STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235566	A. Building B. Wing	04/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Cheboygan	824 South Huron Cheboygan, MI 49721

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on observation, interview, and record review the facility failed to provide assessment, monitoring, and care per facility policy and professional standards for treatment with a nebulizer for one Resident (Resident #2) of one resident reviewed for inhaled medication administration.Findings include: On 4/13/26 at 7:30 PM, during medication administration, Registered Nurse (RN) B was not observed to perform vital signs or respiratory assessment/lung sounds prior or post administration of a nebulized respiratory treatment. RN B did not instruct Resident #2 (R2) to take deep breaths during the treatment and did not remain with resident to observe for change in condition. After completion of the treatment, RN B stated to R2 shh I am trying to listen to your lungs, RN B then leaned closer to the resident. RN B did not have a stethoscope.On 4/13/26 at 7:50 PM, an interview was conducted with RN B regarding assessment pre and post administration of a nebulizer treatment. RN B stated you should listen to lung sounds pre and post treatment. When asked if she had completed a respiratory assessment, she felt she had.Review of R2's Electronic Medical Record (EMR) indicated R2 had no vitals performed since 7:24 AM on 4/13/26. R2 did not have another set of vitals documented until 8:15 AM on 4/15/26, confirming no vitals were completed pre or post nebulizer treatments. Review of treatment log, nurse assessments, and progress notes did not indicate a complete respiratory assessment had been completed for any of R2's 4/9/26 order for three times a day nebulizer treatment.Review of the facility's Nebulizer Therapy policy last reviewed/revised on 5/15/24 indicated . Policy Explanation and Compliance Guidelines: 1. Care of the Resident.f. Obtain resident's vital signs and perform respiratory assessment to establish a baseline.n. Observe resident during the procedure for any change in condition.3. Documentation Record the following information in the resident's medical record .d. Resident vital signs and respiratory assessment. e. Resident's response to treatment.According to Mosby's Clinical Nursing Skills & Techniques 10th edition (2021) checklist for administering medication via a nebulizer: Perform Assessment: Record baseline vital signs, including heart rate, respiratory rate, oxygen saturation, and auscultate lung sounds.Breathing: Instruct the patient to take slow, deep breaths.Reassess: Monitor the patient for adverse reactions, reevaluate lung sounds and respiratory effort.Documentation: Record the medication given, dose, time, patient's pre and post treatment status, and their tolerance of the procedure.

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
	235566	A. Building B. Wing	04/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Cheboygan	824 South Huron Cheboygan, MI 49721

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** Based on interview and record review, the facility failed to ensure follow-up to a change in condition according to professional standards of practice for two Residents (#11 and #75) of three resident's reviewed for change in condition. This deficient practice resulted in the potential for complications and worsening of condition.Findings include:Resident #11 (R11) Review of the Minimum Data Set (MDS) assessment, dated 3/24/2026, revealed R11 was admitted to the facility on 3/ 10/2024 and had diagnoses including Type 2 Diabetes Mellitus with hyperglycemia. Review of R11's April 2026 Medication Administration Record (MAR) and Treatment Administration Record (TAR) revealed the following physician's orders: Humalog KwikPen (rapid-acting insulin) Subcutaneous Solution Pen-Injector 100 unit/ML [milliliter]. Inject per sliding scale: If 0-199 = 0 units; 200-249 = 2 units; 250-299 = 4 units; 300-349 = 6 units; 350-399 = 8 units; 400+ = 10 units. If blood sugar is 400 or greater must contact provider . Start Date: 7/06/2025. Accucheck (point of care blood glucose test) – AC (before meals) & HS (at bedtime) . Notify provider if 70 or below or above 400. Start Date: 9/10/2025. Review of R6's point of care blood glucose results documented on the April 2026 MAR revealed the following readings: 4/03/2025 at 11:00 AM: 427 mg/dL (milligrams per deciliter). 4/05/2026 at 7:00 AM: 442 mg/dL. 4/10/2026 at 11:00 PM: 505 mg/dL. 4/12/2026 at 8:00 PM: 529 mg/dL. 4/13/2026 at 12:00 PM: 402 mg/dL. 4/13/2026 at 8:00 PM: 566 mg/dL. 4/14/2026 at 12:00 PM: 525 mg/dL. It was noted the April 2026 MAR and TAR did not include documentation of physician notification of R11's blood glucose readings greater than 400 mg/dL. Further review of the R11's electronic medication record (EMR), including progress notes and assessments, revealed no documentation of assessment for signs and symptoms of hyperglycemia or physician notification for the blood glucose results greater than 400 mg/dL on 4/03/2026 at 11:00 AM, 4/05/2026 at 7:00 AM, and 4/13/2026 at 8:00 PM. Review of the April 2026 MAR revealed R11 was administered 14 units of Humalog, additional to her regularly scheduled doses, in response to each of the glucose readings above 400 mg/dL on the (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235566	A. Building B. Wing	04/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Cheboygan	824 South Huron Cheboygan, MI 49721

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	following dates: 4/12/2026 at 8:30 p.m. 4/13/2026 at 9:00 p.m. 4/14/2026 at 6:12 p.m. Review of the EMR and April 2026 MAR and TAR revealed no documentation was noted in the EMR regarding R11's physical response (physical assessments or recheck of blood glucose levels) to the additional doses of insulin administered on 4/12/2026, 4/13/2026 and 4/14/2026. During an interview on 4/15/2026 at 9:51 AM, the Director of Nursing (DON) was queried about R11's high blood glucose readings and subsequent treatment. The DON reported R11's blood glucose tended to be high and her physician was reluctant to increase the dose of her scheduled inulin because, She [R11] has a tendency to bottom right out if given too much, if greater than 400 [mg/dL] staff should call physician but he is reluctant to increase her scheduled sliding scale dose so we seem to call him every day. The DON reported if the Resident's condition warranted physician notification all information, including assessment and discussion with the physician or provider should be documented in progress note. When asked when a recheck POC blood glucose is warranted, the DON reported she would not normally test the Resident's blood glucose level again until the next time scheduled on the MAR, even if extra insulin was administered. The DON stated that when she cared for residents she would usually go in and check on the residents. If extra insulin is given, I always go in and reassess. Resident #75 (R75): On 4/13/2026 1:35 PM Resident #75 (R75) was observed lying in bed with her spouse at bedside. R75 said she did not feel well. R75 was unable to explain the reason she did not feel well. The EMR of R75 was reviewed on 4/13/26 at approximately 2:00 PM. The EMR reflected R75 was admitted to the facility on [DATE]. An MDS dated [DATE] documented a BIMS (Brief Interview for Mental Status) score of four, indicating R75 had severely impaired cognition. The MDS assessed R75 as continent of bowel. The MDS coded R75 as receiving hospice services. The EMR contained Certified Nurse Aide (CNA) task documentation for activities of daily living, including toileting and tracking of bowel and bladder elimination. The task record documented R75's last bowel movement as occurring on 4/8/26 at 4:44 AM. Physician's orders in the EMR included an order dated 4/12/26 for: Bisacodyl [a laxative medication] EC [enteric coated] oral tabled delayed release 5 mg give 1 tablet by mouth every 24 hours as needed for constipation. There were no administrations of bisacodyl documented in the month of April on the Medication Administration Record (MAR) or progress notes of R75. The EMR contained a document Evaluation of Bowel – V3 dated 1/19/26. The were no (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235566	A. Building B. Wing	04/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Cheboygan	824 South Huron Cheboygan, MI 49721

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	documented assessments of R75's abdomen or bowels after 1/19/26 contained in the EMR. The instructions on the document read, in part: Directions: Resident should be evaluated at admission and whenever there is a change in.bowel function. There was no documentation located in the EMR of R75 indicating the physician was notified of R75 not having a bowel movement since 4/8/26. A review of the hospice visit log revealed a documented date of the last hospice visit on 4/10/26 by the hospice Registered Nurse (RN). The hospice RN note dated 4/10/26 documented: Pt [patient] oriented to person only. She Believes [sic] she just arrived at [name of facility redacted]. She refuses shower or bed bath. 0 [No] BM [bowel movement] since 4/6/26. Afebrile [no fever] VSS [vital signs stable] Spouse at Bedside [sic]. There was no documented bowel/abdominal assessment documented by the hospice RN. The EMR did not contain a care plan for decreased GI motility or interventions for staff to follow if R75 experienced constipation. The most recent hospice care plan for R75, titled Hospice IDT Comprehensive Assessment and Plan of Care Update report dated 4/1/26, did not include a plan of care for constipation. On 4/14/26 at 9:30 AM, the Nursing Home Administrator (NHA) was asked to provide the facility bowel policy. The NHA said the facility did not have a bowel policy but had a bowel protocol. On 4/14/26 at approximately 9:45 AM, the NHA and corporate director of operations said they do not have bowel protocol or standing orders containing a bowel protocol. On 4/14/26 at 11:52 AM, Licensed Practical Nurse (LPN) D was queried regarding the process for bowel management. LPN D said if a resident does not have a bowel movement in three days, they are placed on the facility's bowel protocol. LPN D explained the facility's bowel protocol included administration of Milk of Magnesia (MOM – a laxative medication) on the third day without a bowel movement, then administration of Bisacodyl if the MOM was ineffective, then a fleets enema if the Bisacodyl was ineffective. LPN D said R75 was on the bowel tracking monitoring log for not having a bowel movement, but no laxative medications were documented as having been administered. When asked the last time R75 had moved her bowels, LPN D reviewed the EMR and said he did not know where to find the information. The DON was interviewed on 4/14/26 at 12:05 PM. The DON reiterated the bowel protocol of MOM, bisacodyl, and enema conveyed by LPN D. The DON said all residents had the bowel protocol entered into their order sets (a pre-defined group of medical instructions in the EMR), and the physician was to be notified if the bowel protocol was ineffective. The DON said if a resident has not had a bowel movement in three days, the resident is added to the bowel protocol list to commence the interventions in the protocol. The DON was asked the last time R75 had a bowel movement. After reviewing the EMR, the DON acknowledged the last documented bowel movement of R75 was six days prior, on 4/8/26. The DON (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235566	A. Building B. Wing	04/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Cheboygan	824 South Huron Cheboygan, MI 49721

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	said the physician should have been notified, and the goal was to keep R75 comfortable and pain-free. The DON agreed constipation was painful and added R75 had a history of constipation. When asked why constipation was not care planned if R75 had a history of constipation, the DON did not provide a response. When asked if an abdominal bowel assessment had been completed, the DON confirmed there was no documented bowel assessment in the EMR. The DON said a bowel assessment should have been completed and documented. RN G was interviewed on 4/14/26 at 1:31 PM. RN G said she was the nurse manager for the unit where R75 resided. RN G said she discussed the concerns with R75's lack of bowel movements with the hospice nurse but there was no documented response from hospice. RN G confirmed there was no documented bowel assessment in the EMR of R75. RN G said R75 had a poor appetite but agreed there should have been bowel movements despite the poor appetite and said a bowel assessment should have been documented. RN G said R75 should have the bowel protocol order set in the EMR. RN G said, I don't know why they [bowel protocol orders] weren't entered [in the EMR] for her [R75]. RN G said she would notify R75's physician immediately for further orders. On 4/14/26 at 2:34 PM, RN G said she completed a bowel assessment on R75 and notified the physician of R75 regarding lack of bowel movements. RN G said orders for laxatives were obtained from the physician of R75. CNA task documentation in the EMR of R75 was reviewed on 4/15/26 at 7:04 AM. The documentation revealed R75 had a bowel movement on 4/14/26 at 3:13 PM.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235566	A. Building B. Wing	04/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Cheboygan	824 South Huron Cheboygan, MI 49721

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 0686 Level of Harm - Minimal harm or potential for 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 ensure wound care was completed according to physician order and professional standards of practice for one Resident (#6) of one resident reviewed for pressure ulcers.Findings include:Resident #6 (R6)Review of the electronic medical record (EMR) revealed R6 was admitted to the facility on [DATE] with a primary diagnosis of Alzheimer's Disease. Review of the Minimum Data Set (MDS) assessment, dated 2/01/2026, revealed R6 had severely impaired cognition and an unhealed, facility-acquired Stage 3 (full-thickness tissue loss) pressure ulcer.Further review of the EMR revealed R6 was currently undergoing daily monitoring for signs and symptoms of sepsis (severe systemic response to infection). Review of the Pertinent Charting - Infections/Signs/Symptoms, dated 4/13/2026 at 3:08 a.m., revealed the following: Follow up to infection signs/symptoms . Site of originally identified infection: sacral wound.Review of the April 2026 Medication Administration Record (MAR) revealed R6 was prescribed Ciprofloxacin HCL [antibiotic medication] 500 MG [milligram] Tablet . by mouth two times a day for wound infection for 10 days.On 4/14/2026 at 2:00 p.m. R6's wound care was observed performed by RN L. Upon initiation of care, R6 was positioned on her right side and as her brief was removed, a border gauze dressing was observed partially adhered to R6's sacral region (area at the bottom of the spine and above the tailbone). The dressing was saturated with a brownish-tan discharge and was adhered on the left side of the dressing only causing the non-adhered portion to be pushed to the left side, exposing the entire wound. It was noted there were initials on the dressing and RN L straightened out the gauze to reveal a written date of 4/13/2026, indicating who performed the dressing change and the date the dressing was applied. The Assistant Director of Nursing (ADON), who was present at the time of the observation, reported the initials on the soiled dressing belonged to RN M, who worked the day shift on 4/13/2026.Further observation during the provision of wound care revealed R6 had a large Stage 3 pressure injury located on her sacrum. The wound was approximately 8 centimeters (cm) long by 7 cm wide, with an approximate depth of 4 cm. The wound bed was observed to be a beefy red with scattered white slough (dead tissue) noted near the center and a foul odor noted coming from the wound.During an interview immediately following completion of wound care, RN L reported R6's wound to be a Kennedy ulcer (ulcer appearing at end of life due to oxygenated blood shifting from the periphery of the body to vital organs). RN L reported R6's was being administered an antibiotic due to the wound currently being infected. When asked about the initials on the dressing that was removed upon initiation of wound care, the ADON confirmed the initials and date on the soiled dressing indicated the wound was last changed the previous day shift by RN M. The ADON and RN confirmed R6's physician order for wound care was for the dressing to be changed twice daily.Review of the April 2026 Treatment Administration Record (TAR) revealed the following order: Wound Care . cleanse with wound spray, apply dakins moistened gauze, cover with bordered dressing. Change dressing BID [twice daily] . Start date: 4/08/2026 .Review of the Pertinent Charting - Infections/Signs Symptoms, dated 4/13/2026 at 5:43 p.m. by RN M, revealed, Dressing change continued as ordered.Review of the Pertinent Charting - Infections/Signs Symptoms, dated 4/14/2026 at 2:08 a.m. by RN C, revealed, Dressing change completed as ordered.Further review of the TAR revealed RN M documented wound care completed on 4/13/2026 for the 8:00 a.m. scheduled dressing change. It was noted, RN C documented the 8:00 p.m. scheduled wound care and dressing change as completed, contrary to the observation during R6's wound care of the presence of the dressing applied by RN M on 4/13/2026 and the ADON's report.During an interview on 4/15/2026 at 10:38 a.m., the Director of Nursing (DON) confirmed the ADON had alerted her to the observation indicating R6's twice daily wound care and dressing change had not been performed on 4/13/2026 per the physician's order. The DON acknowledged the potential for worsening infection and deterioration of the wound if wound care was not performed as ordered. The DON was queried regarding the process for documentation of wound (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235566	A. Building B. Wing	04/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Cheboygan	824 South Huron Cheboygan, MI 49721

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	care to which she confirmed staff should not document care that was not provided.Facility wound care policies were requested on 4/14/2026 at 9:00 a.m. and 4/15/2025 at approximately 10:00 a.m. but were not provided prior to survey exit on 4/15/2026 at 2:00 p.m.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235566	A. Building B. Wing	04/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Cheboygan	824 South Huron Cheboygan, MI 49721

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 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 monitor fluids and provide the diet as ordered for one Resident (R99) of three residents reviewed for fluid concerns.Findings include:Resident #99 (R99)The Electronic Medical Record (EMR) for R99 revealed an admission date of 4/9/2026 with diagnoses including : altered mental status, unspecified, chronic kidney disease, essential (primary) hypertension, and retention of urine. The Physician's orders of 4/9/2026 included, Diet order Fluid Restriction-1200 ml (milliliters) diet Regular texture, Regular fluid, thin consistency.The EMR contained a care plan for R99 which included Focus -Resident is at risk for fluid volume deficit related to POST COVID-19 CONDITION, UNSPECIFIED; CHRONIC KIDNEY DISEASE, STAGE 3A Date Initiated: 04/09/2026. The interventions for this care plan included, Encourage resident to drink fluids of choice unless contraindicated (i.e., fluid restriction); assist as needed. The care plan also included, Offer fluids during activities. Offer fluids of choice. Ensure all beverages offered comply with diet/fluid restrictions and consistency requirements Date Initiated: 04/09/2026 The care plan was updated by the RD with fluid restriction interventions added 4/13/26 to include: Fluid intake restriction as ordered. 1200ml daily fluid restriction. Date Initiated: 04/13/2026, Provide meals/fluids based on resident food preferences and as ordered Date Initiated: 04/13/2026, Provide nutritional supplement(s) as ordered: Family bringing in premier protein or (brand name) protein shake. 325ml each, provided with each meal does not wish to receive drinks from dietary.During a room observation on 4/14/2026 at 8:33 AM, two 16-ounce (oz) styrofoam cups were noted at R99's bedside. One was filled with a brown carbonated beverage and the other was filled with ice water and the cup dated 4/14 DAY. There was also a 12 oz coke bottle at bedside with approximately 3 oz left in the bottle. This amount equals 960 ml in the styrofoam cups and an additional 90 ml in the cola bottle to total 1050 ml of fluid during the morning observation.During an interview on 4/14/2026 at 9:05 AM, Registered Dietitian (RD) H confirmed the bedside waters are 16 oz. This is 480 ml of water toward the fluid diet order.The EMR contained an RD assessment dated [DATE] and read in part, 1200ml daily fluid restriction (family requests only protein shake come with meals [325 ml each]) .During a dining room observation on 4/14/2026 at 11:53 AM, R99 was eating his meal with Family member U. The meal included a 4 oz lemonade and did not contain a protein shake. Family member U stated the shake had been given to R99 in the room.During an interview on 4/14/2026 at 3:20 PM, Nurse Aide (NA) S was observed passing water to each room on the hall. She stated, I pour everyone the same on this hall. I fill up their cups. R99's room included a 16 oz styrofoam cup filled with ice water. She stated water is passed two times per day.On 4/15/2026 at 8:09 AM R99's room was observed and the bedside table had a 16 oz styrofoam cup filled with approximately 8 oz of water.During an interview on 4/15/2026 at 8:20 AM, Registered Nurse (RN) P stated, Yes, (R99) is on a fluid restriction and gets nothing from dietary but a (protein shake) 325 cc at each meal. Everyone knows he is a fluid restriction. (This would total 975 ml from the protein shakes per day.) When asked who tracks R99's fluids she said, The aides do that. When asked how CNAs (Certified Nurse Aides) know the amount of fluid given with medications passed by the nurses, RN P stated, I only give him sips at med pass. RN P confirmed fluid given at medication pass was not accounted for.During an interview on 4/15/2026 at 8:56 AM, the Director of Nursing (DON) stated she would expect a focus that addressed a fluid restriction and she stated the EMR has the totals and referred this surveyor to Assistant Director of Nursing (ADON) I who would know where the totals were found.During an interview on 4/15/2026 at 9:20 AM, ADON I said there are totals for each shift, but each day was not totaled by nursing. ADON I stated the RD totaled the fluids and alerted the staff if the resident was meeting or exceeding the Physician order for fluid restrictions each day.During an interview on 4/15/2026 at 9:24 AM, RD H stated, I do not total the fluids. I know what he is provided from dietary. It was also noted the RD was not present in the facility every day to total the daily fluids.During an interview on 4/15/2026 at 11:39 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235566	A. Building B. Wing	04/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Cheboygan	824 South Huron Cheboygan, MI 49721

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	AM, Family member U stated she brought in the protein shakes daily. She brought them in over the weekend (4/12/26) and left more for the nurses to give to him. Family member U was present each day of the survey and stated she was here every day and made sure (R99) received the supplement at every meal. She went on, He takes it well and drinks it all.The EMR contained fluid intake from the CNA task documentation and revealed a fluid intake of:240 ml, 240 ml, 240 ml on 4/12/26,100 ml, and 240 ml on 4/13/26 325 ml, 525 ml, and 240 ml on 4/14/26These totals do not reflect all of the observed water delivered and present in 16 oz (480 ml) styrofoam cups twice per day (960 ml) , or the cola present in the room, or the 325 ml protein shakes given each day each meal (975 ml), or any fluid given by nursing with medications, or fluids given with meals (such as the observed lemonade on 4/14/26).During an interview on 4/15/2026 at 8:56 AM, the DON was asked to provide a policy on Fluid Restrictions. Only a policy titled Hydration dated as last reviewed 10/26/2023 was presented. It read in part, The facility offers each resident sufficient fluid, including water and other liquids, consistent with resident needs and preferences to maintain proper hydration and health. A policy discussing fluid restricted residents, documentation of fluid, division of fluids between departments, or analyzation of meeting or exceeding the Physician fluid orders was not presented at the time of the survey.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235566	A. Building B. Wing	04/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Cheboygan	824 South Huron Cheboygan, MI 49721

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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to obtain a physician's order for dialysis, monitor a dialysis access site, report dialysis concerns to the physician, care plan potential fluid volume overload, and adhere to physician-prescribed fluid restrictions for one Resident (#8) of one resident reviewed for dialysis.Findings include:Resident #8 (R8)R8 was admitted to the facility on [DATE] with a primary diagnosis of ESRD (End-Stage Renal Disease). A Minimum Data Set (MDS) assessment dated [DATE] documented R8 received hemodialysis treatments at an off-site dialysis facility.Multiple attempts were made to interview R8 on 4/13/26. Registered Nurse (RN) F, the nurse assigned to the unit where R8 resided, said R8 was at dialysis and would be available on 4/14/26.The electronic medical record (EMR) of R8 was reviewed on 4/13/26. The EMR did not contain a physician's order for dialysis. There was no physician's order for monitoring a dialysis vascular access site.Interviews were attempted with R8 on 4/14/26 but she was not in her room. On 4/14/26 at 10:19 AM, the Director of Nursing (DON) said R8 was unavailable due to attending an additional dialysis treatment. When asked the reason for another dialysis treatment, the DON said she did not know but thought it was a concern with excess fluid. When asked if the physician of R8 had been made aware of the additional dialysis treatment, the DON said she didn't know.The DON was asked about R8's vascular access site. The DON said R8 had an AV fistula (arteriovenous fistula - a surgically created connection between an artery and a vein, providing an access point for hemodialysis) and nurses were expected to monitor the AV fistula daily for bruit (an unusual sound produced by blood flow through an AV fistula) and thrill (a vibration that indicates the AV fistula is working).The DON was queried regarding physician's orders pertaining to dialysis. The DON reviewed the EMR of R8 and confirmed there was no physician's order for dialysis and no daily monitoring for thrill and bruit.The DON was asked where documentation was located regarding the reasoning behind the need for an additional dialysis treatment on 4/14/26. The DON reviewed the EMR of R8 and confirmed the absence of documentation providing the reason the additional dialysis treatment was indicated. The DON said she would obtain the documentation.On 4/14/26 at approximately 10:25 AM, the Assistant Director of Nursing (ADON) was interviewed. The ADON said a physician's order for dialysis was required and said there should be a physician's order for the location of the dialysis treatments, frequency of treatments, and monitoring requirements for the vascular access site. The ADON said the vascular access site for R8 should be monitored every shift for thrill, bruit, bleeding, signs and symptoms of infection or other complications.The ADON was asked if the physician had been notified regarding the need for R8 to attend an additional dialysis treatment. The ADON reviewed the EMR of R8 and confirmed that nothing was documented in the EMR.On 4/14/26 at 11:13 AM, the DON provided a Hemodialysis Nursing Home Communication Form dated 4/13/26. There was no documentation on the form indicating the reason for an additional dialysis treatment on 4/14/26.The progress notes in the EMR did not include the reason for the additional dialysis treatment nor did the progress notes include communication to R8's physician that an additional dialysis treatment was requiredRN G was interviewed on 4/14/26 at 1:59 PM. RN G said she was the nurse manager on the unit where R8 resided. RN G said the physician of R8 should have been notified of the need for an additional dialysis treatment, and the nurse should have called the dialysis unit to determine the reason an additional treatment was required. RN G said R8 attended an additional dialysis treatment on 4/14/26 due to fluid volume overload.An interview was conducted with R8 on 4/14/26 at 3:01 PM. R8 said she attended dialysis on Mondays, Wednesday, and Fridays each week but needed to have an additional dialysis treatment on 4/14/26. When asked the reason for an additional dialysis treatment, R8 said she had too much fluid build-up.R8 had a physician's order dated 3/22/26 for a 1,000 ml (milliliter) per day fluid restriction. 520 ml of fluid were to be provided by the dietary department with meals, and 480 ml per day were to be provided by nursing.A Registered Dietitian (RD) nutrition (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235566	A. Building B. Wing	04/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Cheboygan	824 South Huron Cheboygan, MI 49721

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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	summary in the EMR dated 3/22/26 documented, in part: . Resident is agreeable to 1000 ml daily fluid restriction recommended by [name of off-site dialysis facility redacted] RD. 85-100% intake of meals since admission and 720 ml daily average fluid intake with meals [200 ml more than allotted in fluid restriction breakdown for dietary provision of fluids].The care plans of R8 did not contain a care plan or interventions pertaining to fluid volume overload to provide staff with interventions to implement if R8 was consuming an excess amount of fluids above her physician-ordered fluid restriction. The care plans did not indicate R8 was noncompliant with the fluid restrictions.The MDS dated [DATE] did not document any refusals of care or behaviors.A dialysis communication form dated 4/6/26 was reviewed. The dialysis RN documented R8 had a dietary concern fluid gain. The dialysis RN conveyed, 20.3 pound gain since last treatment. There was no documentation found in R8's EMR indicating the facility had addressed or responded to the fluid gain.On 4/15/26 at 9:28 AM, RN G said the certified nurse aides (CNA) document fluid intake through a point-of-care portal (in the Tasks portion of the EMR). RN G said the CNA's only document the amount of fluids consumed at meals.RN G was queried regarding monitoring additional fluids for R8 aside from just the amount consumed at meals, such as fluids at bedside, amount of fluids provided during medication administration, amount provided by nursing, and amount consumed during activities. RN G said nurses do not document fluid intake, and she was unaware of anywhere else fluid intake was documented.The RD was interviewed on 4/15/26 at 9:36 AM. The RD confirmed the CNAs documented the amount of fluids consumed during meals in point-of-care documentation. She said she did not know if, or where, staff documented additional fluids beyond what was offered on the meal trays of R8.The RD said excess fluid intake or noncompliance with fluid restrictions should be included in care plans. The RD said, Nursing needs to document how much fluid they are giving. Point-of-care fluid intake documentation for R8 was reviewed for the month of April to determine if R8 was maintaining the 520 ml of fluids provided by the dietary department as outlined in the physician's order for fluid restrictions. Point-of-care data revealed the following fluid intakes during meals each day:4/1/26: 720 ml4/2/26: 720 ml4/4/26: 960 ml4/7/26: 600 ml4/9/26: 760 ml4/11/26: 840 ml4/12/26: 720 ml4/14/26: 1,200 mlOn 4/15/2026 at 8:22 AM, R8 had a 480 ml Styrofoam cup of clear liquid that appeared to be water on the overbed table. The cup was almost empty. There was another 480 ml Styrofoam cup of dark fluid half empty at on the nightstand. R8 was unable to be interviewed regarding the fluids due to being out of the facility for dialysis.The policy Care Planning Special Needs - Dialysis dated as reviewed/revised 12/28/23 read, in part: . This facility will provide the necessary care and treatment, consistent with professional standards of practice, physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences, to meet the special medical, nursing, mental, and psychosocial needs of residents receiving dialysis. Changes in condition following a dialysis treatment will be reported immediately to the physician.The policy Resident Hydration dated as reviewed/revised 7/1/25 read, in part: .Physician orders to limit fluids will take priority. Nursing will monitor and document fluid intake and the Dietitian will be kept informed of status. IDT [interdisciplinary team] will update care plan and document resident response to interventions until team agrees that fluid intake and relating factors are resolved.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235566	A. Building B. Wing	04/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Cheboygan	824 South Huron Cheboygan, MI 49721

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, interview, and record review, the facility failed to accurately dispense insulin to two Residents (Residents #2, #11) of seven residents reviewed for medication administration resulting in 2 errors in 34 opportunities for error and a 5.88% medication error rate.Findings Include: On 4/13/26 at 7:39 PM, Registered Nurse (RN) B was observed administering insulin to Resident #2 (R2) and held the subcutaneous injection site for six seconds.On 4/13/26 at 7:40 PM, an interview was conducted with RN B regarding how long she was to hold the injection site and replied, Ten seconds. RN B was made aware she only held the needle in place for six seconds. RN B remarked, I must have counted fast .On 4/13/26 at 8:03 PM, RN C was observed administering insulin to Resident #11 (R11) and held the subcutaneous injection site for 5 seconds.On 4/13/26 at 8:05 PM, an interview was conducted with RN C regarding how long she was to hold the injection site and replied, Ten seconds. RN C was made aware she only held the needle in place for five seconds. RN C remarked, I thought I held it longer, you know it's hard to count when talking to the resident .On 4/14/26 at 9:05 AM, an interview was conducted with the Director of Nursing (DON) was asked about medication administration expectations and acknowledged nurses should follow the five rights of medication administration. The DON stated she knew that some insulin pens had different medication administering times, but felt staff should always do the 10 seconds to be safe.Per insulin step by step guide (2022) .STEP 5.INJECT YOUR DOSE Clean site with an alcohol swab. Please see injectionsite options on page 2. Keep the pen straight, insert the needle into your skin. Use your thumb to press the injection button all theway down. When the number in the dose windowreturns to 0 as you inject, slowly count to 10 beforeremoving. (Counting to 10 will make sure you getyour full insulin dose.) Release the button and remove the needle fromyour skin .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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235566	A. Building B. Wing	04/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Cheboygan	824 South Huron Cheboygan, MI 49721

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to:Identify appropriate required Transmission Based Precautions (TBP),Obtain a physician's order timely for isolation precautions,Appropriately apply and remove personal protective equipment (PPE),Utilize PPE when indicated, and;Discontinue an antibiotic medication or document justification for continuing antibiotic medication when test results were negative for Resident #2, affecting three Residents (#2, #16, & #12) of six residents reviewed for infection prevention and control.Findings include:Resident #2 (R2) On 4/13/26 at 11:35 AM, a sign for airborne precautions (an isolation measure used to prevent the spread of infectious agents that can be spread through the air over long distances) was observed posted outside the door of R2's room. The airborne precautions sign read: STOP: AIRBORNE PRECAUTIONS. EVERYONE MUST [sic]: Clean their hands, including before entering and when leaving the room. Put on a fit-tested N-95 [filtering facepiece respirator] or higher-level respirator before room entry. Remove respirator after exiting the room and closing the door. Door to room must remain closed. There was no waste receptacle outside of R2's room to dispose of respirator masks after removing the mask after exiting the room in accordance with the sign instructions. A sign for droplet precautions (an isolation measure used to prevent the spread of infectious agents that are transmitted through respiratory droplets) was observed on a PPE cart outside of R2's room. The sign read: STOP: DROPLET PRECAUTIONS. EVERYONE MUST [sic]: Clean their hands, including before entering and when leaving the room. Make sure their eyes, nose and mouth are fully covered before room entry. Remove face protection before room exit. On 4/13/26 at 11:41 AM, a visitor was observed approaching R2's room. The visitor stopped at a PPE cart outside of the room and applied a surgical mask. The visitor then entered R2's room. Certified Nurse Aide (CNA) O was observed exiting the room of R2 on 4/13/26 at 11:49 AM. CNA O was not wearing any PPE when she exited R2's room, including an N-95 respirator in accordance with the airborne precautions posting, or eye protection as indicated on the droplet precautions posting. Registered Nurse (RN) F was interviewed on 4/13/26 at 11:53 AM. RN F confirmed she was the nurse assigned to care for R2 on 4/13/26. RN F was asked the type of TBP required in the room where R2 resided. RN F said both residents in the room were in airborne precautions for RSV (Respiratory Syncytial Virus – a contagious respiratory virus that can cause severe illness in older adults). RN F said R2 tested positive for RSV and R2's roommate was in airborne precautions due to exposure to RSV. RN F was asked regarding masking requirements. RN F indicated she wore an N-95 respirator mask when she had to enter the room. When asked about removing and disposing of the N-95 respirator mask, RN F said she removed of the mask inside the room and disposed of the mask inside the room. The airborne precautions sign posted on the door was reviewed with RN F, specifically the portion directing: Remove respirator after exiting the room and closing the door. RN F said there was nowhere immediately outside of the room to dispose of PPE, so she removed the N-95 respirator mask and disposed it in the room. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235566	A. Building B. Wing	04/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Cheboygan	824 South Huron Cheboygan, MI 49721

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	When asked about the droplet precautions posting on the PPE cart outside of the room, RN F reviewed the posting and said she did not know the reason the posting was on the cart because droplet precautions required a face shield or goggles and staff were not wearing eye protection when in the room. RN F was asked which precautions the physician had ordered for R2. RN F said she would contact R2's physician to determine the required precautions. The Director of Nursing (DON) was observed placing several signs on the door of R2's room on 4/13/26 at 11:58 AM. The signs were for airborne precautions, droplet precautions, and contact precautions (an isolation measure used to prevent the spread of infectious agents that can be transmitted through direct or indirect contact with patients or their environment). The contact precautions sign read, in part: STOP: CONTACT PRECAUTIONS. EVERYONE MUST [sic]: Clean their hands, including before entering and when leaving the room. PROVIDERS AND STAFF MUST ALSO [sic]: Put on gloves before room entry. Discard gloves before room exit. Put on gown before room entry. Discard gown before room exit. On 4/13/26 at 11:58 AM, RN J was observed approaching R2's room. RN J was asked the PPE requirements for R2. RN J said, Well, since there's three signs now, I guess I'll put on everything. RN J put on a gown, N-95 respirator mask, a face shield, and gloves. At 12:05 PM on 4/13/26, RN J exited R2's room wearing gloves, an N-95 respirator mask, and a face shield. RN J and RN F had a discussion in the hallway regarding where to dispose of the PPE. When asked where the PPE should be disposed, both RN J and RN F said they did not know. RN J went to the nurses' office and removed the PPE and disposed of the PPE in the open waste receptacle in the nurse's office. According to the electronic medical record (EMR), Resident #2 (R2) was admitted to the facility on [DATE]. R2 tested positive for RSV on 4/10/26. An order in the EMR dated 4/13/26 read: Place resident in transmission-based precautions related to RSV All [sic] care and services received in room every shift. An additional order dated 4/13/25 read: Place residents in droplet precautions related to diagnosis of: RSV All [sic] care and services provided in room every shift. There were no physician's orders for TBP prior to 4/13/26, during the three days after R2 tested positive for a contagious respiratory illness. A physician's progress note in the EMR dated 4/9/26 documented, in part: . upon exam [R2] is noted to have newly present congestion and malaise [feeling of discomfort or illness] . [R2] has a new onset cough with congestion concerning for bronchopneumonia [an infection that inflames the air sacs in the lungs] vs pneumonia. Influenza and COVID testing today is negative. Plan: Orders given for chest x-ray 2 v [view], 5 day prednisone [steroid medication], Levaquin [an antibiotic for bacterial infections] 500 mg [milligrams] qd [every day] x 7 days [for] bronchopneumonia vs pneumonia, Rocephin [an antibiotic for bacterial infections] 1 g [gram] IM [intramuscularly] x 3 days [for] bronchopneumonia vs pneumonia. A chest x-ray was obtained on 4/10/26. The x-ray report read, in part: .Conclusion: No acute (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235566	A. Building B. Wing	04/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Cheboygan	824 South Huron Cheboygan, MI 49721

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	abnormality identified. The Medication Administration Record (MAR) of R2 documented administration of Rocephin on 4/9/26, 4/10/26, and 4/11/26. Further review of the MAR disclosed R2 started Levaquin on 4/10/26 and was still receiving the Levaquin as of 4/15/26, five days after the negative chest x-ray was obtained. The Infection Preventionist (IP) E was interviewed on 4/15/26 at 11:32 AM. IP E confirmed R2 was initially prescribed antibiotics for suspected pneumonia. IP E was asked if the physician was notified when the chest x-ray results were reported to determine the need for continued antibiotic therapy. IP E said she provided R'2 nurse with the results of the x-ray, and she expected the nurse to call the physician and follow-up on the need to continue the antibiotic. IP E reviewed the EMR of R2 and said the NP (Nurse Practitioner) acknowledged the chest x-ray result, but the progress note did not include a reason for continuing the antibiotic. IP E said she would have questioned the physician regarding the need to continue with an antibiotic when the chest x-ray was negative for an active disease process. IP E was asked if antibiotics were beneficial to a resident with RSV. IP E responded, No – RSV is a virus not a bacteria. IP E was queried regarding PPE to be worn for the care of R2. IP E said staff should be wearing gowns, gloves, goggles or face shields, and an N-95 respirator mask. IP E was told a staff member had exited the room of R2 with all PPE except a gown and disposed of the PPE in the nurses' office. IP E said PPE should be removed in R2's room and placed in the waste receptacle in the room, and the staff member should not have exited the room and walked to the nurse's office to dispose of the PPE. IP E was asked about precautions for a resident with RSV. IP E said the facility practice was to utilize standard, droplet, and airborne precautions. IP E was asked if the facility had negative pressure rooms (a specialized isolation space designed to prevent airborne contaminants from escaping by maintaining negative air pressure inside the room, also referred to as AIIR [airborne infection isolation room]) or air filtration systems in the rooms. She said they did not. The Centers for Disease Control (CDC) recommendations titled Transmission-Based Precautions Infection Control Basics at www.cdc.gov/infection-control/hcp/basics/transmission-based-precautions.html, read, in part: .Use Airborne Precautions for patients known or suspected to be infected with pathogens transmitted by the airborne route. Ensure appropriate patient placement in an airborne infection isolation room (AIIR) constructed according to the Guideline for Isolation Precautions. In settings where Airborne Precautions cannot be implemented due to limited engineering resources, masking the patient and placing the patient in a private room with the door closed will reduce the likelihood of airborne transmission until the patient is either transferred to a facility with an AIIR or returned home. The policy Transmission-Based (Isolation) Precautions dated as reviewed/revised 12/31/25 read, in part: .It is our policy to take appropriate precautions to prevent transmission of pathogens, based on the pathogens' modes of transmission.An order for transmission-based precautions/isolation will be obtained for residents who are known or suspected to be infected or colonized with infectious agents.The order for transmission-based precautions/isolation will specify the type of precaution. Resident #16 (R16) (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235566	A. Building B. Wing	04/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Cheboygan	824 South Huron Cheboygan, MI 49721

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The medical record for R16 revealed an admission date of 1/21/2026 with a progress note titled Pertinent Charting Infections/Signs Symptoms by nursing on 4/9/2026 which read in part, . Type Other RSV Symptom(s): Abnormal lung sounds (rales, rhonchi, wheezes, etc.) acute functional decline Acute mental status change from baseline. Dry cough. Increased respiratory rate. New or increased sputum production. Oxygen saturation <94% on room air. A Physician order dated 4/9/2026 read, Place resident in transmission-based precautions related to RSV. All care and services received in room. every day and night shift. A follow-up progress note titled Pertinent Charting Infections/Signs Symptoms by nursing on 4/13/2026 read in part, . Follow up to infection signs/symptoms type: .(R16) remains in droplet, contact and airborne precautions at this time. No cough, afebrile and VSS (Vital Signs Symptoms). A follow-up progress note titled Pertinent Charting Infections/Signs Symptoms by nursing on 4/14/2026 read in part, Follow up to infection signs/symptoms type: Respiratory Site of originally identified infection: RSV . RESIDENT REMAINS IN ISOLATIN (sic) AT THIS TIME. NO cough or congestion noted. During observations of the lunch meal delivery on 4/13/2026 at 12:25 PM, CNA R removed a meal tray from the food cart and carried the tray into R16's room without any infection precautions and without wearing PPE. The door for R16's room contained notices including: CONTACT PRECAUTIONS EVERYONE MUST: Clean their hands, including before entering and when leaving the room. PROVIDERS AND STAFF MUST ALSO: Put on gloves before room entry. Discard gloves before room exit. Put on gown before room entry. Discard gown before room exit. Do not wear the same gown and gloves for the care of more than one person. Issued by the U.S Department of Health and Human Services Centers for Disease control and Prevention (CDC) AND DROPLET PRECAUTIONS EVERYONE MUST: Clean their hands, including before entering and when leaving the room. Make sure their eyes, nose and mouth are fully covered before room entry. Remove face protection before room exit. Issued by the U.S Department of Health and Human Services Centers for Disease control and Prevention (CDC) (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235566	A. Building B. Wing	04/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Cheboygan	824 South Huron Cheboygan, MI 49721

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	CNA R did not put on gloves before room entry. CNA R did not put on a gown before room entry. CNA R did not put on a face covering before room entry. During an interview on 4/13/2026 at 12:28 PM, CNA Q stated for R16 . on contact precautions you must glove and gown up when going in and out of the room. The policy titled, Transmission Based Precautions dated as last reviewed on 12/31/25 read in part, . 9 e. Signage that includes instructions for use of specific PPE (personal protective equipment) will be placed in a conspicuous location outside the resident's room, wing, or facility wide. f. The facility will have PPE readily available near the entrance of the resident's room. Staff and visitors will don appropriate PPE before or upon entry into the environment of a resident on transmission-based precautions. 10. d. Donning personal protective equipment (PPE) upon room entry and discarding before exiting the room is done to contain pathogens, especially those that have been implicated in transmission through environmental contamination (e.g. noroviruses, and other intestinal tract pathogens, RSV). Resident #12 (R12) The medical record for R12 revealed an admission date of 3/5/2026 with diagnoses including : cancer of the lip, oral cavity, pharynx (throat), and history of digestive tract resection (surgical removal of parts of the digestive tract) which made R12 dependent on a PEG (percutaneous endoscopic gastrostomy) tube (a flexible feeding tube surgically placed into the stomach), a Physician order dated 3/5/2026 read, Use enhanced barriers (enhanced barrier precautions or EBP) while performing high-contact activity with the resident r/t (related to) PEG tube every day and night shift. There was a sign on R12's door which read: ENHANCED BARRIER PRECAUTIONS EVERYONE MUST: Clean their hands, including before entering and when leaving the room Wear gloves and a gown for the following High-Contact Resident Care Activities. Device care or use: Central line, urinary catheter, feeding tube. On 4/14/2026 at 12:01 PM, RNP was observed administering R12's feeding via the PEG tube. RN P only wore gloves while administering the tube feeding. When exiting the room, the EBP policy on the door was reviewed with RN P including the requirement for gown and gloves while administering tube feeding. RN P stated: I never wear a gown for a tube feed. On 4/14/2026 at 12:13 PM, the EBP expectations were discussed with Regional RN K who stated PPE including gloves and gown should be worn for the administration of a tube feeding. The Care Plan for R12 included a focus of: Resident requires enhanced barrier precautions related to leg wound from bone graft retrieval & PEG tube Date Initiated: 03/04/2026. The interventions included: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235566	A. Building B. Wing	04/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Cheboygan	824 South Huron Cheboygan, MI 49721

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Use gown and gloves when providing direct care. Face protection may be needed if performing activity with risk of splash or spray. Date Initiated: 03/04/2026 Revision on: 04/12/2026 - Utilize Enhanced Barrier Precautions when providing high contact resident care activities (dressing, bathing, transferring, personal hygiene, changing linens, changing briefs/assisting with toileting, device care: central lines, urinary catheters, feeding tubes, tracheostomy/ventilators, wound care, dialysis) Date Initiated: 03/04/2026 The facility policy titled Enhanced Barrier Precautions (EBP) and dated as last reviewed 3/26/2024 read in part, Enhanced Barrier Precautions refers to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and gloves use during high-contact resident care activities. High-contact resident care activities to consider include: dressing, bathing, transferring, personal hygiene, changing linens, changing briefs/assisting with toileting, device care: central lines, urinary catheters, feeding tubes, tracheostomy/ventilators, wound care for chronic wounds.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235566	A. Building B. Wing	04/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Cheboygan	824 South Huron Cheboygan, MI 49721

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 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to offer and administer COVID vaccinations to two Resident (#2 & #4) of five residents reviewed for immunizations.Findings include:Resident #2 (R2)R2 was admitted to the facility on [DATE]. Vaccination consent forms for pneumococcal and Influenza vaccinations were e-signed by R2 on 1/20/26. A vaccination consent form for COVID-19 was not located in the medical record of R2.A Michigan Care Improvement Registry (MCIR - a statewide immunization information system that tracks vaccinations and health data for residents of Michigan) was reviewed on 4/15/26. The MICR documented R2 was [AGE] years of age. The MCIR indicated the immunization status of the COVID-19 2025-26 vaccine was Overdue.On 4/15/26 at 12:53 PM, Registered Nurse (RN) I was interviewed. RN I confirmed she was responsible for tracking vaccine consents and administrations. RN I said R2 was not provided the COVID-19 vaccination consent form when she was admitted on [DATE].Resident #4 (R4)Resident #4 (R4) was admitted to the facility on [DATE]. R4 signed a consent form for COVID-19 vaccine administration. R4 received one dose of the COVID-19 vaccination on 10/6/25.The MCIR of R4 was reviewed on 4/15/26. The MCIR documented R4 as [AGE] years of age. The MCIR indicated a COVID-19 2025-26 vaccine had an accelerated due date of 12/6/25 and was overdue to be administered as of 4/6/26.On 4/15/26 at 12:53 PM, RN I was asked the reason R4 had not received the second COVID-19 vaccination. RN I acknowledged R4 should have had the second COVID-19 vaccination on or before 4/6/26.The facility policy COVID-19 Vaccination dated as reviewed/revised 10/20/23 documented, in part: .It is the policy of this facility to minimize the risk of acquiring, transmitting, or experiencing complications from COVID-19 (SARS-CoV-2) by educating and offering our residents and staff the COVID-19 vaccine. The policy referenced outdated guidelines and vaccines that are no longer in use or recommended by the Centers for Disease Control (CDC).