STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235292	A. Building B. Wing	11/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Sault Ste. Marie	1011 Meridian Road Sault Ste. 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)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intakes 2630912 and 2666718.Based on interview and record review, the facility failed to develop and/or implement policies and procedures for ensuring the reporting of a reasonable suspicion of a crime in accordance with section 1150B of the Act for five Residents (#10, #11, #12, #13, and #16) of five residents reviewed, resulting in the potential for unrecognized and continued abuse.Findings include:Resident #12 (R12) and Resident #13 (R13)Review of a facility incident report submitted to the State Agency on 9/20/2025 at 3:11 p.m. revealed the following: Resident [R12] struck out with closed fist and made contact with upper arm of another resident [R13]. Residents were immediately separated. Skin and pain assessments completed with no injuries noted. Police notified. Guardians and physician notified. Medication regiment review to be completed on [R12] and to be supervised during meals. 5-day investigation to follow.Review of the facility investigation summary received by the SA on 9/29/2025 revealed the following: [Registered Nurse (RN) B] was in the dining room helping residents prior to lunch service. She heard yelling behind her and proceeded toward [R12]. [R12] was yelling at [R13] who was sitting to the left of him at the table. She asked [R13] if he wanted to move to another chair but before she could move him [R12] swung his left arm sideways, and the back of his left hand made contact with [R13's] upper right arm . When (date and time) did the problem occur? 9/20/2025 11:45 AM . Are Law Enforcement involved? Yes . Date contacted: 9/20/2025. Time contacted? 8:52 PM.It was noted in review of the submitted incident documentation, the incident between R12 and R13 occurred on 9/20/2025 at 11:45 a.m. and the facility reported the incident to the SA on 9/20/2025 at 3:11 p.m., one hour and 26 minutes later than the two-hour reporting guideline. It was also noted that law enforcement was contacted regarding the incident on 9/20/2025 at 8:52 p.m. Indicating the facility had not ruled out abuse or criminal act prior to police contact.Review of the Minimum Data Set (MDS) assessment, dated 9/25/2025, revealed R12 was admitted to the facility on [DATE] and had diagnoses including dementia with agitation and adjustment disorder with mixed anxiety and depressed mood. Further review of the MDS revealed R12 was assessed as having severely impaired cognitive skills for daily decision making.Resident #12 (R12) and Resident #16 (R16)Review of R12's electronic medical record (EMR) revealed the following progress note: 11/5/2025 21:30 [9:30 p.m.], Nurses' Note . [R12] was in dining room and asked another resident [identifier redacted] to get him coffee with 4 sugars. The resident [identifier redacted] got him a coffee with 1 sugar. This angered this [R12] and soon began yelling at her in a very loud boisterous manner that scared and intimidated [identifier redacted]. [R12] was asked by this Nurse to please ask staff to get things and not to ask other residents.An interview was conducted on 11/19/2025 at 4:15 p.m. with the Director of Nursing (DON), Nursing Home Administrator (NHA) and Regional Clinical Consultant/Registered Nurse (RN) I. During the interview, RN I reviewed R12's Nurses' Note dated 11/05/2025 at 9:30 p.m. Upon review, RN I identified the second resident listed in R12's note to be R16. The DON reported she was unaware of the incident documented on 11/05/2025 in which R12, began yelling at [R16] in a very loud boisterous manner that scared and intimidated [R16]. RN I then reported the nurse who entered the note to be RN H and that no other (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	documentation was found in the EMR related to the incident. The NHA reported the incident was not investigated or reported to the SA as an allegation of abuse.During a telephone interview on 11/19/2025 at 4:30 p.m., RN H was asked to recall the incident between R12 and R16 that occurred on 11/05/2025. RN H reported the DON and RN I called her just prior to this Surveyor's call regarding the incident. RN H reported in hindsight and after speaking with the DON and RN I, she should not have added that R16 was scared or intimidated in the nurses' notes because she did not witness the incident, only the aftermath. RN H stated I heard [R12} yelling loudly at someone in the dining room. RN H reported she turned toward the dining room from the nurses' station to see R16 exiting the dining room looking startled. RN H reported R16 approached her and told her she only gave [R12] one sugar . I don't know why he's so mad. RN H stated R16 proceeded to walk down the hall toward her room. When asked if any follow up was conducted with R12 or R16 following the event, RN H reported she did not ask any other questions of R16 regarding the incident, including what R12 had said to R16 or if any physical contact had been made between the two Residents. RN H reported she only instructed R12 to ask staff for assistance in the future.Review of R16's EMR revealed no record of the incident.Resident #10 (R10) and Resident #11 (R11)Review of a facility incident report submitted to the SA on 10/31/2025 at 6:27 p.m. revealed the following: [R10] was observed with his hand under another resident's [R11] shirt in the common area. They were immediately separated. Skin and pain assessments completed. Physician, guardian and police notified. [R12] to be line of sight when out of his room. Review of the facility investigation summary submitted to the SA on 11/10/2025 at 7:53 p.m. revealed the following: [CNA A] was walking from the nursing circle toward the dining room. As passing, the residents' TV room noticed an empty wheelchair at the end of the couch near the entrance of the room. This CNA entered the room to see that [R10] was on the couch, sitting on the middle cushion. [R11] was in her wheelchair facing the couch slightly angled toward the wall. She had her hands in her lap. She was leaning toward [R11] and they were kissing. [R10's] left hand was under [R11's] shirt touching her left breast . When (date and time) did the problem occur? 10/31/2025 12:30 PM. Are law enforcement involved? Yes . Date contacted: 10/31/2025. Time contacted: 4:57 PM. It was noted in review of the submitted incident documentation, the incident between R10 and R11 occurred on 10/31/2025 at 12:30 p.m. and the facility reported the incident to the SA on 10/31/2025 at 7:53 p.m., five hours and 23 minutes later than the two-hour reporting guideline. It was also noted that law enforcement was contacted regarding the incident on 10/31/2025 at 4:57 p.m., indicating the facility had not ruled out abuse or criminal act prior to police contact.Review of the MDS assessment, dated 9/25/2025, revealed R11 scored six out of 15 (6/15) on the BIMS, indicating the Resident had severe cognitive impairment.During an interview on 11/19/2025 at 12:00 p.m. the DON was queried as to whether either R10 or R11 had been assessed for the ability to consent to sexual relations. The DON reported she had spoken to the Medical Director about having an assessment completed but as of the date of the survey, no assessment to determine R10's or R11's capacity to consent had been obtained.During an interview on 11/19/2025 at 4:30 p.m., the NHA confirmed the incident involving R10 and R11 on 10/31/2025 and R12 and R13 on 9/20/2025 were not reported to the SA within two hours of the incidents occurring. The NHA reported none of the Residents involved in the incidents sustained serious bodily injury, therefore her understanding was the reporting requirement was to report within 24 hours. When asked why the incident between R12 and R16 was not reported to the SA or investigated as an allegation of abuse, the NHA reported the way the incident was reported to her did not warrant reporting to the SA or an investigation.Review of the facility policy titled, Abuse, Neglect and Exploitation, last revised 1/10/2024, revealed the following: Abuse means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish . Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish . Willful means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm . Sexual abuse is non-consensual sexual (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	contact of any type with a resident . Verbal abuse means the use of oral, written or gestured communication or sounds that willfully includes disparaging and derogatory terms to resident . or within their hearing distance regardless of their age, ability to comprehend or disability . Reporting/Response: The facility will have written procedures that include: Reporting of alleged violations to the . state agency . an all other required agencies (e.g., law enforcement when applicable) within specified timeframes as required by state and federal regulations: Immediately, but not later that 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury .