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	05/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Sault Ste. Marie	1011 Meridian Road Sault Ste. Marie, MI 49783

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. This deficient practice pertains to Intakes 2809637, 3014371, 3014349, 3011210, 3021572, 3021668.Based on observation, interview, and record review, the facility failed to ensure adequate staffing to promote the highest possible level of physical, mental, and psychological well-being for all 73 residents of the facility as evidenced by:Failure to ensure adequate supervision to prevent a resident-to-resident physical altercation.Failure to respond to call lights within an appropriate time frame.Failure to accommodate resident preferences including sleep/wake schedules.Failure to ensure assistance with activities of daily living (ADLs) including toileting and routine incontinence care.Findings include: Review of a facility investigation summary submitted to the State Agency (SA) on 5/11/26 revealed the following: .[On] 5/2/2026 [Certified Nursing Assistant (CNA) A] assigned to D Hall, heard a crying noise coming from [Resident #1 (R1's)] .Upon entering the room staff observed [Resident #2 (R2)] on [R1's] bed. [CNA A] observed [R1] to be tearful with visible markings on her face. At that time [R2] was sitting calmly but refused to leave the room. [CNA A] stayed in the room and called out for help. [Licensed Practical Nurse (LPN) B] entered the room and was able to redirect [R2] out and back to her own room further down the hallway. When asked what happened, [R2] stated, ?She's mean, she's going to get what's coming and she got what she deserved.' [LPN B] then returned to assess [R1]. [LPN B] noted scratches on [R1's] face with blood visible and bruising starting to appear on [R1's] face and hands. When asked what happened, [R1] stated ?she [R2] hit me with the brush, and I asked what was wrong and she slapped me and she squeezed my finger'. [R1] was transferred to ER (emergency room) where she received an evaluation. Review of an Incident Report, dated 5/2/26, written by LPN B read, in part: .Nursing Description: [R2] went into another female resident's room and sat on this resident's bed [R1's] when they were in it and appears/reported (by other resident) attacked the other female [R1]. Resident Description: SHE'S MEAN, SHE'S GOING TO GET WHAT'S COMING AND SHE GOT WHAT SHE DESERVED.Review of a Skin Assessment form, dated 5/2/26, read, in part: .List site(s) of any new abnormal skin areas. right hand (back) - bruising, left hand (back) - bruising, face - bruising-both cheeks and forehead, right lower leg (front) - bruising, left lower leg (front) - bruising, other (specify) - right cheek -abrasion.Review of a Pertinent Charting Follow-Up Change in Condition Form, dated 5/4/26, read, in part: Resident multiple bruising impairment on face, cheeks, forehead and top of her head, bilateral hands and arms and bruising lower extremities. Resident was on the receiving end of a resident-to-resident altercation.On 5/27/2026 at 8:55 AM, R1 was sitting in wheelchair in her room, eating breakfast. A nearly healed, yellow, quarter sized bruise was observed on her central forehead near her hairline. R1 was unable to recall the events related to the physical altercation on 5/2/26.On 5/26/26 at 12:50 PM, a phone interview was conducted with CNA A regarding the physical altercation that occurred on 5/2/26. CNA A stated she was the only aide assigned to D-Hall when she went on break around 4:00 PM. At that time, LPN B was left to supervise the entire hall in addition to her nursing duties. CNA A stated when she returned to the floor at 4:30 PM, she was providing cares and heard crying coming from a few doors down. When she arrived at R1's room, CNA A recalled R1 lying in bed with a large bump on her head and bruising on her face. CNA A remembered there was blood on (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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	total hours - 72 census5/24/26 - 91.60 total hours - 73 censusReview of the night shift schedules between 3/10/26 and 5/25/26 revealed 20 days (26.3% of all shifts) when total CNA working hours were fewer than five CNAs (60 total working hours) as outlined in the Facility Assessment.3/15/26 - 52.8 total hours - 76 census3/16/26 - 44.20 total hours - 75 census3/17/26 - 57.40 total hours - 74 census4/2/26 - 56.30 total hours - 74 census4/6/26 - 50.80 total hours - 74 census4/7/26 - 59.00 total hours - 73 census4/13/26 - 57.40 total hours - 73 census4/16/26 - 47.30 total hours - 71 census4/17/26 - 53.40 total hours - 71 census4/23/26 - 56.70 total hours - 73 census4/24/26 - 55.30 total hours - 75 census4/25/26 - 58.80 total hours - 75 census5/1/26 - 57.70 total hours - 75 census5/2/26 - 58.50 total hours - 76 census5/5/26 - 53.80 total hours - 76 census5/9/26 - 58.90 total hours - 77 census5/14/26 - 47.80 total hours - 77 census5/15/26 - 48.20 total hours - 76 census5/24/26 - 47.80 total hours - 73 census5/25/26 - 42.20 total hours - 72 censusReview of a complaint submitted to the SA on 5/8/26, read, in part: I put my call light on to get turned and boosted in my bed and no one ever comes. I wait for hours sometimes to even see a person. I am unable to get out of bed or turn in bed myself. This happens a lot on the night shift but also happens a lot on the other shifts as well.On 5/27/26 at 5:45 AM, this surveyor arrived at the facility and observed a total of 3 CNAs. Registered Nurse (RN) M confirmed only 3 CNAs worked the midnight shift (6:00 PM - 6:30 AM) with a census of 76 residents. RN M expressed her continued frustration stating the facility continues to schedule just 3-4 CNAs on the night shift.On 5/27/26 at 6:05 AM, an interview was conducted with CNA K who stated she was responsible for the cares on two halls because there was only 3 CNAs scheduled on the night shift. Three call lights were observed illuminated on one of CNA K's designated halls. CNA K stated, It's after 6 [AM] and I still have 3 residents to get up. I have done zero charting, and I'm supposed to be done at 6:00 AM. I was behind on check and changes (incontinence care) all night.On 5/27/26 at 6:15 AM, an interview was conducted with CNA L who had just finished working the midnight shift. When asked how her shift went, CNA L stated, It was horrendous, it was horrible. There were only 3 of us [CNAs]. The last three nights in a row there have only been three of us. I can't possibly get to everybody. CNA L verified residents endured longer call light wait times and incontinent residents waited longer for brief changes.On 5/27/26 at 6:17 AM, Resident #7 (R7) was observed sleeping in his wheelchair at the nurses' station.On 5/27/26 at 6:43 AM, an interview was conducted with R7 while he was being loaded into the facility transport vehicle. R7 indicated he had been sleeping at the nursing circle since 4:30 AM which happens three times per week on the days he has to go to dialysis appointments. R7 stated the aides are forced to get him up at 4:30 AM to ensure he will be on time for his dialysis appointment due to the lack of staff. R7 stated he could be sleeping in bed rather than sleeping in his wheelchair for two extra hours.On 5/27/26 at 6:45 AM, and interview was conducted with Transport Driver/Staff I who verified R7 frequently sleeps in his wheelchair for hours prior to leaving for his dialysis appointments. Staff I indicated R7 often complains of being woken up too early.On 5/27/26 at 7:42 AM, an interview was conducted with Resident #8 (R8) who was observed sitting in a recliner in her room. When R8 was queried about the care she received at the facility, she replied, Staffing is one big problem, and it is a BIG one. You wait and you wait and you wait. When R8 asked if the staffing shortage affects her care, she replied, Just the other night I had to sit here for more than 30 minutes waiting to go to the bathroom. I was actually hurting I had to go so bad.On 5/26/26 at 1:46 PM, an interview was conducted with Family Member (FM) C who voiced their concerns regarding staffing shortages at the facility. FM C stated they try to visit their loved one every evening because they are uncertain their loved one will receive the care they need. FM C stated they often provide incontinence care and prepare their loved one for bed or else they end up waiting an extended period waiting for an available aide.Review of Resident Council Meeting Minutes from 3/10/26 to present day read, in part:5/16/26: Old Business: D Hall call light wait times at night have not improved. 30-45-minute wait. New Business: D Hall call light wait times 30-45 minutes at night.4/30/26: Old Business: D hall night call wait times continue being an issue .4/23/26: Old Business: D hall call light wait times continue to be an issue.4/16/26: New Business: (continued on next page)

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