STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235350	A. Building B. Wing	08/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Gaylord	508 Random Lake Gaylord, MI 49735

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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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: 235350	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/06/2025
NAME OF PROVIDER OR SUPPLIER Medilodge of Gaylord		STREET ADDRESS, CITY, STATE, ZIP CODE 508 Random Lake Gaylord, MI 49735	

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 0600 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake 1234972Based on interview and record review, the facility failed to protect two Residents (#1 and #2) of four resident reviewed for right to be free from sexual abuse. This deficient practice resulted in psychosocial harm including feelings of embarrassment, devastation, anxiety, feelings of being violated, and trauma based on a reasonable person standard.Findings include:Review of a facility five-day investigation summary, submitted to the State Agency (SA) on 7/8/25 at 6:45 p.m., revealed the following: The Director of Nursing (DON) was notified by the Certified Nurses Assistant (CNA) that R1 was found in R2's bed.R2 was wearing her t-shirt and had her brief off.R1 was disrobed from the waist down and kneeling in another resident's bed.Resident #1 (R1)Review of the Minimum Data Set (MDS) assessment, dated 6/14/25, revealed R1 was admitted to the facility on [DATE] with active diagnoses that included: Alzheimer's disease and depression. R1 scored a 2 of 15 on the Brief Interview for Mental Status (BIMS) assessment reflective of severe cognitive impairment.Resident #2 (R2)Review of the MDS assessment, dated 7/4/25, revealed R2 was admitted to the facility on [DATE], with active diagnoses that included dementia and Parkinson's disease. R2 scored a 99 on the BIMS assessment reflective of severe cognitive impairment.During an interview on 8/6/25 at 8:48 a.m., CNA A reported that R1 has tried to grab other residents breasts.we have to keep him away from the ladies.he does not prefer any particular resident, he will try with any of them.He has been sexually inappropriate and this behavior has increased over the last several months leading up to the incident with R2.During an interview on 8/6/25 at 8:55 a.m., CNA B reported R1 asks if he can touch woman's boobs and he has talked that way for a long time. I have worked here for 5 years, and he has been that way the whole time.During an interview on 8/6/25 at 9:02 a.m., Licensed Practical Nurse (LPN) C reported, I worked that night of the incident. When I walked into R2's room I couldn't believe what I was seeing, he was on her bed straddling her.R2 had no incontinence brief on.he (R1) was on his knees hovering over her. R2's legs were spread, if there was any abuse it was brief.she seemed embarrassed, and her face was flushed. R1 will make comments to the other residents and reach out to them, and we have had to watch him with other residents prior to this incident with R2.During an interview on 8/6/25 at 9:49 a.m., the DON reported, R1 was on the end of the bed on his knees and leaning over her.both R1 and R2's incontinence briefs were off, and they were naked from the waist down.During a phone interview CNA D reported, I was the one that found them that morning. When I went into her room he was on top of her and her legs were spread apart. Neither one of them had incontinence briefs on.I don't think R2 understood what was going on and R1 told me that they were making love.He has tried to touch other female resident's thighs and has been touchy with other residents in the past.During a phone interview on 8/6/25 at 10:47 a.m., Family Member E stated, My mom would be devastated and upset if she knew what had happened to her. she would have been in shock.she would have never done this with anyone, only my dad who was the only man she had ever been with.Review of the Electronic Medical Record (EMR) revealed R1 had sexually inappropriate behaviors on the following dates 1/3/25, 1/9/25, 2/13/25, 3/3/25, 4/9/25, 5/5/25, 5/7/25, 5/12/25, 6/2/25, 6/16/25 and 6/26/25.Review of Nurses notes dated 5/21/25 revealed R1 had been Touching and feeling the woman residents this shift. Resident (R1) asked another woman resident how many times she could do it tonight? The woman resident stated she doesn't know because she is old now, [R1] said so am I but I could do it three times tonight one at 9pm one at midnight and one at 3 am.During an interview on 8/6/25 at 10:59 a.m., Social Services worker F reported that she was unaware of the event on 5/21/25 and she was aware that R1 had sexual behaviors in the past, but the facility had not offered behavioral health services to the resident since 2019. Social Service worker F reviewed the EMR and reported there was not a care plan in place to keep the residents safe from R1's sexual inappropriate behaviors.During an interview on 8/6/25 at 12:00 p.m., the DON reported there was no trauma assessment completed on R2 following the incident. The DON acknowledged there was no care plan or interventions to monitor R2 for any catastrophic reactions (emotional or behavioral reactions) from R2.During an interview on 8/6/25 at 12:30 p.m., the Nursing Home Administrator (NHA) reported that she was aware R1 had sexual inappropriate behaviors with staff prior to the incident and was not aware of the event on 5/21/25. The NHA acknowledged there were no care plan interventions following the event for R2, the facility did not offer behavioral health services for R1, there were no care plan interventions prior to the incident for R1 regarding sexual inappropriate behaviors in order to keep other residents safe Review of policy titled Abuse, Neglect, and Exploitation date