/2026 at 9:04 a.m. to 70/43 mmHG on 2/16/2026 at 4:39 p.m. The DON reported she was unable to determine through review of the EMR if a follow-up assessment or physician notification had occurred in response to the change in condition but would continue to review and report back to the survey team. On 3/04/2026 at 10:35 a.m., the DON presented documentation of physician notification through the notification messaging application used by the facility. Review of the notification documentation with the DON revealed a message was sent to the covering provider by RN C on 2/16/2026 at 8:30 p.m. The DON confirmed the provider was notified of the initial blood pressure reading of 70/43 mmHg nearly four hours after the Resident's blood pressure was recorded at 4:39 p.m. The DON reported messages conveyed via the application were not part of the EMR. The DON reported R68 was seen by two providers on 2/16/20026. Review of the documentation provided by the DON revealed R16 was assessed by Nurse Practitioner (NP) F on 2/16/2026 at 10:00 a.m. Review of NP F's progress note revealed no mention of R68's hypotension and listed the Resident's blood pressure as 122/56 mmHg, which correlated with the blood pressure documented under vital signs in the EMR on 2/16/2026 at 1:39 a.m. Further review of the documentation provided by the DON revealed a New Follow Up Note ., dated and signed by NP G for a date of service listed as 2/16/2026 at 3:04 p.m. It was noted in review, NP G documented [R68} is also having some light headedness . may need midodrine if not able to stay above 90 SBP [systolic blood pressure] . Vitals . BP [blood pressure] 101/71 [mmHg] . It was noted R68's blood pressure reading referenced by NP G in the progress note correlated with the Resident's blood pressure documented under vital signs in the EMR on 2/16/2026 at 9:04 a.m. It was noted in review of the documentation provided by the DON that both NP assessments were conducted prior to R68's blood pressure dropping to 70/43 on 2/16/2026 at 4:30 p.m. The DON also presented the following documentation: Pertinent Charting Follow-Up – Infections/Signs & Symptoms – V2, dated 2/16/2026 at 2:06 p.m. Follow up to infection/signs & symptoms that occurred on: 2/06/2026 . Pneumonia . No s/sx of infection noted or reported today. It was noted in review, the document did not apply to the Resident's change in condition noted by the drop in blood pressure on 2/16/2026 at 4:39 p.m. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a Progress Note, dated 2/17/2026 at 8:00 a.m., signed by Nurse Practitioner (NP) F, revealed the following: . [R68] was having low blood pressures this morning, midodrine was added with no relief as the day went on, he continued to have significantly low blood pressure without explanation . Vital signs . Blood pressure: 86/55 mmHg . Will be sent to the emergency department for evaluation as a differential for this is broad. Review of R68's February 2026 Medication Administration Record (MAR), revealed an order for Midodrine HCL Tablet 5 MG [milligram]. Give 1 tablet by mouth one time only for hypotension for 1 day. Start Date: 2/17/2026 0815 [8:15 a.m.]. One dose of the midodrine was documented as administered at 9:00 a.m. Further review revealed a subsequent order for Midodrine 5 MG Tablet. Give 1 tablet by mouth two times a day for hypotension. Start Date: 2/17/2026 1100 [11:00 a.m.]. One dose of midodrine 5mg was documented as administered on 2/17/2026. The dose administration was not time stamped therefore the time of administration could not be verified. It was noted the intervention initiated to treat R68's hypotension did not occur until nearly 16 hours after the initial drop in blood pressure on 2/16/2026 at 4:39 p.m. Review of the SBAR Communication Form and progress note – V4, dated 2/17/2026 at 1:13 p.m., revealed the following: Situation: The change in condition, symptoms, or signs I am calling about is/are: Low blood pressures . This started on 2/17/2026 . Most recent blood pressure . 79/50 (mmHg) . One time order for midodrine given this morning with no results, second dose given with no change in BP. Resident is no reporting some minor dizziness . Transfer to the hospital . Reported by [NP G] on 2/17/2026 [no time entered] . On 3/4/2026 at 12:45 p.m., the DON reported no more documentation was available related to the response for R68's drop in blood pressure from 2/16/2026 at 4:39 p.m. through the Resident's hospitalization on 2/17/2026.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, interview, and record review, the facility failed to ensure smoking paraphernalia was stored in a secure location for one Resident (#52) of two residents reviewed for smoking.Findings include:Resident #52 (R52)Review of R52's electronic medical record (EMR) revealed initial admission to the facility on 8/25/17 with diagnoses including chronic obstructive pulmonary disease (COPD), malignant neoplasm of the lung (cancer), and personality disorder. On 3/2/2026 at 1:45 PM, an interview was conducted with R52 who confirmed he was a smoker. A vape (a battery-operated electronic device used to heat liquid into a vapor that can be inhaled), approximately the size of a pen, filled with a light brown liquid, was observed in R52's lap. An unopened package of four pocket lighters was observed on an unused electric fireplace underneath the windowsill. An oxygen concentrator was positioned next to the bed with a nasal canula laying over an adjacent bedside table. On 3/2/2026 at 4:09 PM, R52 was observed ambulating out to the designated smoking area at the predetermined smoking time. R52 was observed removing a lighter from his jacket pocket and removing a box of cigarettes from a bag attached to his four wheeled walker. R52 subsequently lit the cigarette and began smoking and returned the items to their respective places.On 3/4/2026 at 9:58 AM, an interview was conducted with R52 who verified he keeps his own cigarettes and lighter because he's independent and can leave the building when he wants to smoke. R52 indicated there are other residents in the facility who also keep their own cigarettes in their room. R52 confirmed he did have a vape but only uses it outside. When asked about the oxygen concentrator, R52 said he utilizes it when his oxygen gets below a certain saturation. The pocket lighter package was observed to be opened on top the unused electric fireplace with one lighter missing.Review of R52's Plan of Care reviewed a Focus initiated on 8/22/23 which read, Resident chooses to smoke. An intervention, dated 11/16/23, read, Keep oxygen away from smoking materials. Ensure removal prior to resident smoking, if applicable.On 3/4/26 at 12:30 PM, an interview was conducted with the Director of Nursing (DON) regarding the facility's smoking policy. The DON indicated all smoking paraphernalia should be locked up and stored by staff when not in use.Review of the facility policy titled, Smoking Policy Smoking Campus-Residents, revised 12/31/25, read, in part: It is the policy of this facility to establish and maintain safe resident smoking practices. This policy also includes electronic cigarettes. smoking items (cigarettes, lights, etc.) will be kept secured in a designated area with limited staff access. Residents with smoking privileges small not be permitted to retain any types of smoking articles, to include cigarettes, tobacco, etc., either on his or her person or within his/her living or sleeping area, at any time.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to appropriately assess and implement timely interventions for weight loss for one Resident (R54) of three reviewed for weight loss. Findings include:Review of R54's Electronic Medical Records (EMR) revealed admission to the facility on 7/11/25 with diagnoses including vascular dementia with anxiety and muscle weakness. R54's 1/23/26 Quarterly Minimum Data Set (MDS) assessment revealed a Brief Interview for Mental Status (BIMS) score of 2/15, indicating severe cognitive impairment.On 3/3/26 at 9:05 AM, R54 was observed sitting in a geri chair in her room. An interview was attempted with R54, but she was unable to answer questions appropriately. R54 appeared well dressed but thin with fragile skin. A review of R54's weights revealed the following entries: 8/5/25 - 142 lbs (pounds) 9/2/25 - 142.4 lbs 10/1/25 - 140.8 lbs 11/1/25 - 138.4 lbs 12/1/25 - 138.9 lbs 1/9/26 - 130.8 lbs 2/8/26 - 124.4 lbs 2/12/26 - 125.4 lbsThese results showed that R54 had a 9.4% weight loss in three months and an 11.7% weight loss in six months.Review of R54's Progress Notes read, in part, 1/19/26 weight 131# (pounds).was 141# 180 days ago.recommend med pass 2.0 60 cc (cubic centimeters) daily.written by Registered Dietitian (RD) T 2/26/26; 125.4 pounds; weight down 6# from last month.unintentional weight loss.recommend increase (med pass 2.0) to BID (twice a day).for desired planned weight gain.recommend weekly weights.written by RD T)An interview was conducted with the Nursing Home Administrator (NHA), Director of Nursing (DON), and Regional RD S on 3/3/26 at 2:45 p.m. The NHA, DON, and Regional RD S confirmed RD T was late to document R54's more recent weight loss and implement interventions for unintentional weight loss.RD T was unable to provide rationale why the documentation and intervention was delayed two weeks after R54's most recent weight loss.An interview was conducted with R54's Designated Power of Attorney (DPOA) U for medical decisions on 3/4/26 at 8:34 AM. DPOA U stated the facility had not been in contact regarding R54's weight loss stating that he did not know what R54 currently weighed now but appeared to be [NAME] when he came to visit last. DPOA U stated that he would like to be informed and could offer ideas of different foods R54 might like to try. When asked if DPOA U was informed of R54 starting med pass 2.0, he stated, No. I have no idea what that is.Review of the facility's Weight Monitoring policy dated 10/26/23, read, in part, Based on the resident's comprehensive assessment, the facility will ensure that all residents maintain acceptable parameters of nutritional status.interventions will be identified, implemented, monitored and modified (as appropriate), consistent with the resident's assessed needs, choices, preferences, goals and current professional standards to maintain acceptable parameters of nutritional status.A weight monitoring schedule will be developed upon admission for all residents: Residents with weight loss - monitor weight weekly.Documentation: The Registered Dietitian or Dietary Manager should be consulted to assist with interventions; actions are recorded in the nutrition progress notes.

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	03/04/2026

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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to complete, readily act upon, and implement monthly pharmacy recommendations for two Residents (#2 &#101) of five residents reviewed for medication review.Findings include: Resident #2 (R2) Review of R2's Electronic Medical Record (EMR) revealed initial admission to the facility on 4/3/25 with diagnoses including dementia, repeated falls, and post-traumatic stress disorder (PTSD). Review of R2's EMR revealed Pharmacy Medication Review Progress Notes on 9/20/25 and 12/1/25 that read, Monthly medication regimen review performed. Comment/Recommendation noted – see report. On 3/3/26 at 1:59 PM, this Surveyor requested a copy of both reports from the Nursing Home Administrator (NHA) and Director of Nursing (DON). The reports were not provided by the time of survey exit. Review of a Nursing Recommendation written by Consultant Pharmacist H on 11/7/25 read, in part: [R2] has an order for [antipsychotic medication] which may cause orthostatic hypotension (a sudden, significant drop in blood pressure that occurs within three minutes of standing up). Please consider periodic checks for possible orthostatic hypotension by taking BP [blood pressure] reclining and then standing. A drop of 20 points in systolic or 10 points in diastolic pressure points in diastolic pressure indicates orthostatic hypotension which may be a cause of falls. Please add monthly OR quarterly checks to MAR [medication administration record]. Review of the EMR revealed no physician response but a hand-written note on the recommendation reading, orthos [blood pressure checks for orthostatic hypotension] added in 2/1/26 quarterly, over two months after the initial recommendation. Review of the facility policy titled, Addressing the Medication Regimen Review Irregularities, revised 12/28/23, read, in part: It is the policy of this facility to provide a Medication Regimen Review (MRR) for each resident to identify irregularities and respond in a timely manner to prevent the occurrence of an adverse drug event. Any irregularities noted by the pharmacist during this review must be documented on a separate, written report which may be in paper or electronic form. The report will be sent to the attending physician, the facility's medical director and director of nursing and lists, at minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. The attending physician must document in the resident' medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. The report should be submitted to the DON within 10 working days of the review. If documentation of the findings is not in the active record, it will be maintained within the facility and will be readily available for review. (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	03/04/2026

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

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R101 Review of R101's EMR revealed initial admission to the facility on [DATE] with diagnosis including chronic systolic heart failure. Review of R101's EMR revealed Pharmacy Medication Review Progress Note on 11/20/25 that read, Monthly medication regimen review performed. Comment/Recommendation noted – see report. Review of R101's Nursing Recommendations- Includes the following Classifications: MRR (Monthly Medication Review) for recommendations created between 11/1/25and 11/27/25 revealed the following recommendation, Lidocaine Patches may remain in place for up to 12 hours in any 24-hour period. Please add a note to the MAR (Medication Administration Record) Date 11/20/25 lidocaine patch order that clarifies the patch should be left on for 12 hours and then removed. It was noted that a physician signature, undated, signed off on this recommendation. Review of R101's MAR for March 2026 revealed the following order, Lidocaine Pain Relief Patch 4%; Apply to right knee topically in the morning for pain, on AM off PM; Start Date: 2/7/26. An interview conducted with the Nursing Home Administrator (NHA) on 3/4/26 at 11:43 AM confirmed that R101's MRR for November 2025 was not correctly entered into R101's EMR.

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	03/04/2026

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on observation, interview, and record review, the facility failed to accurately dispense insulin to one Resident (Resident #28) of one resident reviewed for insulin administration resulting in a significant medication error.Findings include:On 3/3/26 at 7:25 AM, an observation was made of Licensed Practical Nurse (LPN) N drawing up insulin for Resident #28 (R28). LPN N drew up R28's insulin lispro and placed it on the top of her medication cart, locked her computer screen, and her cart. LPN N was proceeding to R28's room to administer his insulin and this Surveyor asked LPN N how many units R28 was to receive and to see the insulin she had drawn up in the syringe. This surveyor had observed LPN N had drawn up the incorrect dose of insulin for R28 and returned the syringe to LPN N who returned to R28's insulin order and then realized that she had the incorrect amount in the syringe. LPN N had drawn up 14 units and R28 was only to receive 9 units. LPN N commented, I should have double checked the dose.On 3/3/26 at 7:28 AM, LPN N was observed administering insulin to R28 and held the subcutaneous injection site for four seconds.On 3/3/26 at 7:30 AM, an interview was conducted with LPN N regarding how long she was to hold the injection site and replied, Ten seconds. LPN N was made aware she only held the needle in place for four seconds. LPN N remarked, I guess I counted fast .Review of R28's insulin order, dated 3/2/26, revealed an order for insulin lispro on a sliding scale and a blood glucose level of 144. Reflecting R28 was to receive 9 units of insulin and not 14 units of insulin LPN N had originally drawn up.On 3/4/26 at 7:35 AM, an interview was conducted with Registered Nurse/Unit Manager R, who was asked what his expectations were for medication administration and acknowledged nurses should be double checking insulin doses as well as all other medications administered prior to administration.On 3/4/26 at 8:05 AM, an interview was conducted with the Director of Nursing (DON) and the Nursing Home Administrator (NHA) both were asked about medication administration expectations and acknowledged nurses should follow the five rights of medication administration and double check all medication doses including insulin.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 infection. Policy Explanation and Compliance Guidelines.10. Review MAR (Medication Administration Record) to identify medication to be administered. 11. Compare medication source with MAR to verify resident name, medication name, form, dose, route, and time of administration.