STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235209	A. Building B. Wing	09/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Leelanau	124 W 4th Street Suttons Bay, MI 49682

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 34568 This citation pertains to intake: MI00146857 Based on interview and record review, the facility failed to report an allegation of staff to resident sexual abuse to the State Agency (SA) for one Resident (R900) of three residents reviewed for abuse. Findings include: Review of the complaint filed with the SA on 9/10/24 read, in part, .Complainant states the facility therapist (Occupational Therapist (OT) C) had been having sex with Resident (R900). Complainant states everyone knew about it and staff member [Certified Nurse Aide (CNA) D] went to the administrator about it . An interview was conducted with the Nursing Home Administrator (NHA) on 9/12/24 at 9:00 a.m. The NHA was asked if any abuse allegations were brought to him within the last 30 days. The NHA stated there were none reported in the last 30 days. An interview was conducted with CNA D on 9/12/24 at approximately 10:30 a.m. CNA D stated that while outside of the facility on 8/29/24, she was told that OT C and R900 were having sex. CNA D stated she reported this information directly to the NHA on 8/30/24 when she returned to work. An interview was conducted with the Director of Nursing (DON) on 9/12/24 at 10:54 a.m. The DON stated CNA D did report an allegation of sexual abuse between OT C and R900. The DON stated that the facility's legal team was contacted because it was believed R900 had been on a leave of absence (LOA) from the facility when the allegation occurred. The DON stated the legal team felt this was not reportable to the SA. This Surveyor requested the incident/accident report and interview statements from the DON. On 9/12/24 at approximately 11:05, the DON and NHA brought the file which contained one interview between the NHA and R900. There were no further interviews or witness statements. The NHA stated he misunderstood the request for abuse allegations in the last 30 days this morning and confirmed an allegation of sexual abuse was brought forward to him on 8/30/24 from CNA D. The NHA confirmed the facility did not report this allegation to the SA. (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235209	A. Building B. Wing	09/13/2024

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Medilodge of Leelanau	124 W 4th Street Suttons Bay, MI 49682

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's Abuse, Neglect and Exploitation policy dated 1/10/24 read, in part, .Reporting of alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (e.g., law enforcement when applicable) within specified timeframes as required by state and federal regulations: immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury .

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 34568 This citation pertains to intake: MI00146857 Based on interview and record review, the facility failed to conduct a thorough investigation for a staff to resident sexual abuse allegation for one Residents (R900) of three residents reviewed for abuse. Findings include: Review of the complaint filed with the SA on 9/10/24 read, in part, .Complainant states the facility therapist (Occupational Therapist (OT) C) had been having sex with Resident (R900). Complainant states everyone knew about it and staff member (Certified Nurse Aide (CNA) D went to the administrator about it . An interview was conducted with CNA D on 9/12/24 at approximately 10:30 a.m. CNA D stated while outside of the facility on 8/29/24, she was told that OT C and R900 were having sex. CNA D stated she reported this information directly to the NHA on 8/30/24 when she returned to work. CNA D stated she was not asked to write a statement of what she had heard and was asked no further questions regarding the allegation. An interview was conducted with the Director of Nursing (DON) on 9/12/24 at 10:54 a.m. The DON stated CNA D did report an allegation of sexual abuse between OT C and R900. The DON stated the facility's legal team was contacted because it was believed R900 had been on a leave of absence (LOA) from the facility when the allegation occurred. This Surveyor requested the incident/accident report and interview statements from the DON. On 9/12/24 at approximately 11:05, the DON and NHA brought the file which contained one interview between the NHA and R900. There were no further interviews or witness statements. The NHA stated he did not gather further statements from staff, including from the alleged perpetrator per the legal team's advice. The NHA stated OT C was transferred to another facility at the discretion of the corporate therapy company. The NHA acknowledged this was not a complete investigation per the facility's abuse policy. Review of the facility's Abuse, Neglect and Exploitation policy dated 1/10/24 read, in part, .Investigation of alleged abuse, neglect and exploitation: An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur. Written procedures for investigations include Identifying staff responsible for the investigation, exercising caution in handling evidence that could be used in a criminal investigation (e.g., not tampering or destroying evidence), Investigating different types of alleged violations. Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations, Focusing the investigation on determining if abuse, neglect, exploitation and/or mistreatment has occurred, the extent, and cause, and providing complete and thorough documentation of the investigation .