STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235038	A. Building B. Wing	01/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Grand Rapids	2000 Leonard N E Grand Rapids, MI 49505

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 47955 This citation pertains to intake #MI00148777 Based on observation, interview, and record review the facility failed to preserve resident dignity during care in 2 (Resident #100 and Resident #103) of 4 residents reviewed for dignity resulting in the potential for a reasonable person to experience feelings of embarrassment, shame and/or a loss of self-esteem. Findings include: Resident #100 Review of an Admission Record revealed Resident #100 had pertinent diagnoses which included: Cerebral infarction due to occlusion, epilepsy with simple partial seizures, (abnormal electrical impulses in the brain, seizure disorder), spastic diplegic cerebral palsy, (neurological condition that causes disruption to normal movements, (causes stiffness to arms and legs)), and hydrocephalus (buildup of fluid in the cavities around the brain). On 12/26/24 at 9:54 AM., Resident #100 was observed in her bed and was noted to have significant facial hair, on her upper lip, chin, and both cheeks; a mustache and beard. Review of Care Plan for Resident #100 focus/goals/interventions: revealed Resident has an ADL (activity of daily living) self-care performance deficit .interventions: I prefer my facial hairs to be shaved daily with an initiation date of 5/14/2024. On 12/26/24 at 11:43 AM., Director of Nursing (DON) B and Certified Nurse Assistant (CNA) E were observed repositing Resident #100 in her bed. CNA E reported that Resident #100 gets a shower twice a week, and that facial shaving was done on shower days. DON B confirmed that shaving should be done on shower days. In an interview on 12/27/24 at 9:30 AM CNA G reported that shaving was done on shower days per the resident preference. CNA G reported that Resident #100's shower was scheduled today. During an interview on 12/27/24 at 10:00 AM., CNA O reported that male and female residents should be shaved on their shower days per their preferences. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235038	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/10/2025
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/27/24 at 10:21 AM., Resident #100 was observed in the shower room with CNA O providing a shower. On 12/27/24 at 1:25 PM., Resident #100 was observed in her reclining wheelchair, in her room, and was noted to have significant facial hair, on her upper lip, chin, and both cheeks, a mustache and beard as observed previously. In an interview on 12/26/24 with Resident #100's family member, FM Z indicated Resident #100 was a beautiful caring woman, and should be treated as such, she should not have significant facial hair, and he believed that Resident #100 would be embarrassed when she was unshaven. FM Z reported often times he had to shave Resident #100's face when he visited. Resident #100 was non-verbal, and unable to verbally express her own thoughts due to her mental diagnoses, based on the reasonable person concept Resident #100 had the potential to experience feeding of embarrassment and decreased self-worth related to her unkempt appearance with significant facial hair. Resident #103 Review of an Admission Record revealed Resident #103 had pertinent diagnoses which included: cerebral palsy and contractures of muscles (inability for muscles to stretch and retract as normal). On 12/26/24 at 11:12 AM., Director of Nursing (DON) B and Certified Nurse Assistant (CNA) H were observed from the hallway, transferring Resident #103 via a mechanical lift, into her recliner chair, in her, through an open doorway. In an interview on 12/26/24 at 11:12 AM., CNA H reported she should have closed the door to Resident #103's room and the curtain around her bed before the transfer and confirmed she did not close the door. Resident #103 had decreased ability to express her own thoughts due to her mental diagnosis and declined to engage in verbal conversation, based on reasonable person concept Resident #103 had the potential to experience feelings of decreased self-worth and embarrassment while being transferred with a mechanical lift with her room door open for anyone in the hallway to observe the care process. Review of facility policy titled Promoting/Maintaining Resident Dignity with an implementation date of 10/30/2020 wand a revision date of 10/26/2023 revealed 4. The residents' former lifestyle and personal choices will be considere4d when providing care and services to meet the residents' needs and preferences . 9. Groom and dress residents according to resident preference . 12. Maintain resident privacy .

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 47955 This citation pertains to intake #MI00148777 Based on interview and record review, the facility failed to notify a resident's responsible party regarding a change in condition for 1 (Resident #100) of 2 residents reviewed for change in condition resulting in a delay in resident transfer to emergency room for evaluation and treatment. Findings include: Resident #100 Review of an Admission Record revealed Resident #100 had pertinent diagnoses which included: Cerebral infarction due to occlusion, epilepsy with simple partial seizures, (abnormal electrical impulses in the brain, seizure disorder), spastic diplegic cerebral palsy, (neurological condition that causes disruption to normal movements, (causes stiffness to arms and legs)), and hydrocephalus (buildup of fluid in the cavities around the brain). Review of Nurses' Notes for Resident #100 dated 10/14/24 at 10:34 AM., authored by Registered Nurse (RN) N revealed Upon entering room to administer meds resident was noted to have eyes open with no tracking; looking straight forward. Vitals are WNL (within normal limits). When given heavy stimulation such as sternal rub and speaking very loudly; her eyes tracked. She is not speaking or answering questions at this time. No meds administered at this time. (Name Omitted) Medical Doctor (MD) and (Name Omitted) ADON (assistant director of nursing) made aware of presentation. Review of Nurses' Note dated 10/14/24 at 20:48 (8:48 PM) authored by RN J revealed Resident continues to present as lethargic, and LOC (level of consciousness) decreased from baseline. Resident will track with eyes momentarily, and then continue to stare past writer; continues to not be willing or able to swallow medications . During an interview on 12/26/24 at 2:11 AM., RN N reported she did not think she contacted Resident #100's family when she had a noted change in condition in October (2024). RN N confirmed the process for a resident change in condition included notifying the provider and guardian/family/decision maker. In an interview on 12/26/24 at 2:35 PM., ADON C reported she did not contact the family when Resident #100 had a noted change in condition on October 14, 2024. ADON C confirmed that family should be contacted when a resident has a change in condition. In an interview on 12/26/24 at 11:37 AM., MD Y reported she did not contact family when Resident #100 had a noted changed in condition on October 14, 2024. In a telephone interview on 12/27/24 at 2:07 PM., RN J reported she did not contact family when Resident #100 had a noted changed in condition on October 15, 2024. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 12/27/24 at 2:33 PM., Director of Nursing (DON) B reported her expectations were that family was notified when a resident was noted to have a change in condition. In a telephone interview on 12/27/24 at 5:49 PM., Licensed Practical Nurse (LPN) R reported she noticed something was wrong with Resident #100 and had been told in shift-to-shift report at the beginning of her shift that the provider was aware of the changed in condition, and the staff was to monitor Resident #100's condition. LPN R reported when Resident #100's family arrived at the facility on 10/15/24 in the evening and they reported something was clearly wrong with Resident #100. LPN 'R reported that Family Member (FM) Z was not aware of the change in condition for Resident #100 prior to his arrival to the facility. LPN R reported FM Z asked that Resident #100 be sent to the emergency room for evaluation. In an interview on 12/26/24 at 12:28 PM., FM Z reported he had not been made aware of the change in condition of Resident #100 until he arrived to see her on the same day she was transferred to the emergency room . FM Z reported that he visited the resident on 10/15/24 in the evening after work, and noticed Resident #100 was not herself. FM Z reported he went to DON B and told her something was wrong with Resident #100 and DON B told him they we're monitoring Resident #100. FM Z reported he requested Resident #100 be sent to the emergency room immediately. FM Z reported he was unable to instruct the facility to send Resident #100 to the emergency room for evaluation when the changed in condition was first noticed because he was never made aware of her change in condition. Review of Resident #100's medical record revealed no noted documentation that Resident #100's responsible party was notified when the facility staff identified a change in her condition on 10/14/24 and 10/15/24. Review of facility policy titled Notification of Changes implemented on 10/30/2020 with a revision date of 8/29/24 revealed the purpose of this policy is to ensure that facility promptly informs the resident, consults the resident's physician; and notifies, consistent with his or her authority, resident's representative when there is a change requiring notification. Definitions: life-threatening conditions example-heart attack or stroke . circumstances requiring notification include .significant change in the resident's physical, mental or psychosocial condition such as deterioration in health, mental, or psychosocial status this may include a. life-threatening conditions .

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46999 Based on observation, interview, and record review the facility failed to ensure wound care and compression stocking physician orders were in place for 1of 3 residents (Resident#102) reviewed for professional standards, resulting in the resident receiving care without the direction of a physician, and the potential for worsening of medical conditions. Findings include: Review of an Admission Record revealed Resident #102 was originally admitted to the facility on [DATE] with pertinent diagnoses which included: varicose veins (enlarged veins) of the bilateral (both) lower extremities with pain, chronic kidney disease (kidneys are damaged and can't filter blood the way they should), right bundle branch block (delayed electrical signal in heart's right bundle branch), and waldenstrom macroglobulinemia (cancerous changes to the white blood cells). Review of a Minimum Data Set (MDS) assessment for Resident #102, with a reference date of 12/11/24, section M revealed the resident had no skin issues at the time of the assessment. Review of a Care Plan for Resident #102, with a reference date of 12/5/24, revealed a focus/goal/interventions of: Resident is at risk for impaired skin integrity related to right bundle branch block, CKD (chronic kidney disease), Waldenstrom macroglobulinemia .Goal: Resident will have intact skin to the extent allowed .Interventions: .administer medications as ordered .notify Physician of any new areas of skin impairment . Review of physician orders for Resident #102 revealed no orders for wound care of his right hand or use of compression stocking for swelling of lower extremities. Review of a Nurses Note dated 12/24/24 revealed Resident grabbed gaitbelt (sic) from CNA and cut hand on metal teeth of gaitbelt (sic). Bandage applied . No notes were found regarding physician notification of the wound. During an observation on 12/26/24 at 2:14pm, Certified Nursing Assistant (CNA) V donned (putting on) thigh high compression stockings on Resident #102. Director of Nursing (DON) B then approached and completed a dressing change to Resident #102's right palm. In an interview on 12/26/24, at 2:29pm, DON B confirmed that Resident #102 did not have a physician's order in place for wound care to his right palm or for the use of compression stockings on his lower extremities. When further queried about the rationale for the compression stockings, DON B reported the resident's spouse requested them but added the resident really wasn't having any swelling to warrant the use. In an interview on 2/26/24 at 3:19pm, Registered Nurse (RN) W reported a resident with a wound should have physician orders in place to direct the care of the wound. RN W also reported physician orders were necessary prior to use of compression stockings because they are used to treat specific conditions and could cause circulation issues if they used inappropriately. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Fundamentals of Nursing revealed, The health care provider (physician or advanced practice nurse) is responsible for directing medical treatment. Nurses follow health care providers' orders unless they believe that the orders are in error, violate agency policy, or are harmful to the patient. [NAME], [NAME] A.; [NAME], [NAME] Griffin; Stockert, [NAME]; Hall, [NAME]. Fundamentals of Nursing - E-Book (Kindle Locations 20717-20719). Elsevier Health Sciences. Kindle Edition.

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety 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** 47955 This citation pertains to intake #MI00148777 Based on interview and record review, the facility failed to implement treatment measures when a change in condition was identified (acute stroke) in 1 (Resident #100) of 2 residents reviewed for change in condition, resulting in an Immediate Jeopary when on 1014/24, Resident #100 had sign and symptoms of a stroke and facility staff did not identify them resulting in the diagnosis of a cerebral infarction due to occlusion (Stroke caused by a blockage in a blood vessel) and a 27-day hospitalization . Findings include: The immediate jeopardy began on 10/14/2024 and was identified on 12/27/2024 due to the facility's failure to implement treatment measures when a change in condition was identified resulting in Resident #100 being hospitalized for 27 days and diagnosed with a cerebral infarction due to an occlusion (Stroke). On 12/27/24 at 4:06 PM., the Nursing Home Administrator was verbally notified and received written notification of the Immediate Jeopardy. The surveyor confirmed that the immediate Jeopardy was removed on 12/27/24 but noncompliance remains at the scope of isolated and severity of actual harm due to not all staff had not received the education and sustained compliance has not been verified by the State Agency. Resident #100 Review of an Admission Record revealed Resident #100 had pertinent diagnoses which included: Cerebral infarction due to occlusion, epilepsy with simple partial seizures, (abnormal electrical impulses in the brain, seizure disorder), spastic diplegic cerebral palsy (neurological condition that causes disruption to normal movements and causes stiffness to arms and legs), and hydrocephalus (buildup of fluid in the cavities around the brain). Review of Nurses' Notes for Resident #100 dated 10/14/24 at 10:34 AM., authored by Registered Nurse (RN) N revealed Upon entering room to administer meds resident was noted to have eyes open with no tracking; looking straight forward. Vitals are WNL (within normal limits). When given heavy stimulation such as sternal rub and speaking very loudly; her eyes tracked. She is not speaking or answering questions at this time. No meds administered at this time. (Name Omitted) Medical Doctor (MD) and (Name Omitted) ADON (Assistant Director of Nursing) made aware of presentation. Review of Nurses' Notes for Resident #100 dated 10/14/24 at 19:01 (7:01 PM) authored by RN N revealed . no meals taken today. Resident more alert, but slow to respond. Review of Nurses' Note dated 10/14/24 at 20:48 (8:48 PM) authored by RN J revealed Resident continues to present as lethargic, and LOC (level of consciousness) decreased from baseline. Resident will track with eyes momentarily, and then continue to stare past writer; continues to not be willing or able to swallow medications . (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Nurses' Note dated 10/14/24 at 6:11 AM authored by RN J revealed .has not voided (urinated) throughout shift, has had no oral intake in over 24 hours . During an observation on 12/26/24 at 9:54 AM., Resident #100 was noted lying in her bed with her eyes open, unfocused, and staring towards the television in the room. Resident #100 did not respond in any way (verbal or physical movement) when this surveyor spoke to her. In an interview on 12/26/24 at 11:15 AM., Certified Nurse Assistant (CNA) H reported Resident #100 was now non-verbal, and that she did talk before her stroke in October (2024). In an interview on 12/26/24 at 11:45 AM., Director of Nursing (DON) B reported Resident #100 was now non-verbal and was dependent on staff for all cares, including continuous tube feeding for nutrition and hydration needs. In an interview on 12/26/24 at 2:11 PM., RN N reported she thought that Resident #100's change in condition on 10/14/24 was a seizure, or that her shunt (a tube in the brain that redirects fluid) was malfunctioning. RN N reported she mentioned to the provider and the DON that Resident #100 was experiencing a change in condition, but she did not send her to the emergency room . RN N reported Resident #100 was sent frequently to the emergency room and the emergency room would do nothing and just send her back. RN N was asked if she contacted Resident #100's family when she noted the change in condition, and RN N stated I do not believe I contacted the family. RN N reported the process for a resident change in condition included a complete assessment, full vital signs, completion of the changed in condition assessment form, and a progress note needs to be completed. Also notify the provider, guardian/family/decision maker/ and then transfer to the emergency room . RN N reported she does not do the progress notes all the time due to things getting busy on the unit. RN N reported that both Medical Doctor (MD) Y and ADON C assessed Resident #100 on 10/14/24 and Resident #100 was not sent to the emergency room until the next day. In an interview on 12/26/24 at 2:35 PM., ADON C reported she was notified of Resident #100's change in condition and was asked to assess Resident #100. ADON C reported she was not aware of Resident #100's baseline status and was only advisory to RN N at the time. ADON C confirmed she did not document anything regarding Resident #100's condition on 10/14/24. In an interview on 12/27/24 11:37 AM., MD Y reported a couple of days before Resident #100 was sent to the emergency room , she assessed her, and nothing indicated that anything was different, there was nothing concrete that indicated Resident #100 needed to be seen by the ER (emergency room). MD Y reported she expected the nurses to monitor the resident and confirmed that she had not provided specifically what to monitor the resident for. MD Y reported she did not order Resident #100 be sent to the hospital; her family requested she be sent to the hospital. The MD Y was asked if she contacted the family to discuss Resident #100's condition and she replied she did not contact the family the nurse did. This surveyor asked MD Y about her documentation regarding assessment and visit to Resident #100 on 10/14/24 and MD Y stated I didn't document the visit. In an interview on 12/27/24 at 2:33 PM., DON B reported her expectations for a change in condition for a resident included the nurses performing a nursing assessment, vital signs, communication with the provider, contact family regarding the resident's condition, send the resident to the emergency room if indicated and that it be documented in the Resident's medical record. DON B stated If it wasn't documented it didn't happen. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In a telephone interview on 12/27/24 at 2:07 PM., RN J reported she was told in shift-to-shift report on 10/14/24 about Resident #100 change in condition and that the provider was aware of the change, and she was to monitor Resident #100's condition. RN J reported that she documented Resident #100's condition during her shift and was concerned with Resident #100 ability to swallow and she did not provide anything to her orally during her shift. RN J reported there was no protocol in place for what to do if a resident has no noted oral intake for 24 hours. RN J reported she did not contact the provider during her shift. In a telephone interview on 12/27/24 at 5:48 PM., Licensed Practical Nurse (LPN) R reported she sent Resident #100 to the emergency roiagnom on [DATE]. LPN R reported she noticed something was wrong with Resident #100 and had been told in shift-to-shift report that the provider was aware, and the staff was to monitor Resident #100's condition. LPN R reported when Resident #100's family arrived at the facility on 10/15/24 in the evening and they reported something was clearly wrong with Resident #100 and asked for her to be sent to the emergency room . LPN R reported she called the provider on call for a verbal order and transferred Resident #100 to the emergency room . In an interview on 12/26/24 at 12:28 PM., Family Member (FM) Z reported Resident #100 was sent to the hospital per family request in October where the hospital determined Resident #100 had suffered a stroke. FM Z reported that he visited the resident on 10/15/24 in the evening after work, and noticed Resident #100 was not herself. FM Z reported he went to DON B and told her something was wrong with Resident #100 and DON B told him they we're monitoring Resident #100. FM Z reported he requested that Resident #100 be sent to the emergency room immediately. FM Z reported he was angry that the facility staff was aware that something was wrong with Resident #100 and had done nothing for her. FM Z reported he had not been made aware of the change in condition of Resident #100 until he arrived to see her on the same day she was transferred to the emergency room . Review of Resident #100's medical record revealed no noted documentation from MD Y, ADON C, nor DON B regarding any assessment of Resident #100's change in condition, any specific monitoring or follow up, or any treatment measures for Resident #100's condition, nor any noted documentation regarding Resident #100's transfer to the emergency room during the dates of 10/14/24 and 10/15/24. Review of facility policy titled Notification of Changes implemented on 10/30/2020 with a revision date of 8/29/24 revealed the purpose of this policy is to ensure that facility promptly informs the resident, consults the resident's physician; and notifies, consistent with his or her authority, resident's representative when there is a change requiring notification. Definitions: life-threatening conditions example-heart attack or stroke . circumstances requiring notification include .significant change in the resident's physical, mental or psychosocial condition such as deterioration in health, mental, or psychosocial status this may include a. life-threatening conditions . According to the Mayo Foundation for Medical Education and Research, 1998-2010, retrieved online on 10/22/10, It should be noted when signs and symptoms of a stroke begin, because the length of time they have been present may guide treatment decisions. Seek immediate medical attention if you notice any signs or symptoms of a stroke, even if they seem to fluctuate or disappear. Call 911 or your local emergency number right away. Every minute counts. Don't wait to see if symptoms go away. The longer a stroke goes untreated, the greater the potential for brain damage and disability. To maximize the effectiveness of evaluation and treatment, it's best that you get to the emergency room within 60 minutes of your first symptoms. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The immediate Jeopardy that began on 10/14/2024 was removed on 12/27/2024 when the facility took the following actions to remove the immediacy: On October 14, 2024, the facility identified that the resident had a change in condition. The resident was transferred to the emergency room for evaluation on October 15, 2024. On December 27, 2024, the facility identified treatment was not implemented for a change in condition for Resident #100. On December 27, 2024, the Director of Nursing and/or designee began education of the facility staff on signs and symptoms of a stroke, to include specifically decreased oral intake, unresponsiveness, inability to take medications and decreased level of consciousness. How to seek medical direction and treatment for urgent levels of care. Notification of family of change in condition. Physician/provider notification of change in condition. Documentation of notifications and assessments. How to identify acute changes in condition. No staff will not be permitted to work prior to receiving the education. The DON and/or designee completed a chart audit of all residents on 12/27/24 to determine if any other residents had sustained an acute change of condition. No others were found. The QAPI committee had reviewed the change in condition policy on 12/27/24 and deemed it appropriate. The facility had an Ad Hoc QAPI Meeting, including the Medical Director on December 27, 2024, and deemed this removal plan appropriate.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46999 Based on observation, interview, and record review, the facility failed to provide adequate supervision to prevent falls with injury in 1 (Resident #102) of 3 residents reviewed for accident hazards and supervision, resulting in Resident #102 suffering pain, a head laceration which required stitches, and a hematoma on his forehead. Findings include: Review of an Admission Record revealed Resident #102 was originally admitted to the facility on [DATE] with pertinent diagnoses which included: muscle weakness, unsteadiness on feet, other abnormalities of gait (manner of walking) and mobility, disorientation, cognitive communication deficit, restlessness and agitation, and need for assistance with personal care. Review of a Minimum Data Set (MDS) assessment for Resident #102, with a reference date of 12/11/24 revealed a Brief Interview for Mental Status (BIMS) score of 12/15 which indicated Resident #102 was moderately cognitively impaired. Section GG of the MDS revealed Resident #102 required moderate (helper does less than half the effort) to transfer from bed to chair, transfer to the toilet, and to ambulate 10'. Section J revealed Resident #102 had a history of falls prior to his admission and had suffered a fall with injury since his admission to the facility. Review of a Care Plan for Resident # 102, with a reference date of 12/5/24, revealed a focus/goal/interventions of: Resident is at risk for falls .Goal: reduce the risk of injury through the next review. Interventions: .educate resident on safety interventions, encourage resident to keep needed items within reach, encourage resident to use call light . Review of an Incident Report dated 12/11/24 revealed Resident #102 was found lying on the floor of his room at 2:45pm. Resident #102 was bleeding from the right side of his head. A statement from a staff member who cared for Resident #102 on 12/11/24 indicated the resident had tried to stand and transfer on his own throughout the shift and multiple reminders were given to him. Review of an Initial Fall Evaluation for Resident #102, with a reference date of 12/11/24, revealed: pain evaluation: right side of head, pain level 5 .physical evaluation: right side head injury with bleeding .plan of care review .describe other interventions: constant reminders to use call light and to not self-transfer . Review of an After Visit Summary for Resident #102, with a reference date of 12/11/24 revealed the resident was diagnosed with: ground level fall, injury of head, laceration of scalp, at a local emergency roiagnom on this date. Review of an Interdisciplinary Progress Note for Resident #102, with a reference date of 12/12/24 revealed: Resident told staff he stood up from his wheelchair, did not use his call light and tipped over. Resident had laceration to right side of head and was sent to ER (emergency room) .upon return, staff determined a good intervention would be to provide more frequent checks on him . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235038	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/10/2025
NAME OF PROVIDER OR SUPPLIER Medilodge of Grand Rapids		STREET ADDRESS, CITY, STATE, ZIP CODE 2000 Leonard N E Grand Rapids, MI 49505	

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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 0689 Level of Harm - Actual harm Residents Affected - Few	Review of an Incident Report dated 12/12/24, revealed Resident #102 was found lying on the floor in the common area after an unwitnessed fall. Review of an Initial Fall Evaluation for Resident #102, with a reference date of 12/12/24, revealed: Describe other interventions: Resident to be in common areas of staff .Resident is impulsive. Needs constant reminders and monitoring. Review of an Incident Report dated 12/13/24, revealed Resident #102 had an unwitnessed fall in his room at 4:34pm. Review of an Incident Report dated 12/15/24, revealed Resident #102 was found on the floor in the common area after an unwitnessed fall. Review of an Incident Report dated 12/16/24, revealed Resident #102 was found on the floor in his room after an unwitnessed fall. Review of an After Visit Summary dated 12/19/24, revealed Resident #102 was diagnosed with ground level fall, closed head injury, traumatic hematoma of forehead at a local emergency roiagnom on this date. During an observation on 12/26/24 at 9:07am, Resident #102 sat fully reclined in a recliner chair outside his room. A large hematoma with bruising surrounding it, was present on the right side of Resident #102's forehead. No staff were present during the 5-minute observation. In an interview on 12/26/24, at 12:03pm, Family Member (FM) CC reported Resident #102 needed more supervision to remain safe at the facility. FM CC reported she visited the resident daily and often times did not see any staff while she was visiting. FM CC stated He is falling more here than he did at home, because he's getting less supervision. FM CC reported she requested the resident get more supervision during his care conference because she was worried about his safety, and she was told the facility was in the process of hiring additional staff. FM CC reported Resident #102 had been sent to the emergency room twice in recent weeks because he fell and hit his head. The resident received stitches to his right forehead during both visits to the emergency room . FM CC stated They just need more staff to give him the supervision he needs. In an interview on 12/26/24, at 3:19pm, Registered Nurse (RN) W reported Resident #102 needed constant supervision to avoid falling. RN W reported she cared for Resident #102 on 12/19/24 and he fell after being left unsupervised. RN W reported although Resident #102 needed constant supervision to remain safe, the facility did not have enough staff to provide the supervision he needed. In an interview on 12/26/24 at 3:25pm, Registered Nurse (RN) N reported she had cared for Resident #102 in recent weeks and felt the facility did not provide the amount of supervision the resident needed to remain safe. RN N reported Resident #102 constantly attempted to stand up and when he did so, the resident would stand up and fall on his head. RN N reported the facility had provided Resident #102 with 1:1 supervision at times but did not have enough staff to always do so. (continued on next page)

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	235038	A. Building B. Wing	01/10/2025

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Medilodge of Grand Rapids	2000 Leonard N E Grand Rapids, MI 49505

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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 0689 Level of Harm - Actual harm Residents Affected - Few	In an interview on 12/27/24 at 9:19am, Certified Nursing Assistant (CNA) L reported on 12/19/24 while she was in another resident's room, she was alerted by Resident #102's roommate that he had fallen. CNA L reported she and another CNA found Resident #102 actively bleeding, lying on the floor in his room. CNA L reported she was aware Resident #102 was unsafe to be alone, but the staffing level did not allow for a staff member to always be with Resident #102 and she and the other CNA were caring for a resident that needed the assistance of 2 staff members, when Resident #102 fell . CNA K reported Resident #102's unit only had 2 CNA's at the time, one of which was a trainee, who could not be left alone with Resident #102. During an observation on 12/27/24 at 9:24am, Medical Records Coordinator (MR) I sat next to Resident #102 as he slept in a recliner chair in the common area of the facility. In an interview on 12/27/24 at 9:27sm, MR I reported she was providing supervision to Resident #102 as she sat with him on this date. MR I reported she was asked to provide supervision to Resident #102 for the first time on 12/26/24, was happy to help, but had not been asked previously. In an interview on 12/26/24 at 1:22pm, CNA V reported Resident #102 was supposed to be checked on frequently, but she was unsure exactly how often staff were expected to check on him. CNA V added, He moves so fast, unless you're right there, he will fall. In an interview on 12/26/24 at 2:29pm, Director of Nursing (DON) B reported Resident #102 required a lot of supervision to remain safe. DON B reported the resident was placed on frequent checks which meant he could not be expected to ask for help before attempting to get up and should be within line of sight of staff when he was awake. DON B reported the expectation was for Resident #102 to always be with staff when he was awake. When further queried about the amount of supervision the facility had provided to Resident #102, DON B became tearful and reported the facility had done what it could to provide the level of supervision Resident #102 needed and had been successful with providing supervision while the resident was awake in the last few days. No additional interventions beside supervision were discussed or considered. In an interview on 12/27/24 at 1:35pm, Registered Nurse (RN) W reported the facility recognized Resident #102 needed constant 1:1 supervision to remain safe at times, but there was not enough staff to provide that level of supervision. In an interview on 12/27/24 at 1:43pm, Confidential Informant (CI) DD reported Resident #102 needed 1:1 supervision to maintain his safety when he was restless. CI DD reported the facility staffing had suffered through a perfect storm in recent weeks due to open nursing positions, staff illness, and the recent holidays. When queried about the facility's ability to meet the supervision needs of Resident #102, CI DD stated All I can say is look at the nursing schedules. Review of the nursing schedules for (12/11, 12/12, 12/13, 12/15, 12/16, 12/19), each day/shift on which Resident #102 had a fall, revealed the facility was operating with less nursing staff than it deemed necessary for Resident #102's unit. Review of a facility policy, Fall Prevention Program with a reference date of 10/26/23 revealed Policy: Each resident will .receive care and services in accordance with the level of risk to minimize the likelihood of falls.

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NAME OF PROVIDER OR SUPPLIER Medilodge of Grand Rapids		STREET ADDRESS, CITY, STATE, ZIP CODE 2000 Leonard N E Grand Rapids, MI 49505	

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46999 Based on observation, interview, and record review, the facility failed to ensure sufficient staffing to provide adequate care for 2 (Resident #102) of 4 residents reviewed for staffing. This deficient practice resulted in falls and avoidable pain for Resident #102 due to lack of supervision, Resident #100 not receiving proper grooming, and a potential for additional unmet care needs for residents who reside in the building. Findings include: Review of Association of Staffing Instability With Quality of Nursing Home Care, Mukamel, [NAME], [NAME], Journal of American Medical Association, January 2023, revealed: Conclusion: this study suggests that holding average staffing levels constant, day to day staffing stability, especially avoiding days of low staffing of licensed practical nurses and certified nurse aides, is a marker of better quality of nursing homes. Resident #102 Review of an Admission Record revealed Resident #102 was originally admitted to the facility on [DATE] with pertinent diagnoses which included: muscle weakness, unsteadiness on feet, other abnormalities of gait (manner of walking) and mobility, disorientation, cognitive communication deficit, restlessness and agitation, and need for assistance with personal care. Review of a Minimum Data Set (MDS) assessment for Resident #102, with a reference date of 12/11/24 revealed a Brief Interview for Mental Status (BIMS) score of 12/15 which indicated Resident #102 was moderately cognitively impaired. Section GG of the MDS revealed Resident #102 required moderate (helper does less than half the effort) to transfer from bed to chair, transfer to the toilet, and to ambulate 10'. Section J revealed Resident #102 had a history of falls prior to his admission and had suffered a fall with injury since his admission to the facility. Review of a Care Plan for Resident # 102, with a reference date of 12/5/24, revealed a focus/goal/interventions of: Resident is at risk for falls .Goal: reduce the risk of injury through the next review. Interventions: .educate resident on safety interventions, encourage resident to keep needed items within reach, encourage resident to use call light . Review of an Initial Fall Evaluation for Resident #102, with a reference date of 12/11/24, revealed: pain evaluation: right side of head, pain level 5 .physical evaluation: right side head injury with bleeding .plan of care review .describe other interventions: constant reminders to use call light and to not self-transfer . Review of an After Visit Summary for Resident #102, with a reference date of 12/11/24 revealed the resident was diagnosed with: ground level fall, injury of head, laceration of scalp, at a local emergency roiagnom on this date. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of an Initial Fall Evaluation for Resident #102, with a reference date of 12/12/24, revealed: Describe other interventions: Resident to be in common areas of staff .Resident is impulsive. Needs constant reminders and monitoring. Review of an Incident Report dated 12/13/24, revealed Resident #102 had an unwitnessed fall in his room at 4:34pm. Review of an Incident Report dated 12/15/24, revealed Resident #102 was found on the floor in the common area after an unwitnessed fall. Review of an Incident Report dated 12/16/24, revealed Resident #102 was found on the floor in his room after an unwitnessed fall. Review of an After Visit Summary dated 12/19/24, revealed Resident #102 was diagnosed with ground level fall, closed head injury, traumatic hematoma of forehead at a local emergency roiagnom on this date. During an observation on 12/26/24 at 9:07am, Resident #102 sat fully reclined in a recliner chair outside his room. A large hematoma with bruising surrounding it, was present on the right side of Resident #102's forehead. No staff were present during the 5-minute observation. In an interview on 12/26/24 at 9:12am, Registered Nurse (RN) N reported the facility was staff with 2 nurses and 3 Certified Nursing Assistants (CNA's) for the day shift on this date, which was below the minimum staffing level the facility had deemed necessary. RN N reported she was caring for 28 residents; each aide was caring for approximately 18 residents. RN N reported this staffing level was below the number of staff the facility had deemed necessary for the current resident population. In an interview on 12/26/24 at 9:18am, Certified Nursing Assistant (CNA) V reported she was the only CNA for Resident #102's unit today. When further queried, CNA V reported Resident #102 needed more supervision than she could provide given the current staffing level. In an interview on 12/26/24, at 12:03pm, Family Member (FM) CC she visited Resident #102 daily and often did not see any staff around during her visits. FM CC reported Resident #102 needed more supervision to remain safe at the facility. FM CC stated He is falling more here than he did at home, because he had less supervision at the facility. FM CC reported she requested the resident get more supervision during his care conference because she was worried about his safety, and she was told the facility was in the process of hiring additional staff. FM CC reported Resident #102 had been sent to the emergency room twice in recent weeks because he fell and hit his head and required 4 stitches to his right forehead during both visits to the emergency room . FM CC stated They just need more staff to give him the supervision he needs. During an observation on 12/26/24 at 3:15pm, Resident #102 was asleep in a recliner chair in the common area of the facility. No staff were present. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 12/26/24, at 3:19pm, Registered Nurse (RN) W reported Resident #102 needed constant supervision to avoid falling. RN W reported she cared for Resident #102 on 12/19/24 and he fell after being left unsupervised. RN W reported although Resident #102 needed constant supervision to remain safe, the facility did not have enough staff to provide the supervision he needed. RN W reported the facility had 2 nurses and 3 aides to provide care for 54 residents on this date which was far below the staffing level the facility had deemed necessary. In an interview on 12/26/24 at 3:25pm, RN V reported in recent weeks, Resident #102 had been constantly up and trying to walk. RN V reported the resident was confused and did not realize he was unable to safely walk, so he would literally stand up and fall on his head. RN V reported the facility provided some 1:1 supervision for the resident but did not have enough staff to always provide this level of supervision, and as a result, Resident #102 had fallen. In an interview on 12/26/24 at 3:32pm, CNA M reported she was currently the only CNA for Resident #102's unit and he needed more supervision than she could provide. CNA M reported she could not supervise Resident #102 while also providing cares for other residents privately. In an interview on 12/27/24 at 9:19am, Certified Nursing Assistant (CNA) L reported on 12/19/24 she was alerted by Resident #102's roommate, while she was in another resident's room, that Resident #102 had fallen. CNA L reported she and another CNA found Resident #102 actively bleeding, lying on the floor in his room. CNA L reported the facility was staffed with less nursing staff than it had deemed necessary for Resident #102's unit that day and all staff were busy caring for other residents when Resident #102 fell . CNA L reported the unit had 2 CNA's but 1 was a trainee who was not allowed to provide cares independently. In an interview on 12/26/24 at 1:22pm, CNA V reported Resident #102 was supposed to be checked on frequently, but she was unsure exactly how often staff were expected to check on him. CNA V added, He moves so fast, unless you're right there, he will fall. In an interview on 12/26/24 at 2:29pm, Director of Nursing (DON) B reported the facility had determined the necessary staffing levels to provide quality care were as follows: 3 nurses and 6 CNA's on day shift, 2 nurses until 10:30pm and 5 CNA's on afternoon shift, and 1 nurse, 3 CNA's overnight. DON B described the current staffing situation as the perfect storm in recent weeks. DON B reported the facility had several open schedule slots for the nursing staff due to open positions, staff illness, and the holidays. DON B reported she and other members of the leadership team were frequently working as floor staff, but some positions could not be filled. DON B reported Resident #102 should be with staff when he is awake due to his safety needs. When further queried about the amount of supervision the facility had provided to Resident #102, DON B became tearful and reported the facility had done what it could to provide the level of supervision Resident #102 needed and had been successful with providing supervision while the resident was awake in the last few days. Review of the nursing schedules for (12/11, 12/12, 12/13, 12/15, 12/16, 12/19), each day/shift on which Resident #102 had a fall, revealed the facility was operating with less nursing staff than it deemed necessary for Resident #102's unit. Review of a list of residents who were dependent (required assistance of 2 staff members for cares), provided by Nursing Home Administrator (NHA) A, revealed 21 of 53 residents required assist of 2 staff members for cares. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A list of current open nursing positions for the facility was requested but not provided at the time of exit conference. In an interview on 12/27/24 at 9:27am, Activity Assistant (AA) Q reported she witnessed residents experiencing long waits for assistance and a lack of supervision of residents due to low nursing staffing. In an interview on 12/27/24 at 9:43am, Housekeeper (HSK) BB described the nursing staffing at the facility as horrible and reported she witnessed resident's waiting for more than 60 minutes to receive care. 47955 Resident #100 Review of an Admission Record revealed Resident #100 had pertinent diagnoses which included: Cerebral infarction due to occlusion, epilepsy with simple partial seizures, (abnormal electrical impulses in the brain, seizure disorder), spastic diplegic cerebral palsy, (neurological condition that causes disruption to normal movements, (causes stiffness to arms and legs), and hydrocephalus (buildup of fluid in the cavities around the brain). In an interview on 12/26/24 at 9:35 AM., Registered Nurse (RN) W reported staffing on this day was two nurses and three Certified Nurse Assistants (CNA). Census was reported to be 54 residents. In an interview on 12/26/24 at 9:41 AM., CNA D reported he had been called in to help and that he was scheduled to work until 10:30 PM this day. CNA D reported he was called in to work early most of the days he was scheduled to work . In an interview on 12/26/24 at 9:45 AM., RN N reported staffing was terrible. RN N reported there was not enough staff to supervise residents, there was an increase in falls, behaviors, and meals and medications were late. On 12/26/24 at 11:05 AM., Director of Nursing (DON) B and CNA H were observed exiting a resident's room. DON B reported that she does have to work the floor to cover open shifts. CNA H reported she was the only CNA on the unit, and she needed another staff member to complete a mechanical lift transfer. CNA H reported staffing was short this day, there were only 3 CNAs and 2 nurses, and she was behind with resident's cares. In an interview on 12/26/24 at 11:15 AM., CNA H reported Resident #100 does not get out of bed and into her wheelchair on days when staffing was short. CNA H indicated that this dates, staffing was short with only 3 CNAs and that Resident #100 would not get out of bed this shift. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Care Plan for Resident #100 revealed Focus/Goal/Interventions: Resident has an ADL (activity of daily living) self-care deficit relate to activity intolerance, cognitive deficits, deconditioning, fatigue, impaired balance, limited mobility .have resident up between breakfast and lunch and again between lunch and dinner as tolerated, initiated on 12/11/2024. I prefer to have my facial hairs shaved daily initiated on 5/14/2024. On 12/26/24 at 11:43 AM., DON B and CNA E were observed repositioning Resident #100 in bed. In a telephone interview on 12/26/24 at 12:28 PM., Family Member (FM) Z reported DON B was working the cart on the units because the facility did not have enough staff to fill the open shifts. On 12/26/24 at 1:45 AM., the call light to room [ROOM NUMBER] on the birchwood unit was activated. On 12/26/24 at 1:50 PM., CNA H was observed entering a room [ROOM NUMBER] on the birchwood unit. Activity staff was noted on the unit engaging several residents in bingo in the dining area on the birchwood unit. No other staff was noted on the unit. On 12/26/24 at 2:05 PM., the call light to room [ROOM NUMBER] on the birchwood unit was still on, and a female voice could be heard yelling hello. On 12/26/24 at 2:11 PM., CNA H was noted to answer the call light for room [ROOM NUMBER] on the birchwood unit. The call light was noted to be active for 21 minutes. In an interview on 12/26/24 at 3:15 PM., CNA E reported staffing affects resident care. Shower are delayed or not done, call light wait times are longer for residents when staffing was short. On 12/26/24 during the times of 9:00 AM., and 4:00 PM., Resident #100 was not observed to have significant facial hair and was not out of her bed to sit in her wheelchair during these times. In an interview on 12/27/24 at 9:27 AM., CNA V reported staffing was an issue and directly affected resident showers, two person check and changed, and call light wait times. CNA V reported that bed baths were given in place of showers due to low staffing numbers. CNA V reported when only one CNA was on the unit, the call light wait times increased significantly because we cannot be in two places at once. On 12/27/24 at 9:40 AM., the alarm on Resident #100's feeding pump was sounding, and the screen displayed a message indicating flow error. In an interview on 12/27/24 at 9:50 AM., CNA O reported she needed a second staff member to assist Resident #100 into the shower. CNA O reported she does nothing with Resident #100's feeding pump, and she needed the nurse to silence the alarm that was still sounding and disconnect the feeding for the shower. On 12/27/24 at 10:00 AM., Resident #100's feeding pump alarm was acknowledged by RN N after sounding for 20 minutes. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 12/27/24 at 10:13 AM., CNA K reported that corners get cut when staffing was short. CNA K identified tasks that were eliminated during short staffing to be using PPE for enhanced barrier precautions, showers, oral care, and shaving. On 12/27/24 at 10:21 AM., Resident #100 was noted to be in the shower with CNA V. On 12/27/24 at 1:25 PM., Resident #100 was noted to be sitting in her reclining wheelchair in her room, dressed, but with significant facial hair noted.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 47955 This citation pertains to intake #MI00148997 and MI000149141 Based on observation, interview, and record review the facility failed to 1. ensure proper use of personal protective equipment (PPE) for 2 (Resident #100 and Resident #103) on enhanced barrier precautions and 2. properly clean resident shared equipment, resulting in the potential for the spread of infection, cross-contamination, and disease transmission for residents residing in the facility. Findings include: Resident #100 Review of an Admission Record revealed Resident #100 had pertinent diagnoses which included: Cerebral infarction due to occlusion, epilepsy with simple partial seizures, (abnormal electrical impulses in the brain, seizure disorder), spastic diplegic cerebral palsy, (neurological condition that causes disruption to normal movements, (causes stiffness to arms and legs)), and hydrocephalus (buildup of fluid in the cavities around the brain). At 9:54 AM., on 12/26/24 signage was noted on Resident #100's door to her room indicating the resident was in enhanced barrier precautions and staff must perform hand hygiene, apply gloves and a gown prior to providing any care. Review of Care Plan for Resident #100 revealed Focus/goal/interventions: Resident requires enhanced barrier precautions related to feeding tube, use gown and gloves when providing direct care. Initiated 11/11/24. In an interview on 12/26/24 at 11:15 AM., Certified Nurse Assistant (CNA) H reported that Resident #100 was in enhanced barrier precautions and that meant staff was to wear a gown and gloves during cares. On 12/26/24 at 11:34 AM., Director of Nursing (DON) B was observed rehanging tube feeding formula for Resident #100 and was only wearing gloves when the procedure was performed. On 12/26/24 at 11:37 AM., DON B and CNA E were observed repositioning Resident #100 in her bed and neither staff member were wearing a gown as indicated by the signage on the door for enhanced barrier precautions. In an interview on 12/26/24 at 2:11 AM., Registered Nurse (RN) N reported Resident #100 was not in enhanced barrier precautions, but she should be. In an interview on 12/26/24 at 3:15 PM., CNA E reported staff was to wear a gown and gloves when providing cares to a resident who was in enhanced barrier precautions. CNA E reported that Resident #100 was not on enhanced barrier precautions. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235038	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/10/2025
NAME OF PROVIDER OR SUPPLIER: Medilodge of Grand Rapids		STREET ADDRESS, CITY, STATE, ZIP CODE: 2000 Leonard N E Grand Rapids, MI 49505	

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	In an interview on 12/26/24 at 3:26 PM., RN W reported enhanced barrier precautions were indicated if a resident had a peg tube (feeding tube). RN W reported staff was to wear a gown and gloves during cares. During an observation and interview on 12/27/24 at 10:21 AM., Resident #100 was in the shower room and no PPE was noted available for use in the shower room. CNA V indicated there was no PPE stored in the shower room. Resident #103 Review of an Admission Record revealed Resident #103 had pertinent diagnoses which included: cerebral palsy and contractures of muscles (inability for muscles to stretch and retract as normal). On 12/26/24 at 11:12 AM., DON B and CNA H were observed from the hallway, transferring Resident #103 via a hoyer lift (mechanical lift), into her recliner chair, in her room, through an open doorway. Noted on Resident #103's door was signage indicating that Resident #103 was in enhanced barrier precautions, indicating that staff must wear a gown and gloves during care activities including transferring. Neither staff member was wearing any PPE. CNA H was observed placing the hoyer lift in the hallway and did not clean it. In an interview on 12/26/24 at 11:12 AM., CNA H reported Resident #103 was on enhanced barrier precautions and staff needed to wear a gown and gloves during cares. CNA H reported enhanced barrier precautions did not include transfers. CNA H was observed reading the signage posted on Resident #103's door and stated, it does include transfers, I need to be better educated on enhanced barrier precautions. Review of Care Plan for Resident #103 revealed Focus/goal/interventions: Resident requires enhanced barrier precautions related to feeding tube, use gown and gloves when providing direct care. Initiated 4/8/24. In an interview on 12/26/24 at 3:35 PM., DON B reported her expectations we if the room was posted with enhanced barrier precautions signage that the PPE be worn by staff when providing cares. DON B initially indicated that PPE was not needed when performing transfers, then changed her mind, and transfers should be included, and staff should wear PPE when transferring residents. DON B confirmed that she was not wearing PPE when she administered the tube feeding and when she assisted with the repositioning of Resident #100, and she confirmed she was not wearing PPE when she assisted with the transfer for Resident #103. During an observation and interview on 12/27/24 at 9:27 AM., CNA G and CNA V were observed in the room with Resident #103, preparing to transfer her from her reclining wheelchair to her bed, when Staff Development/Infection Control (SD/IC) U entered Resident #103's room and instructed the CNAs to apply PPE. CNA G and CNA V confirmed they would have transferred Resident #103 without any PPE if SD/IC U had not instructed them to put PPE on. CNA G was observed exiting the room with the hoyer lift and placing it outside the room. CNA G did not clean the lift. In an interview on 12/27/24 at 9:34 AM., CNA V reported lifts should be cleaned before and after use for all residents. CNA V reported the lifts do not get cleaned as they should. CNA V confirmed she did not clean the lift after it was used for Resident #103. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Medilodge of Grand Rapids		STREET ADDRESS, CITY, STATE, ZIP CODE 2000 Leonard N E Grand Rapids, MI 49505	

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	In an interview on 12/27/24 at 9:36 PM., CNA G reported she does not know anything about cleaning the lifts, she has never been instructed to clean the lift, and she confirmed she did not clean the lift after she used it with Resident #103. In an interview on 12/27/24 at 10:24 AM., Staff Development/Infection Control (SD/IC) U reported she was in training for the infection control and was not certified. SD/IC U reported DON B was certified for the building. SD/IC U confirmed she had educated the two CNAs transferring Resident #103 and she confirmed there was no PPE present in the shower room. SD/IC reported her expectations was that PPE should be worn during resident showers for those in enhanced barrier precautions. On 12/27/24 at 2:53 PM., the facility provided a copy of DON B certificate of completion for nursing home infection preventionist training course that was dated 12/27/24. 46999 During an observation on 12/26/24 at 9:14am, shared equipment stored in the hallway near the shower room of the Pineridge Unit was noted to be heavily soiled. A white shower chair had a dried, baseball sized, yellow liquid stain on the seat. 2 sit to stand machines were soiled with dust, hair, food crumbs, and debris on the foot platform, where resident's place their feet during transfers. One sit to stand machine had a whole almond and partial peanut on the foot platform. The bars on one machine, where the resident places their hands during a transfer, were soiled with a dried white liquid. During an observation on 12/27/24 at 9:37am, the shared equipment stored near the shower room of the Pineridge Unit was on the opposite side of the hallway from the previous day. The equipment was arrnaged in a different order than from the previous day.The equipment remained soiled. A mechanical lift labeled #11, had blue padded hand grips for the residents to hold. The hand grips of the lift were heaviliy soiled with dust and debris that covered their entire surface. In an interview on 12/27/24 at 9:39am, Certified Nursing Assistant (CNA) V reported the shared equipment stored by the shower room on Pineridge Unit was actively in use for residents, some of which had been used on this date.