

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235292	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/26/2025
NAME OF PROVIDER OR SUPPLIER Medilodge of Sault Ste Marie		STREET ADDRESS, CITY, STATE, ZIP CODE 1011 Meridian Rd Sault Sainte Marie, MI 49783	

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)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>40383</p> <p>This citation pertains to intakes MI00150502 and MI00150541.</p> <p>Based on interview and record review, the facility failed to protect residents' rights to be free from abuse for four Residents (#21, #22, #23, #26) of four residents reviewed for sexual abuse.</p> <p>Findings include:</p> <p>Resident #20 (R20), Resident #21 (R21), Resident #22 (R22)</p> <p>On 2/11/25, the State Agency (SA) received an initial facility reported incident summary which stated, Resident (R20) kissed (R22) on the cheek. (R20) also touched resident (R21) on the thigh.</p> <p>An Investigation Summary was received by the SA on 2/20/25 and read in part, R20 had multiple diagnoses including dementia with agitation, dementia with psychotic disturbance, and adjustment disorder with mixed anxiety and depressed mood. R20 had a Brief Interview for Mental Status (BIMS) score of 8, indicating moderate cognitive impairment. R22 had multiple diagnoses including Parkinson's disease with mood disturbance and a BIMS score of 14 indicating intact cognition. R21 had multiple diagnoses including dementia, anxiety disorder, depression, cognitive communication deficit, and a BIMS score of 5 indicating severe cognitive impairment. The investigation summary stated, The incident was reported to (the SA) as abuse.</p> <p>Resident #23 (R23), R20, R21, R22</p> <p>On 2/14/25, the SA received an additional initial facility reported incident summary which stated, Resident (R20) touched (R22) on the thigh near the genital area. Before we had the opportunity to get (R20) on a 1:1 (a system to closely monitor R20) he touched (R23) on the breast .</p> <p>An Investigation Summary was received by the SA on 2/24/25 indicating R23 had multiple diagnoses including dementia, psychotic disturbance, mood disturbance and anxiety, major depressive disorder and a BIMS score of 0 indicating severe cognitive impairment. The investigation summary stated, The incident was reported to (the SA) as abuse.</p> <p>(continued on next page)</p>

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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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 2/26/25 at 9:45 AM, CNA A was interviewed in the presence of the Nursing Home Administrator (NHA) per CNA A's request. CNA A could not give the details of the date, time of day (morning or afternoon) or location of either incident. CNA A said she saw R20 touch R21 high up on her legs and reported that to the NHA. After this happened, she witnessed R20 touching another resident on her breast and reported it to the NHA.</p> <p>On 2/26/25 at 11:12 AM, CNA B was interviewed regarding R20's behaviors. CNA B had been listed on the SA report. CNA B stated R20 and R21 previously held hands frequently and the staff would redirect them. CNA B recalled she witnessed R20 just talking to R23 and the next thing I knew he was feeling up on her boobs right in the nursing circle (where the staff meet and work). CNA B stated R20 had both hands on the top of R23's shirt and yet R23 did not really react. CNA B stated they . kind of agreed it was inappropriate . for R20 to touch a female resident's breast like that.</p> <p>Resident #26 (R26), R20, R21</p> <p>During a phone interview on 2/26/25 at 11:22 AM, CNA C stated she had seen R20 rubbing his arm on R26 at the nursing circle. R20 was facing R26 and was rubbing R26's upper arm. CNA C separated them as it was part of R26's care plan and CNA C reported this incident to the NHA.</p> <p>The medical record for R26 was reviewed and included a care plan which read in part, Focus of Resident (R26) has an impaired mood/psychiatric status related to depression/anxiety Date Initiated: 08/02/2023 Revision on: 08/02/2023. Resident prefers not to have (R20) within personal space during activities, nursing circle. Redirect (R20) away from her or assist resident to room. Date Initiated: 07/25/2024</p> <p>During an interview on 2/26/25 at 12:20 PM, Social Service Staff E reported she was aware of these incidents with R20 including R21, R26, and others. Staff E stated R20 had touched legs, touched breasts and patted legs. Staff E stated the interdisciplinary team had discussed the incidents.</p> <p>R20, R21, R23</p> <p>On 2/26/25 at 1:52 PM, CNA F was interviewed regarding R20's behavior. CNA F stated during lunch (uncertain date) R20 was sitting at the same table as R21 and rubbed on R21's thigh and one hand moved up to her private area. CNA F stated, We moved (R21) away to another table and (R20) snuck over to (R21's) table, and he did it again. We moved (R21) again. (R21) said something and (R20) started yelling. CNA F said after lunch R20 was leaving the dining room and wheeled into the nursing circle and sat next to R23. CNA F said, I looked up and saw (R20) had his hand under (R23's) shirt. CNA F explained R23 does not wear a bra so R20 was directly touching R23's breast. The residents were separated, and it was reported to management.</p> <p>During an interview on 2/26/25 at 3:15 PM, the NHA stated there had not been an evaluation as to whether R21, R22, R23 or R26 had the capacity to consent to the advances of R20. The NHA stated these residents were confused and did not have capacity to consent. The events were confirmed to have occurred and the NHA stated R20 had willfully touched the female residents.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The facility policy titled, Abuse, Neglect and Exploitation dated as revised on 1/10/2024 read in part: III. The facility will implement policies and procedures to prevent and prohibit all types of abuse .A. Establishing a safe environment that supports, to the extent possible, a resident's consensual sexual relationship and by establishing policies and protocols for preventing sexual abuse. This may include identifying when, how, and by who determinations of capacity to consent to a sexual contact will be made and where this documentation will be recorded .</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Respond appropriately to all alleged violations.</p> <p>40383</p> <p>This citation pertains to intakes MI00150502 and MI00150541.</p> <p>Based on interview and record review, the facility failed to thoroughly investigate allegations of sexual abuse for one Resident (#20) of one resident reviewed for sexual abuse. This deficient practice resulted in the potential for additional exposure to sexual abuse for cognitively impaired resident, including Residents (#21, #22, #23, #26).</p> <p>Findings include:</p> <p>On 2/11/25, the State Agency (SA) received an initial facility reported incident summary which stated, Resident (R20) kissed (R22) on the cheek. (R20) also touched resident (R21) on the thigh.</p> <p>An Investigation Summary was received by the SA on 2/20/25. The investigation summary stated, The incident was reported to (the SA) as abuse. The one witness listed in the report was documented as Certified Nurse Aide (CNA) A.</p> <p>On 2/14/25, the SA received an additional initial facility reported incident summary which stated, Resident (R20) touched (R22) on the thigh near the genital area. Before we had the opportunity to get him (R20) on a 1:1 (a system to closely monitor R20) he touched (R23) on the breast .</p> <p>An Investigation Summary was received by the SA on 2/24/25. The investigation summary stated, The incident was reported to (the SA) as abuse. The two witnesses listed were CNA A and CNA B.</p> <p>On 2/26/25 the investigation folders were examined. There were three witness statements present CNA A, CNA C and CNA F.</p> <p>- CNA A: the entire statement read: 2/14/25 I saw resident (R20) touching ladies between legs and breast. Signed by CNA A and dated 2/14/25.</p> <p>- CNA C: the entire statement read: 2/11/25 I saw (R20) kiss resident (R22) on the cheek and touch resident (R21) on her leg. No signature was present on the witness statement, but a sticky note was affixed with the name of CNA C on it.</p> <p>- CNA F: the entire statement read: 2/14/25 I saw (R20) touching other residents between legs and touching breasts of the residents. Signed by CNA F and not dated.</p> <p>On 2/26/25 at 9:45 AM, CNA A was interviewed in the presence of the Nursing Home Administrator (NHA) per CNA A's request. CNA A could not give the details of the date, time of day (morning or afternoon) or location of either incident. CNA A said she saw R20 touch R21 high up on her legs and reported that to the NHA. After this happened, she witnessed R20 touching another resident on her breast and reported it to the NHA.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 2/26/25 at approximately 10:00 AM, the NHA was asked about CNA A's statement at 9:45 AM. The NHA acknowledged the lack of details given. The NHA did not have a more complete statement containing the details of the date, time of day (morning or afternoon) or location of either incident. The witness statement was only one line and was dated 2/14/24. There was not a witness statement dated 2/11/25 (the date of the previous incident) although CNA A was listed on both SA incident reports.</p> <p>On 2/26/25 at 11:12 AM, CNA B was interviewed regarding R20's behaviors. CNA B had been listed on the SA report as a witness. CNA B recalled she witnessed R20 (unsure of the date) just talking to R23 and the next thing I knew he was feeling up on her boobs right in the nursing circle (where the staff meet and work). There was not a witness statement from CNA B in the investigation file.</p> <p>During a phone interview on 2/26/25 at 11:22 AM, CNA C stated she had seen R20 rubbing his arm on R26 at the nursing circle. R20 was facing R26 and was rubbing R26's upper arm. CNA C separated them as it was part of R26's care plan and CNA C reported this incident to the NHA. The witness statement in the investigation file for CNA C was a typed sentence 2/11/25 I saw (R20) kiss resident (R22) on the cheek and touch resident (R21) on her leg. No signature was present on the witness statement, but a sticky note was affixed with the name of CNA C on it. The witness statement involved R22, but the interview conducted with CNA C, involved a different incident with R20 and R26. There was no investigation of the report of R20 touching R26.</p> <p>On 2/26/25 at 1:52 PM, CNA F was interviewed regarding R20's behavior. CNA F stated during lunch (uncertain date) R20 was sitting at the same table as R21 and rubbed on R21's thigh and one hand moved up to her private area. CNA F stated, We moved (R21) away to another table and (R20) snuck over to (R21's) table, and he did it again. We moved (R21) again. (R21) said something and (R20) started yelling. CNA F said after lunch R20 was leaving the dining room and wheeled into the nursing circle and sat next to R23. CNA F said, I looked up and saw (R20) had his hand under (R23's) shirt. CNA F explained R23 does not wear a bra so R20 was directly touching R23's breast. The residents were separated, and it was reported to management.</p> <p>During an interview on 2/26/25 at 3:02 PM, the NHA was asked about the two incidents reported to the SA. There were two separate incidents involving R20 touching two female residents at separate times. The NHA stated staff had reported all the events. He was unsure of the exact time the incidents were reported and could not recall the names of the staff who reported each event. One witness statement had been signed and the NHA did not know who gave the statement and could not read the signature. He had spoken with the employees who made the reports but had not documented the details.</p> <p>The facility policy titled, Abuse, Neglect and Exploitation dated as revised on 1/10/2024 read in part: .An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse neglect or exploitation occur. B. Written procedures for investigations include: . 4. Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations .</p>		