STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235292	A. Building B. Wing	11/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Sault Ste. Marie	1011 Meridian Road Sault Ste. Marie, MI 49783

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake 2645585.Based on interview and record review, the facility failed to accurately reconcile medications on admission and failed to monitor blood glucose levels according to facility policy and professional standards of practice for one Resident (#10) of three residents reviewed for quality of care.Findings include:This citation pertains to intake 2645585.Based on interview and record review, the facility failed to accurately reconcile medications on admission and failed to monitor blood glucose levels according to facility policy and professional standards of practice for one Resident (#10) of three residents reviewed for quality of care.Findings include:Resident #10 (R10)Review of the Minimum Data Set (MDS) assessment, dated 10/7/2025, revealed R10 was admitted to the facility on [DATE] and had severe cognitive impairment. Review of R10's diagnoses list from the electronic medical record (EMR), revealed active diagnoses including dementia, diabetes with long-term use of insulin and chronic kidney disease. Further review revealed R10's diagnosis of diabetes with long-term use of insulin was entered into the electronic medical record (EMR) on 10/3/2025.Review of R10's, ED [emergency department] Provider Notes, dated 10/16/2025 at 9:01 p.m., revealed the following: EMS states that she was hyperglycemic for them and she apparently has not been receiving her insulin for the last 2 weeks .Review of R10's hospital, H&P [History and Physical], dated 10/17/2025 at 1:40 p.m., revealed the following: Upon arrival to [ED] . blood glucose 482 [normal reference range listed as 65 -139] . Plan: Sepsis secondary to UTI [urinary tract infection] . Hyperglycemia in Type 2 Diabetic . patient has not been receiving her insulin in 2 weeks since moving from [previous facility] . as this medication was not listed on her med list from [current facility] received from [previous facility] .Review of R10's hospital, Inpatient Discharge Summary, dated 10/19/2025 at 10:53 a.m., revealed the following: Primary Discharge Diagnosis: Sepsis secondary to UTI [urinary tract infection] . Type 2 diabetes mellitus with kidney complication, with long-term current use of insulin . The patient was admitted for acute metabolic encephalopathy secondary to UTI . Her glucose was poorly controlled on presentation possible due to UTI and per the family she had not been receiving insulin prior to arrival. Adequate control was obtained with Lantus 15 units nightly and sliding scale. Continue on this regimen at DC [discharge] .Review of R10's EMR revealed the following documentation:10/16/2025 at 5:39 a.m., Nurses' Notes. Received report at shift change last evening, that this resident had increased confusion. Resident had a fever of 101.3 .10/16/2025 at 7:45 a.m., Nurses' Notes. Call out to on call provider regarding fever overnight .10/16/2025 at 1:32 p.m., Nurses' Notes. Spoke with MD regarding resident status and fever overnight. New orders for CBC, CMP, Magnesium, Iron studies, UA C&S and wound cultures .10/16/2025 at 4:55 p.m., Pertinent Charting - Change in Condition . Resident noted to have chills. Temperature checked and was 99.5 [degrees Fahrenheit] .10/16/2025 at 8:58 p.m., Transcribed Physician Progress Note . She is noted to have a low grade temp. She is diaphoretic [perspiring heavily] and presents with malaise [general feeling of illness or uneasiness]. Labs, wound culture and UA have been ordered . PMH [past medical history] . type 2 diabetes mellitus with diabetic chronic kidney disease . long term (current) use of insulin . Plan: Shipped to ER for evaluation .Review of R10's, IDT - Interdisciplinary Progress Note, dated 10/17/2025 at 7:45 a.m., revealed a timeline of (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	events leading from admission on [DATE] through hospitalization on 10/16/2025. The IDT Note revealed the following: When resident was admitted on [DATE] from [prior facility] there were no diabetic medications in her orders to indicate that she was to be placed on diabetic medications . Labs drawn on 10/9/2025. Results received and printed out on 10/10/2025 and given to the provider.Review of R10's laboratory test results, dated 10/9/2025 at 6:45 a.m., revealed a random glucose level of 348 (normal range below 140) and a Hemoglobin A1C level (blood test used to assess the average glucose level over a three-month period) of 11.6.Review of the American Diabetic Association's, Understanding A1C (https://diabetes.org/about-diabetes/a1c), accessed on 10/23/2025, revealed the following: The goal for most adults with diabetes is an A1C that is less than 7% . The higher the percentage, the higher your blood glucose levels over the past two to three months.Review of R10's, Order Summary Report, accessed 10/22/2025 at 1:55 p.m. and the October 2025 Medication and Treatment Administration Record (MAR/TAR) revealed no insulin, oral hypoglycemic medication, or point of care blood glucose testing was ordered or provided by the facility from R10's date of admission on [DATE] until 10/19/2025, after the Resident returned from hospitalization.An interview was conducted with the Director of Nursing (DON), in the presence of the Nursing Home Administrator (NHA) and the Regional Nursing Home Administrator (NHA A) on 10/22/2025 at 4:00 p.m. The DON was asked what the process was for review of resident referral documents upon admission. The DON reported, the IDT received an email from the admission Coordinator listing the anticipated date of admission which included any admission documents, including the resident's medication lists and physician documentation from the referring facility. When asked who was responsible for reviewing the referral documents, the DON reported the responsibility fell among the entire IDT and there was not a designated staff person delegated to review the documents. Therefore, the responsibility fell upon whomever had time. During the interview, NHA A conducted a review of R10's referral documents received by the facility 9/26/2025 and confirmed the documents included progress note clearly indicating the physician's assessment of R10's insulin use and a physician's medication list showing a current order for Lantus 12 units daily. NHA A continued the record review and stated the referring facility had sent another set of documentation in a separate email that did not list insulin on R10's medication list.Review of R10's Medication Profile, reported by NHA A as received from the referring facility on 10/8/2025, revealed no order for the Lantus 12 units daily, as documented in R10's physician notes received by the facility on 9/26/2025.Review of the Referral documents provided to the facility prior to R10's admission, with a received date of 9/26/2025, revealed a physician Progress Note, dated 9/5/2025. The progress note revealed the following: Patient [R10] was seen at [previous facility] as a housecall [sic] follow-up for her diabetes . She remains on Lantus [long-acting insulin] 12 units daily . Assessment/Plan: Type 2 diabetes mellitus with stage 1 chronic kidney disease, with long-term current use of insulin . Medication Changes: None.Included with R10's Referral documents was a medication list Valid as of: September 26, 2025, at 10:47 AM. Further review of the medication list revealed the following: This is your record. Keep this with you and show to your community pharmacist(s) and physician(s) at each visit . Medications . Lantus Solostar U-100 Insulin . Inject 0.12 ml [milliliters] (12 units total) under the skin daily. Start Dated: 7/31/2025. End Dated: no end date.It was noted in review of the referral documents, there was no indication of facility review of the physician notes and ordered medication list or when a review was completed prior to or upon R10's admission to the facility on [DATE].During a follow up interview on 10/23/2025 at 8:10 a.m., the DON reported she was unable to determine who reviewed R10's Referral documents, including R10's physician progress notes and physician's medication list provided to the facility on 9/26/2025 from the referring facility. The DON reported the facility had investigated the incident following R10's hospitalization on 10/16/2025 and discovered R10 was not being administered insulin at the previous facility per the physician's order which was why the medication was not listed on the facility medication reconciliation form but was listed on the physician notes and medication list. The DON confirmed the facility should have sought (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	clarification from R10's previous physician and her current provider due to the differences on the two medication lists received by the referring facility. The DON was asked if the facility had a protocol for checking blood glucose levels for diabetic residents on admission or in response to a change in condition. The DON stated point of care glucose checks were on the standard admission order set.During an interview on 10/23/2025 at 10:25 a.m., R10's Durable Power of Attorney, Family Member (FM) E reported she was unaware R10 was not receiving insulin or blood glucose monitoring prior to her hospitalization on 10/16/2025. FM E was informed by the facility that the assisted living home R10 transferred from had not included insulin on the medication list sent with the nursing notes on admission. FM E reported she investigated the matter, and it appeared the transferring facility did not refill the prescription per the physician order therefore the medication was not included on the medication list sent with the nursing notes but was listed on the physician medication list sent with the physician progress notes. FM E was asked if the facility inquired upon admission as to what medications R10 was using to manage diabetes. FM E reported no inquiry regarding insulin or diabetes in general was made by the facility until emergency medical services (EMS) arrived to transport R10 to the ED on 10/16/2025.Review of the Diabetic Protocol, provided by NHA A, revealed the following: Resident that have a diagnosis of diabetes or on medications that could lower blood sugar should have orders for glucose monitoring and treatment of hyperglycemia, unless otherwise ordered by the practitioner. A bedside blood glucose test should be administered for any resident reporting or experiencing symptoms of hyperglycemia such as . malaise . confusion .Review of the facility policy titled, Medication Reconciliation, dated as reviewed on 1/30/2024, revealed the following: Preadmission Processes: Obtain current medication list from referral source (i.e. hospital, home health, hospice or primary care provider) . admission Processes: Compare orders to hospital records, etc. Obtain clarification orders as needed . Verify medications received match the medication orders. Licensed staff to verify that all medications are accounted for and that medications on hand match physician orders.