

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 06/23/2026
NAME OF PROVIDER OR SUPPLIER Medilodge of Grand Rapids		STREET ADDRESS, CITY, STATE, ZIP CODE 2000 Leonard NE 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.			
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F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake #3003696 Based on observation, interview and record review the facility failed to recognize a change in condition, ensure residents received care in accordance with professional standards and ensure resident's care choices were followed for 4 Residents (#60, #51, #3, and #30) of 24 reviewed for quality of care, resulting in a delay in treatment for an infection requiring hospitalization and toe amputation for Resident #3, delay in post fall nursing assessment and treatment for a closed nondisplaced oblique fracture of shaft of right femur and closed fracture of proximal end of right fibula for Resident #30, and a delay in treatment for an unrecognized hip fracture requiring surgical repair for Resident #60, and delay in specialized care for Resident #51 who experienced increased pain. Findings include: Resident #60 (R60) Review of a Face Sheet revealed R60 was originally admitted to the facility on [DATE] with pertinent diagnoses which included: muscle weakness and cognitive communication deficit (difficulty with communication caused by decreased thinking skills). Review of a Minimum Data Set(MDS) assessment for R60 with a reference date of 3/18/26, revealed a Brief Interview for Mental Status (BIMS) assessment score of 13/15, which indicated the resident was cognitively intact. Section GG revealed R60 required moderate assistance to transfer to and from the toilet. Section J revealed R60 had falls in the last 90 days. Review of a Care Plan for R60 with a reference date of 6/19/24 revealed the following focus/goal/interventions: Focus: Resident is at risk for falls related to hx (history) of falls,.Resident frequently self-transfers and is non-compliant is asking nursing staff for assistance.Goal: Reduce the risk of injury.Interventions: Educate resident to look behind him prior to sitting.keep bed at lowest position.Resident educated on asking for assistance.Resident to use dycem (material that provides friction) in WC(wheelchair), discourage from wrapping self in blanket when up in his wheelchair.keep bed remote within reach. Review of a Fall Assessment for R60 with a reference date of 5/1/26 revealed Date of fall: 5/1/26.was in the bathroom and self-transferring from toilet to wheelchair.pain level: 3.Any injury or suspected injury: No. In an interview on 6/17/26 Licensed Practical Nurse (LPN) VV reported she was called to R60's around 5:20pm on 5/1/26 where she found him sitting on the floor with his back against a cupboard in his bathroom. LPN VV reported she completed a Fall Assessment for R60 and did not feel he had any injuries at that time, but he did require the use of mechanical lift to get him to bed. Of note, R60 was normally independent for walking short distances and out of bed multiple times throughout the day (continued on next page)		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0684 Level of Harm - Actual harm Residents Affected - Few	prior to the fall. In an interview on 6/23/26 at 9:58am, Certified Nursing Assistant (CNA) T reported she cared for R60 on the evening of 5/1/26 and he was not the same after the fall that occurred that day around 5:30pm. CNA T reported R60 complained of pain, would not get out of bed and required assistance of 2 staff for cares. CNA T reported prior to the fall, R60 did most cares without any assistance. CNA T reported she told the nurse on duty on 5/1/26 that R60 was having significant pain and that R60 told her he thought he broke his leg. In an interview on 6/18/26 at 9:28am, CNA I reported she cared for R60 on 5/2/26 and noticed around 6:30pm that the resident's leg was swollen, so she told the nurse on duty (LPN V) as well as the nurse coming in to work the night shift. CNA I stated I told them that I thought he needed an x-ray because R60 complained of more pain, said he thought he broke his hip, his leg was swollen, and he would not get out of bed. In an interview on 6/18/26 at 11:03am, LPN V, who cared for R60 on 5/2 and 5/3/26, reported the resident did not get out of bed all weekend and guarded his leg when she attempted to assess it. LPN V reported she could not recall if R60's leg appeared swollen or rotated. LPN V reported R60 was normally up and down all day and ate meals in the dining room. LPN V confirmed that CNA I told her R60 was in pain and his leg was swollen but she could not confirm that happened on 5/2/26. LPN V reported she contacted a provider on 5/3 for further direction and received an order for an x-ray. Review of Physician Orders for R60 with a reference date of 5/3/26 revealed the provider ordered a hip x-ray at 6:30am. Review of an Emergency Department Provider Note for R60 from a local hospital, with a reference date of 5/3/26 revealed Patient seen and evaluated. physical exam is notable for obvious deformity to the right femur (upper leg) with mild tenderness, right lower extremity shortened, externally (outward) rotated with decreased passive range of motion. Of note, I did speak with social work regarding concerns of the care patient received at (facility name omitted). He has an obvious deformity of his right femur with fall 2 days ago. Resident #51 (R51) Review of an Face Sheet revealed R51 was originally admitted to the facility on [DATE] with pertinent diagnoses which included: major depressive disorder(a serious mental health condition characterized by persistent feeling of sadness, hopelessness, and loss of interest in activities once enjoyed), pyoderma gangrenosum (rare skin condition that causes rapidly enlarging, extremely painful ulcers), thrombocytosis (condition in which the body produces too many platelets resulting in increased risk of blood clots), venous insufficiency (condition causing poor blood circulation) and hemiplegia (loss of movement on one side of the body). Review of a Minimum Data Set(MDS) assessment for R51 with a reference date of 6/2/26, revealed a Brief Interview for Mental Status (BIMS) assessment score of 15/15, which indicated the resident was cognitively intact. Section D of the MDS revealed R51 experienced little interest or pleasure in doing things during 12-14 days of the 14-day assessment period. Review of a Care Plan for R51 with a reference date of 9/25/25 revealed the following focus/goal/interventions: 1. Focus: Resident is at risk for an ADL self-care performance deficit (continued on next page)		

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F 0684 Level of Harm - Actual harm Residents Affected - Few	for ongoing management.venous insufficiency (poor blood flow causing swelling, wounds, poor healing in lower extremities). If ulcers fail to improve or there are signs of cellulitis (infection in the skin), consider vascular or wound clinic referral. In an interview on 6/18/26 at 11:29am Nurse Practitioner (NP) JJ confirmed R51 had not been evaluated by the wound clinic and that she had not ordered a referral for R51 to be evaluated by a vascular specialist until 6/16/26. NP JJ confirmed R51 had multiple wounds on both lower legs, had been treated with antibiotics for an infection and had a new wound develop in the last 30 days. Review of Wound and Skin documentation for R51 dated 6/2/26 revealed a new wound located on the right front lateral lower leg measuring 2.08cm x 1.69cm; further documentation on 6/9/26 indicated the wound had stalled (neither improving or worsening) and was measured to be 3.72 cm x 2.58cm. The comparison of the wound measurements indicated the wound increased in size. Review of the Wound and Skin documentation for R51 dated 6/2/26 revealed a wound located on the left lateral calf measured length 3.48cm x1.88cm, further documentation on 6/1/6/26 revealed the wound measured 3.1cm x 2.85 and was stalled with characteristics of plateauing, meaning the wound was unchanged. In a follow up interview on 6/23/26 at 9:11am, R51 reported growing concern about his health and the wounds he had on his lower legs. R51 stated I'm getting weaker, having more pain in my legs, and I'm afraid I'm going to relapse like I did a few years ago. R51 reported the staff did not seem to have time to follow up on his need to see a specialist, then stated I want to live so bad.I have to fight for what I need every day. I still don't have an appointment. Review of a Medication Administration Record (MAR) for R51 with a reference date of 5/2026 revealed the resident never rated his pain level above a 4 on the numeric pain scale of 0-10, throughout that entire month. Review of a Medication Administration Record (MAR) for R51 with a reference date of 6/2026 revealed the resident started taking Tramadol (synthetic opioid pain reliever prescribed to treat moderate to severe pain) on 6/18/26. R51 began experiencing increased pain on 6/8/26 with a rating of 6 on the numeric pain scale of 0-10, then continued to experience increased pain above a rating of 4 on at least 7 occasions between 6/8-6/17/26. In an interview on 6/23/26 at 9:20am, LPN Q reported R51 received a prescription for Tramadol for his leg pain. In an interview on 6/23/26 at 9:01am Medical Doctor (MD) XX reported a resident with a history of circulatory issues requiring stenting should be re-evaluated by a vascular specialist at the onset of new wounds. MD XX reported patients with certain circulatory issues requiring stenting can develop wounds that might rapidly deteriorate. MD XX confirmed additional symptoms such as swelling and pain would elevate his level of concern for a patient in this situation. MD XX reported NP JJ was responsible to monitor R51 for his care needs and consult with MD XX as needed. When further queried, MD XX reported he was not aware R60 had open wounds, and he felt the resident should be evaluated by a vascular specialist to ensure his stents had not become occluded (blocked). Resident #3 (continued on next page)		

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of a Face Sheet revealed Resident #3 was originally admitted to the facility on [DATE] with pertinent diagnoses which included assistance with personal care and type 2 diabetes mellitus without complications (elevated blood sugar due to insulin resistance or deficiency, but without any diabetes-related organ damage or secondary health problems) Review of a Minimum Data Set (MDS) assessment for Resident #3, with a reference date of 5/29/26 revealed a Brief Interview for Mental Status (BIMS) score of 15/15 which indicated Resident #3 was cognitively intact. During an interview on 6/16/2026 at 3:49 PM, Resident #3 reported that she had a diabetic ulcer on her toe that had gotten infected and required amputation. Resident #3 reported concerns with staff consistently completing wound care treatments as ordered. Review of Resident #3's Skin Issues note dated 3/25/26 revealed, Location: Right medial forefoot. Issue type: diabetic foot ulcer. Progress: deteriorating .Painful: Yes. wound pain (frequency): At dressing. Pain description: sharp. Wound pain interventions: change positions. Wound pain interventions: medicate after dressing change. Relief from interventions: yes. Length (cm-centimeters): 2.24. Width (cm): 2.47. Depth (cm) 0.2 . Eschar (necrotic tissue, meaning the skin cells underneath are dead and no longer viable, typically forming over full-thickness injuries such as third-degree burns, severe pressure ulcers, or deep infections): 100%. Exudate (fluid naturally produced by the body in response to tissue injury, beginning immediately after the skin barrier is compromised): moderate . Review of Resident #3's Progress note dated 3/26/26 and documented by Nurse Practitioner (NP) JJ revealed, .Assessment and plan . type 2 diabetes mellitus without complications: continue routine glucose monitoring and diabetes regimen as documented. Reinforce foot care and glycemic control to support wound healing and reduce infection risk . Noted that NP JJ did not address Resident #3's pain that was noted in her foot ulcer on 3/25/26. Review of Resident #3's Skin issue note dated 3/31/26 revealed, Location: Right medial forefoot. Issue type: Diabetic foot ulcer. Progress: Deteriorated. Wound acquired in house. Painful: Yes. Wound pain (frequency) at dressing. Pain description: sharp. Wound pain interventions: medicate prior to dressing change. Relief from interventions: Yes. Length (cm): 2.76. Width: 3.49. Depth (cm): 0.3 . Slough (non-viable, dead tissue in a wound, that can impede healing and harbor bacteria): 50%. Eschar: 50%. Exudate amount: moderate . Noted that the measurements in the wound increased in size from previous assessment. Review of Resident #3's Progress Note dated 4/1/26 and documented by NP JJ revealed, Chief complaint: low hemoglobin (protein in red blood cells that carries oxygen and carbon dioxide) level identified on recent labs Nursing reports no recent falls or change in wound drainage from the sacral pressure ulcer or the right knee prosthesis (artificial body part) site . Noted that NP JJ's note did not address Resident #3's diabetic ulcer or the change in condition to the ulcer (pain reported by Resident #3 and increase in wound size.) Review of Resident #3's Progress Note dated 4/3/26 revealed, dressing change done per order to right foot during this shift, strong odorous smell and large amount of serosanguinous (thin, watery, pink-tinged fluid that is a normal part of wound healing, composed of blood serum and a small number of red blood cells) drainage on old dressing . (continued on next page)		

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #3's Skin issues note dated 4/7/26 revealed, Location: right medial foot. Issue type: diabetic foot ulcer. Progress: stable. Previously deteriorating wound characteristics plateaued. Wound acquired in house . Painful: yes. length (cm): 2.73. Width (cm): 2.18. Depth (cm): 0.7 . 40% slough 60% eschar. Exudate amount: moderate .odor after cleansing: faint Noted that the measurements in the wound increased in size from previous assessment. Review of Resident #3's Progress Note dated 4/8/26 and documented by NP JJ revealed, Chief complaint: Follow up for anemia . Physical Exam: Skin: sacral pressure area and wound care documented in the chart . Noted that NP JJ's note did not address Resident #3's diabetic ulcer on her foot. Review of Resident #3's Skin issues note dated 4/14/26 revealed, Location: right medial foot. Issue type: diabetic foot ulcer. Progress: improving. overall wound characteristics improved. Wound acquired in house . Painful: No. length (cm): 3.05 Width (cm): 2.33 Depth (cm): 0.2 . 20 % slough . Noted that the measurements in the wound increased in size from previous assessment. Review of Resident #3's Skin issues note dated 4/21/26 revealed, Location: right medial foot. Issue type: diabetic foot ulcer. Progress: Stalled. Previously improving wound characteristics have plateaued. Wound acquired in house. Painful: No. length (cm): 3 Width (cm): 2 Depth (cm): 0.2 . Slough: 80%. Exudate amount: Moderate . Review of Resident #3's Skin issues note dated 4/28/26 revealed, Location: right medial foot. Issue type: diabetic foot ulcer. Progress: Stalled. Previously improving wound characteristics have plateaued. Wound acquired in house. Painful: Yes. Wound pain frequency: at dressings. Pain description: aching . length (cm): 3.17 Width (cm): 1.8 Depth (cm): 0.2 . Slough: 100%. Exudate amount: Moderate . Noted that the measurements in the wound increased in size from previous assessment. Review of Resident #3's Progress note dated 4/29/26 revealed, Dressing changed per order. Gauze saturated with brownish drainage. Foul odor from wound, painful to touch. Cleansed, patted dry, new dressing secured. Review of Resident #3's Progress note dated 5/1/26 and documented by Medical Doctor (MD) UU revealed, The patient (Resident #3) is seen today for evaluation of acute concern of right great toe diabetic ulcer. Patient states that the wound has been there for several weeks . Assessment and plan: Infected right great toe diabetic ulcer: patient has failed to improve with wound care by staff at the facility. Wound has now been present for several months. Will add ciprofloxacin (antibiotic) to address infection and cover pseudomonas (common opportunistic pathogen in wound infections). Will also have patient referred to formal wound care clinic . Review of Resident #3's Progress Note dated 5/3/26 revealed, Resident complains of malaise (fatigue) with nausea .pain to right foot noted with the highest pain during dressing change . Review of Resident #3's Progress Note dated 5/4/26 and documented by NP JJ revealed, Chief complaint: reported fever. History of present illness: patient seen today by this NP for a reported temperature . She is currently at increased risk of infection given a history of infection/inflammatory reaction related to internal right knee prosthesis and osteomyelitis involving the sacral region . I assessed for any concerning changes in mental status, pain, or wound appearance and will continue close monitoring given her high risk history . Physical exam . Skin: Known sacral stage 3 pressure ulcer in context of chronic wounds; no acute dramatic change documented today Assessment: 1. (continued on next page)		

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F 0684 Level of Harm - Actual harm Residents Affected - Few	current status of Resident #3's wounds and reported to this writer that she would need time to review her notes. When this writer queried as to when, if at all, was the last time that she had assessed Resident #3's wounds, NP JJ reported that she did not know. NP JJ was not able to report if Resident #3 had been followed at a wound care clinic as she had documented in her visit notes. NP JJ reported that she relied on the photos and assessment that UM S would complete weekly to determine treatment orders for Resident #3. NP JJ reported that she typically followed UM S recommendations for wound care treatments. NP JJ confirmed that UM S was a Licensed Practical Nurse, and therefore, was able to initiate treatment orders for wound care. On 6/23/26 at 9:51 AM, this writer requested via email to Nursing Home Administrator (NHA) A a list of dates where a Physician and/or Nurse Practitioner had assessed Resident #3's wounds since her admission to the facility. The facility did not provide the information requested prior to survey exit. Resident #30 Review of a Face Sheet revealed Resident #30 was originally admitted to the facility on [DATE] with pertinent diagnoses which included vascular dementia (cognitive decline caused by reduced blood flow to the brain, leading to memory, thinking, and behavioral changes), repeated falls and muscle weakness. Review of a Minimum Data Set (MDS) assessment for Resident #30, with a reference date of 6/12/26 revealed a Brief Interview for Mental Status (BIMS) score of 7/15 which indicated Resident #30 was moderately cognitively impaired. During an interview on 6/16/2026 at 2:03 PM, Family Member (FM) KK reported that she had concerns with the facility's fall prevention and supervision of Resident #30. FM KK reported that Resident #30 had fallen out of her bed in November and fractured her leg. FM KK reported that the details of Resident #30's fall did not make sense to her, and she was worried that Resident #30 would continue to fall and get injured again. Review of Resident #30's Incident Report dated 11/22/25 and documented by Licensed Practical Nurse (LPN) X revealed, Incident Description: Approximately at about 00:30 (12:30 AM) when this nurse came back from lunch break, resident's (Resident #30) CNA (Certified Nursing Assistant) reported that during her rounds, she caught resident self-transferring out of bed. CNA tried to help resident back into bed, but it was too late, and CNA assisted resident to the floor. When this nurse went to check on resident, res (resident) was asleep. Res woke up at around 3:10 AM screaming out in pain. Res right lower leg swollen, turned inward resident refused ROM (range of motion) stating, it hurts. On call provider notified, new order received to send resident to ER (emergency room) for evaluation . Review of Resident #30's Hospital Record dated 11/22/25 revealed, Chief Complaint Leg pain . Apparently, the patient has had multiple falls recently. Today, she was about to fall, and she was guided to the floor by staff. Patient has a severe right leg deformity. Medics are unsure when this injury occurred . Patient was given fentanyl (pain medication) for excruciating pain of the right leg and Zofran (nausea medicine) for nausea. Patient is unable to tell me what hurts other than her right leg . Physical exam: General: She is in acute distress (Patient in pain from right leg deformity). Appearance: She is ill-appearing . Musculoskeletal: swelling, tenderness, deformity, (Obvious right lower extremity deformity with bruising and swelling with malformation of the right lower leg .and signs of injury present. Right lower left leg: edema (swelling) present . X-ray tib-fib (two long bones of the lower leg) showed fracture of distal femoral meta diaphysis (distal femoral metaphysis is the (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 06/23/2026
NAME OF PROVIDER OR SUPPLIER Medilodge of Grand Rapids		STREET ADDRESS, CITY, STATE, ZIP CODE 2000 Leonard NE 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 0684 Level of Harm - Actual harm Residents Affected - Few	region where the shaft widens and connects to the knee joint) and nondisplaced proximal fibular head/neck fracture. CT (Computed tomography) right lower extremity showed acute periprosthetic fracture of distal femoral metadiaphysis with no displacement, was unable to assess fibula fracture. Orthopedic surgery was consulted and recommended placing me immobilizer and 2 week outpatient follow up. Patient was admitted to medicine for sepsis secondary to UTI. She developed recurrent hypotension (low blood pressure) on the floor received additional IVF (intravenous fluids) and was transferred to ICU (intensive care unit) and started on norepi (norepinephrine- medication used to treat low blood pressure) She became more hypotensive and was found to have a hgb (hemoglobin) of 6.5 from 9.8 with significant ecchymosis(bruising) of her lower extremity to likely be the culprit. She required 2 units PRBC (packed red blood cells) the morning of 11/23 and ortho was contacted for reassessment . Patient family would like to discharge her back to her facility. Spoke with patient's son who said family plans to assign patient for hospice after discharge to the facility . During an interview on 6/18/2026 at 3:03 PM, LPN X reported on 11/22/25 she had been working overnight with CNA O and had returned from her break sometime around midnight when CNA O told her that she had had forgotten to tell her that she watched Resident #30 try to get out of bed and that she had to help lower her to the ground. LPN X reported that when she went into check on Resident #3, she was in her bed asleep, and she did not want to wake her up. LPN X confirmed that she did not assess Resident #3 when she found her asleep because Resident #3 could be behavioral when she was woken up. LPN X confirmed th[TRUNCATED]		