STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235358	A. Building B. Wing	07/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Ludington	1000 East Tinkham Avenue Ludington, MI 49431

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 - Minimal harm or potential for 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

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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 0600 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 1268402Based on observations, interview, and record review, the facility failed to ensure 1 resident (Resident#1) of 3 was free from verbal abuse when a staff member swore about the resident's behavior. Findings include:Review of Policy Abuse, Neglect and Exploitation last revised 1/10/24 revealed, It is the policy of this facility to provide protections for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation, and misappropriation of resident property. The policy defined Abuse means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish, which can include staff to resident abuse and certain resident to resident altercations. Abuse also includes deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain, or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology.Findings:Review of an admission Record reflected Resident #1 (R1) admitted to the facility with pertinent diagnoses that include Bipolar Disorder, Obsessive Compulsive Disorder, persistent mood disorder, anxiety disorder and frontal lobe and executive function deficit (Damage to the frontal lobe can lead to deficits in functions resulting in difficulties with planning, organization, decision-making and emotional regulation.)During an interview on 7/08/25 at 9:10 AM, DON revealed R1 is behavioral, has hoarding tendencies, he scrubs his body raw while cleaning himself using the bathroom sink and floods the flooring. DON further revealed resident is afraid of the dark/night, has poor eyesight, is derogatory towards women, a germaphobe, and is followed by CMH (Community Mental Health).During an interview on 7/08/25 at 11:30 AM, NHA & DON provided past non-compliance for this intake. DON stated, We wrote ourselves up. On 7/08/2025 at 12:10 PM, Lunch was observed being delivered to R1's room. Resident was observed in bed wearing a brief and sheet. During the interview R1 stated, I am a sick, sick man. Staff come when I do not want to see them and don't come when I want to see them. Resident#1 was asked if staff came when he pushed his call light. R1 replied, of course staff come when I push my call light, they have to, it's their job. The resident further revealed he did not like 3rd shift, and that he did have a problem with someone, but she's gone. They have to wait on me and do everything I say cause it's their job. (Resident#1 became very loud and agitated during the interview.) Interview concluded when R1 started muttering under his breath, I'm done, done, done.During an observation/interview on 7/08/25 at approximately 12:15 PM, R1's Guardian D was observed sitting in a chair and stated, He is in a bad mood today. He is acting like he can't hear a thing. R1's Guardian D states her son likes the staff; he just does not like nights. Staff are very good overall & I have no issues with them communicating with me. She further stated that he needs to go away for a psyche stay. Review of an Incident Report dated 5/24/25 reflected that Certified Nurse Aide (CNA) L and Registered Nurse (RN) K witnessed/heard R1 yelling and swearing at CNA J in his room and the hallway about ice and ice water. R1 further yelled to CNA J she was to listen to him and no one else. CNA J responded to R1 stating you have the wrong butt wiper, and I don't F*cking care. CNA J then shut R1's door and walked to the desk. The report reflected initial actions taken were to ensure R1's safety, contact NHA, DON and guardian, remove/suspend staff member (CNA J), assess the resident and collect statements. Review of CNA J's written statement 5/23/25 at 12:30AM, I answered his call light with ice water in hand. I had gloves on, he opened the lid to the cup and said there is only four cubes in there, but the cup was full of ice, and so he was getting upset, I walked to his bathroom and cleaned up the wet linen and dried up the wet floor. He wanted a cup with just ice so I came out to get his ice and when I came back to his room the nurse was talking to me, and the resident was still in bed yelling at me about the ice. I couldn't hear the nurse, so I told him to wait a minute because I was talking to the nurse. He didn't like that and started yelling and cursing at me and saying I'm to only listen to him and no one else. So, I spoke his language and said I didn't F*cking care, and he didn't have to yell at me like that. He says I hurt him, but I don't see how, I was never close to him.Review of CNA L's handwritten statement on 5/24/25 at 12:30 AM, CNA L wrote I was sitting at the nurses' station when she heard patient and (Name of) CNA J arguing about ice in a cup. CNA L stated she was trying to tell CNA J how he liked it when he yelled to (Name of CNA J) to listen to him and not out there. She responded you got the wrong butt wiper, I don't F*cking care. As the patient was yelling, she shut the door and walked