STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235356	A. Building B. Wing	12/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge at the Shore	900 South Beacon Boulevard Grand Haven, MI 49417

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. (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 - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation refers to intake 2647067. Based on interview and record review, the facility failed to report timely of an allegation of abuse to the state survey agency for 2 of 5 residents (R3 and R4) reviewed for abuse. Findings include:R3 A review of R3's admission Record, dated 12/10/25, revealed R3 was an [AGE] year-old resident admitted to the facility on [DATE]. In addition, R3's admission Record revealed they had multiple diagnoses that included anxiety, chronic pain, and insomnia. A review of R3's Minimum Data Set (MDS) (a tool used for assessing a resident's care needs), dated 9/25/25, revealed a Brief Interview for Mental Status (BIMS) (a scale used to determine a resident's cognitive status) score of 15 which revealed R3 was cognitively intact. A review of R3's Pertinent Charting-Behavior note, dated 10/2/25 at 3:36 PM, revealed, Resident had a physical altercation with another resident during second shift on 10/1/25. R4 A review of R4's admission Record, dated 12/10/25, revealed R4 was a [AGE] year-old resident admitted to the facility on [DATE]. In addition, R4's admission Record revealed multiple diagnoses that included dementia and anxiety. A review of R4's MDS, dated [DATE], revealed a BIMS score of 15 which revealed R4 was cognitively intact. A review of R4's Nurses' Notes, Late Entry: dated 10/4/25 for 10/1/25, revealed, Incident between roommates, physical altercation. No injuries sustained by either resident, no complaints of pain. A review of the Facility Reported Incident (FRI), dated 10/9/25, revealed that on 10/1/25 at approximately 8:30 PM, R3 and R4 were heard with raised voices in their shared room. R4 stated R3 made contact with her arms and shoulder area with open hand. The residents were immediately separated, assessed, and no physical injuries or harm were noted. In addition, the FRI revealed the facility reported the incident to the state survey agency on 10/2/25 at 1:30 PM (17 hours after the incident occurred). The FRI also revealed that the facility was able to substantiate that contact had occurred, however there was no marks, injury, or pain. A review of Certified Nursing Assistant (CNA) L's typed and unsigned statement, dated 10/1/25, revealed she was standing in the doorway to the shower room talking to CNA A and CNA D when she heard a commotion behind her. She wrote she looked into R3's and R4's room and saw R3 standing over and leaning into R4 who was lying in her bed. CNA L also wrote R3 had her hands wrapped around R4's hands/arms and was punching R4 in the face and chest. CNA L wrote she shouted, ran into R3's and R4's room, grabbed R3's hands, and pulled R3 back away from R4. She wrote the other CNA's (CNA A and CNA D), and the nurse were in the room at this point and everyone physically separated R3 from R4. During an interview on 12/10/25 at 11:30 AM, the Nursing Home Administrator (NHA) stated she was called on 10/1/25 and told by the nurse that R3 and R4 had a verbal argument. She stated she told the nurse to talk with the residents and find out what happened. The NHA stated the nurse spoke to the residents and called her back. She stated that R3 said she was coughing and R4 told her she needed to see a doctor. The nurse told her that R3 and R4 started arguing and they had to be separated. The NHA stated she was told that both residents said they felt safe in their room and neither one wanted to move rooms. The NHA stated they had a staff member stay in the hallway and monitor R3 and R4 for the rest of the shift. The NHA stated she came in the next morning and spoke with both residents. She stated neither one said there was physical contact. The NHA stated that they only said they had a verbal argument. The NHA stated a few hours after she spoke to R3 and R4 (around 11:10 AM), she was told R4 wanted to talk to her. She stated when she spoke with R4, R4 told her she wanted the police notified because she wanted to press charges against R3. The NHA stated she told R4 that she would call the police, but charges may not be pressed if there was not any physical contact. The NHA stated the police came and took a report. During the interview on 12/10/25 at 11:30 AM, the NHA was asked if she was ever told that R3 and R4 had physical contact. She stated she was not told that. When I asked her why the facility concluded that there was physical contact (per the FRI that the facility submitted to the state survey agency) if R3 and R4 only verbally argued, she stated R3 and R4 had only had physical contact with crossed arms. The NHA further stated that neither resident hit the other one and there was not any physical injury or evidence that they had. I informed the NHA that according to CNA L's typed statement she had noted that she had seen R3 punching R4 in the face and chest. I then asked the NHA if she had seen CNA L's statement and knew what it said. She stated she had seen the statement and when she read it she called CNA L to ask her about it. The NHA stated when she spoke with CNA L over the phone, CNA L told her that everything happened so fast that she could not be sure if R3 actually hit R4 or if she just saw them swinging at each other and/or contacting each other's crossed arms. The NHA stated she did not document the phone

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake #: 2674458Based on observation, interview, and record review, the facility failed to ensure resident care plans were reviewed, revised, and implemented for 1 of 15 residents (Resident #6) reviewed for comprehensive person-centered care plans.Findings:Resident #6 (R6)Review of an admission Record revealed R6 was a [AGE] year-old female, admitted to the facility on [DATE], with pertinent diagnoses which included: dementia, Alzheimer's Disease, dysphagia (difficulty swallowing), peripheral vascular disease, and urinary incontinence. R6 had an activated DPOA (Durable Power of Attorney).Review of R6's Admin Order dated 9/17/25 revealed, .(R6) needs to be in a geri chair with direct supervision.and she should NOT be up in a broda chair as it is not supportive enough.Review of R6's care planned intervention dated 12/24/24 revealed, Resident uses a manual wheelchair for locomotion.Review of R6's Physician Order dated 11/20/25 revealed, Tramadol 5 MG/ML (Tramadol HCl) Take 10 ml by mouth twice a day and additional 10 ml once daily as needed for pain (one hour before wound dressing change).Review of R6's Care Plans did not reflect the administration of the pain medication 1 hour prior to dressing changes.Review of R6's Electronic Medical Record revealed new onset of seizures beginning on 8/23/25.Review of R6's Care Plans did not reflect the diagnosis of seizures or include interventions for preventing injuries and/or monitoring.Review of R6's provider Progress Note dated 10/30/25 revealed, .continue with frequent repositioning and incontinence care. Review of R6's care planned intervention dated 12/24/2024 revealed, Assist resident with turning and repositioning as needed and did not reflect the need for frequent repositioning.Review of R6's Skin & Wound Evaluation dated 11/18/25 and 11/18/25 revealed her unstageable pressure injury on the right gluteus was deteriorating.Review of R6's Care Plans revealed no new interventions were implemented despite the documented deterioration of the pressure injury on 11/11/25 and 11/18/25 (examples: head of bed less than 30 degrees to reduce pressure, use of a wedge offloading device, frequency of turn schedule, etc.)Review of R6's Weight Summary revealed she was 116.2 pounds on 9/1/25 and 105.2 pounds on 12/4/25 (9.47% decrease in approximately 3 months).Review of R6's care planned intervention dated 12/25/24 revealed, Provide meals/fluids based on resident food preferences and as ordered. The Care Plan did not include meals and/or snacks that R6 previously enjoyed or suggestions from R6's DPOA and did not include a list of dislikes and/or foods to avoid.Review of R6's Electronic Medical Record and Pain Summary revealed R6 was experiencing increased pain due to her Stage 4 pressure injury.Review of R6's care planned intervention dated 12/24/24 revealed, Offer non-pharmacological interventions to relieve pain and observe for effectiveness. The Care Plan did not include non-pharmacological interventions that had been previously effective or other interventions to try.Review of R6's Admin Order dated 9/24/25 revealed a dietary order for puree, nectar thick, liquids by teaspoon. 1:1 feed small bites/sips, slow rate. Stop feeding if coughing. Use metal utensils and glass/hard plastic cups.Review of R6's care planned intervention dated 9/18/25revealed, 1:1 feeding assist. (Do not use plastic utensils, straws or Styrofoam cups as she will chew through them. R6's Care Plan did not reflect the therapeutic diet order or the use of a teaspoon for liquids. During an observation and interview on 12/10/2025 at 8:58 AM, CNA N reported R6 required 1:1 feeding assistance and required pureed food and nectar thick liquids. CNA N reported her diet order and type of feeding assistance was listed on the meal ticket found on her meal tray as well as on her care plan. R6's meal tray contained pureed food and hard plastic cups with straws. CNA N assisted R6 with drinking the thickened liquids with the straw. During an observation and interview on 12/10/2025 at 12:15 PM, CNA N reported the importance of reviewing resident care plan prior to working the shift and especially if pulled to an unfamiliar unit. CNA N was observed feeding R6 and assisting her with using the straw for her thickened liquids. Review of R6's Meal Ticket displayed on her meal tray revealed Dys (dysphagia) puree-regular, Nectar Thickened Liquids, no Styrofoam cups. Review of Fundamentals of Nursing ([NAME] and [NAME]) 11th edition revealed, A nursing care plan includes nursing diagnoses, goals and/ or expected outcomes, individualized nursing interventions, and a section for evaluation findings (see Chapter 20). The plan promotes continuity of care and better communication because it informs all health care providers about a patient's needs and interventions and reduces the risk for incomplete, incorrect, or inappropriate care measures.The plan gives all nurses a central document that outlines a patient's diagnoses/ problems, the plan of care for each diagnosis/ problem, and the outcomes for monitoring and evaluating patient progress. The plan of care communicates nursing care priorities to nurses and other health care providers. It also

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake #: 2674458Based on interview and record review, the facility failed to 1.) implement the facility policy for pressure injuries/wound management and 2.) ensure treatments were completed as ordered, for 5 of 15 residents (Resident #6, #9, #11, #12, and #13) reviewed for alterations in skin integrity. Findings:Resident #6 (R6)Review of an admission Record revealed R6 was a [AGE] year-old female, admitted to the facility on [DATE], with pertinent diagnoses which included: dementia, Alzheimer's Disease, dysphagia (difficulty swallowing), peripheral vascular disease, and urinary incontinence.Review of a Minimum Data Set (MDS) assessment for R6, with a reference date of 9/19/25 revealed R6's cognitive skills for decision making was severely impaired. Further review of R6's MDS revealed there were no pressure injuries present at that time, however, R6 was at risk for the development of pressure injuries. Review of R6's Functional Abilities assessment dated [DATE] revealed that R6 was dependent on staff with eating (1:1 feeding assistance), personal hygiene, bed mobility (rolling left and right in bed), and transferring (bed to chair). Review of R6's Braden Scale for Predicting Pressure Sore Risk dated 6/17/25 and 9/17/25 revealed a score of 11 which indicated R6 was high risk for the development of a pressure injury.Review of R6's Skin Assessment dated 10/4/25 no new skin breakdown.A Skin Assessment was not completed on 10/11/25. Review of R6's Skin Assessment dated 10/18/25 revealed, Are there any new abnormal skin areas? Yes . Coccyx-opening in skin about pea sized.Review of R6's Electronic Medical Record (EMR) revealed no documentation that the provider or DPOA was notified of the pressure injury or that a wound treatment was initiated at the time of the discovery of the wound. There was no wound assessment completed.Review of R6's Incident Report dated 10/21/25 revealed, Incident Description: Pressure area observed to resident's right buttock. The physician and DPOA were not notified of the pressure injury until 10/29/25.Review of R6's Order Summary dated 10/22/25 revealed, Cleanse with NS (normal saline) and apply foam dressing to coccyx every day shift for Pressure Ulcer.Review of R6's Treatment Administration Record (TAR) revealed the coccyx pressure injury treatment was not completed on 10/26/25.During an interview on 12/10/2025 at 11:08 AM, the Director of Nursing (DON) confirmed that the licensed nurse did not follow the facility policy and procedure following the identification of skin breakdown and confirmed the missing skin assessment on 10/11/25. Review of R6's Skin & Wound Evaluation dated 10/28/25 revealed a facility acquired unstageable pressure injury on the right gluteus measuring 1.7 cm (length) by 1.0 cm (width) and 0.2 cm (depth). 70% of the wound was filled with slough (yellow/white viscous dead tissue). (The base of R6's wound bed was obscured by slough and therefore an accurate depth measurement was unattainable.) Interventions to implement were cushion, foam mattress, incontinence management, moisture control, and turning/repositioning program.Review of R6's provider Progress Note dated 10/30/25 revealed, .(R6) appears increasingly uncomfortable while wound is assessed especially when touching near the area of the wound. A pressure wound is noted to the right side of her sacrum on a bony prominence approximately 2cm x 2cm with unknown depth due to the presence of slough to wound bed. Tissue surrounding wound has discoloration with both light and dark areas surrounding. New dressing applied during visit and urinary incontinence is noted (facility Registered Nurse) tells me that they have been repositioning (R6) frequently on alternating sides using a pillow.Encouraged (facility) staff to report any acute changes or signs of infection to (provider). continue with frequent repositioning and incontinence care.Review of R6's Care Plan revealed, Resident has impaired skin integrity as evidenced by: Unstageable pressure ulcer to right buttock Date Initiated: 10/28/2025.Assist resident with turning and repositioning as needed Date Initiated: 12/24/2024. The care plan did not include the turning/repositioning program or with frequent repositioning and incontinence care.Review of R6's Skin & Wound Evaluation dated 11/4/25 revealed her unstageable pressure injury on the right gluteus now measured 2.0 cm (length) by 1.6 cm (width) and 0.6 cm (depth). The wound bed was filled with 20% slough and there was moderate serosanguineous (thin, watery, light pink fluid) exudate (drainage) with a saturated dressing. Increased pain was also identified. No new interventions were implemented. There was no documentation that the provider was notified of the deterioration of the wound. Review of R6's Wound Evaluation dated 11/4/25 revealed a handwritten order for APM (alternating pressure mattress)-ensure set to alternating.Review of R6's Care Plan revealed .Pressure redistribution mattress to bed Date Initiated: 10/29/2025. Pressure redistribution mattress to bed Date Initiated: 11/25/2025. The care plan did not include the APM settings (level 1-5) or to ensure it was set on alternating versus float Review of