STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235175	A. Building B. Wing	04/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Frankenmuth	500 West Genesee Frankenmuth, MI 48734

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 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to Intake Number 2726226. Based on observation, interview and record review the facility failed to implement individualized interventions to address the dementia care needs of one resident (Resident #606) of six residents reviewed for dementia. Findings Include:Resident #606:On 4/6/2026 at 11:00 AM, a tour was completed of the locked memory care unit. We entered through the common room area where residents were observed at tables with two facility staff members. Once in the hallway there was no nursing staff observed. Upon entering room [ROOM NUMBER], a gentleman was observed sleeping in bed b and Supervisor A stated that was not Resident #603 but Resident #606. He stated he resides next door as their rooms connect via the bathroom and it's possible, he entered through the bathroom. Supervisor A left the room to locate a staff member to assist in redirecting Resident #606 back to his room. He returned a few moments later with a staff members observed earlier in the common area and as she was assisting the resident another aide came up the hallway and stopped to assist as well.It can be noted as the tour with Supervisor A was occurring on the memory unit Resident #606 wandered into room [ROOM NUMBER] and there was no nursing staff visible in the hallway at that time.On 4/6/26 at approximately 11:20 AM, CNA (Certified Nursing Assistant) B stated Resident #606 does wander in/out of resident rooms and they have to keep an eye on him and redirect as needed. CNA B continued they do have stop signs they put on resident doors as well as a deterrent. The CNA was asked if there was stop sign inside the bathroom that may possibly deter the resident and he stated there was none. On 12/6/26 at 11:45 AM, an interview was conducted with Social Worker C regarding Resident #606's persistent wandering into other residents' rooms (specifically Resident #603). Social Worker C stated Resident #606 likes to wander in/out of resident's bedrooms and within this year this behavior has been more prominent. They initially thought he had a preference of a one room (Resident #603' room) and completed a room change but found after room change that it did not make a difference.Social Worker C was asked did they account for two residents sharing bathrooms once the room change was completed and she stated they did not. She was further asked what other interventions are in place to deter Resident #606 from wandering and subsequently getting into other residents' beds. She reported the residents did not have an issue with Resident #606 wandering into their rooms and getting into their beds. Social Worker C was questioned regarding how that would be an accurate statement, given the residents on the memory care unit cognitive status and inability to be interviewed. It was unknown how she came to this deduction and was queried if communication was sent to their responsible parties to verify their acceptance of bed sharing. She stated notification was not sent out to responsible parties.Social Worker C continued Resident #606 wandering and sleeping in other residents' bed is a part of his dementia diagnosis. It can be noted she was not able to provide any other interventions implemented and/or trialed by the facility. She further stated during Resident #603's care conference they asked his wife had it improved and she stated it had not. She expressed her frustration but stated she would just have to accept it, as nothing was changing. Social Worker C shared they asked his wife what she would like the facility to do to mitigate her concerns and she stated she did not know.It appeared the (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 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	facility placed responsibility on Resident #606's wife to provide solutions for Resident #606's wandering/bed hopping. On 4/6/2026 at 12:50 PM, an interview was conducted with Infection Preventionist H regarding Resident #606's wandering. She reported in the month that she has been in their role she has observed him in 3-4 different rooms/beds, but he has been easily redirectable. Preventionist H stated it would be the expectation that staff would change the linen and send any personal bedding to laundry if Resident #606 was found sleeping in a room not his own.On 4/6/2026 at 1:20 PM, Resident #603's wife explained when she voiced her concerns to floor staff and they informed her they could not consistently monitor him (Resident #606) when he gets out the bed and walks the hallways. She reported that she visits about twice a week and she observed Resident #606 in her husband's bed at least once during her visits. She stated it was frustrating as the issue persisted and it was unsanitary as they were not stripping the bed every time they would find the other resident in his bed.On 4/6/2026 at 3:00 PM, Nurse M shared Resident #603's bed was Resident #606's old bed and he does frequent his room/bed. They will redirect him and offer a snack which is usually effective. At times Resident #606 can be incontinent and they were educated today to change linens on the bed when he (Resident #606) is found in someone else's bed. From her recollection these behaviors began around December 2025.On 4/6/2026 at 3:15 PM, CNA L, shared Resident #606 does wander into other residents' rooms and sleeps/rests in their beds, but that is a behavior of his due to his dementia. They can redirect him and attempt to catch him prior to him laying down in another resident's bed.Resident #606:On 4/6/2026 at approximately 1:00 PM, a review was conducted of Resident #606's medical records and it revealed he admitted to the facility on [DATE] with diagnoses that included, Alzheimer's, Hyperlipidemia, Vascular Dementia, Insomnia and Anxiety. Further review of the records yielded the following:Review was completed of past 30 days of documented instances of Resident #606 being found in other residents' bed. It was documented 31 times that Resident #606 was found sleeping/resting in another resident's bed. Care Plan:Focus: .Like to sleep in other residents' beds at times.Interventions: .If found in another resident's bed, and the other resident is upset, gently redirect (Resident #606) to his own bed.It can be noted it is unclear if staff allow Resident #606 to continue sleeping in other residents beds and there is no mention of cleaning practices when he is found in another room.Practitioner Notes:3/6/26 at 20:16: .Staff reports patient often wanders on memory unit and goes into other peoples rooms. He was seen in another person's room had been laying down in their bed and staff report lets him thus what he does. He was not taken out of the room at this point as there was no agitation or irritability on his part nor did staff wish to promote that at this moment.3/20/2026 at 21:27: .There are persistent intrusive behaviors, poor boundaries, and repeated episodes of grabbing, antagonizing, and violating personal space of staff and residents. There is persistent wandering, frequent entry into other residents' rooms.Progress Notes:2/20/26 at 12:25: .tends to wander unit and has been found sleeping in 28b bed; Resident redirected to his own room.3/4/26 at 23:07: Care on going Resident is pleasant / found in different beds at time redirected to his own room.4/2/26 at 12:01: pt (patient) is going in and out of residents bedrooms urinating in their closets. Resident #603:On 4/6/2026 at approximately 1:10 PM, a review was conducted of Resident #603's medical records and it revealed he admitted to the facility on [DATE] with diagnoses that included, Dementia, Anxiety, Hypertension, Dysphagia and Hyperlipidemia. Further review yielded the following:Concern Forms:1/23/26: .She is tired of (Resident #606) sleeping in (Resident #603)'s bed.Progress Notes:3/13/2026 at 11:08: Spoke to resident and wife about a room move for (Resident #603) as there is another resident that likes to sleep in that room/bed. Let them know will be moving (Resident #603) to room [ROOM NUMBER]. There were no questions or concerns at this time.On 4/6/2026 at 4:20 PM, the DON (Director of Nursing) and Administrator were informed of the observations made and subsequent concerns. They both expressed understanding of the concern.Review was conducted of the facility policy entitled, Comprehensive Care Plans, revised 6/30/2022. The policy stated, It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with their resident rights.