STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235399	A. Building B. Wing	08/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Portage	7855 Currier Dr Portage, MI 49002

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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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: 2575789, 2567564Based on interview and record review, the facility failed to prevent resident to resident sexual abuse in 1 of 3 sampled residents (Resident #102) reviewed for abuse, resulting in the potential for a decline in mental and psychosocial well-being.Findings include: Resident #102: Review of an admission Record revealed Resident #102 was a female with pertinent diagnoses which included major depressive disorder, reduced mobility, hemiplegia and hemiparesis (paralysis) following cerebral infarction affecting left non dominant side, and anxiety. Review of a Minimum Data Set (MDS) assessment for Resident #102, with a reference date of 6/20/25 revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated Resident #102 was cognitively intact. Review of current Care Plan for Resident #102, revised on 3/19/2025, revealed the focus, .Resident has an impaired mood/psychiatric status related to major depressive do (disorder), anxiety. Has depression r/t (related to) stroke dx (diagnosis). Resident chooses to keep concern forms in her room to use as notes rather than share them with staff. with the interventions .Periodically complete the PHQ-9 (questionnaire used to screen, diagnosis, and monitor depression severity).Provide resident with quality listening time and encourage expressions of feelings. Encourage resident to share her concerns so that we can assist her. Review of Order dated 7/17/25, revealed, .Ensure stop sign is hung across bedroom doorway at night at bedtime. Review of Nurses' Notes dated 7/17/2025 at 04:15 AM, revealed, .Resident reported to nurse that resident (Resident #103) in room (Room Hallway and Number) was in her room and she called the police, asked what happened and resident states I woke up because I felt someone touching me and it was him! Then she states that he was touching her in her breasts and vaginal area so she screamed for him to leave and he did and so she called the police, the police arrived and spoke with resident who does want to press charges, writer called and notified administrator who is also the abuse coordinator, writer had seen both residents asleep in their rooms after midnight med pass. The CNA (Certified nursing assistant) reports they were both sleeping in their beds at 0300 rounds.Review of Social Services Progress Notes dated 7/17/2025 at 3:39 PM, revealed, .SS (social services) followed up with resident r/t (related to) recent incident that occurred with another resident.SS did voice that she wants to press charges in which she has been in communication with the police. Resident has a stop sign located outside her door in which order is being put in to ensure that it is put up over doorway during the night. Resident voiced that she is happy that the resident that the incident occurred with has been moved to another hall. Resident was seen by the psych NP (nurse practitioner) today 7/17 and continues to be followed by services for continued support. Review of Social Services Progress Notes dated 7/18/2025 at 3:16 PM, revealed, .SS (social services) visited with resident to see how she is doing. Resident stated I'm good and I'm feeling safer now that that guy is not on the hall anymore. Resident is referring to (Resident #103) who has entered her room the other day while she was sleeping. Resident #103: Review of an admission Record revealed Resident # 103 was a male with pertinent diagnoses which included dementia with other behavioral disturbance, major depressive disorder, and insomnia. Review of Care Plan for Resident #103, revised on 6/30/25, revealed the focus, .Resident has behaviors of sexual comments, gestures towards staff. May become intimate with other residents such as kissing. Physical and verbal aggression toward staff. Exit seeking behaviors. with the interventions .Observe and document episodes of inappropriate behaviors, explain that behavior is inappropriate.Revision on: 04/22/2025. Offer/provide activities of interest to keep resident engaged in positive interactions.Date Initiated: 04/22/2025.Review of Care Plan for Resident #103, revised on 7/25/25, revealed the focus, .Resident has behaviors of sexual comments, gestures towards staff such as grabbing at inappropriate areas. May become intimate with other residents such as kissing. At times prefers to lay naked in his bed, declining to put clothing on. Physical and verbal aggression toward staff. Exit seeking behaviors. with the interventions .1:1 at all times until further notice.Observe and document episodes of inappropriate behaviors, explain that behavior is inappropriate. Offer/provide activities of interest to keep resident engaged in positive interactions.Redirect to activity of interest- Watching Westerns, baseball games and boxing, listening to country music.Review of Nurses' Notes dated 6/22/2025 at 11:09 PM, revealed, .observed resident walking down the hallway without wheelchair multiple times during shift. redirected resident multiple times. redirection effective for a short period of times, repeated getting up ambulating down the hall. resident noted having hallucinations of seeing a person and dog in room. Resident redirected to wheelchair, spent time with nurse at nurse cart during med

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, interview and record review, the facility failed to ensure that a urinary drainage bag was not resting on the floor to prevent the risk of urinary tract infection for 1 (Resident #101) of 3 residents reviewed for urinary catheter use, resulting in the potential for infection. Findings include:A urinary catheter is a tube placed in the body to drain and collect urine from the bladder .An indwelling catheter collects urine by attaching it to a drainage bag. The bag has a valve that can be opened to allow urine to flow out. Some of these bags can be secured to your leg. This allows you to wear the bag under your clothes. An indwelling catheter may be inserted into the bladder in 2 ways: Most often, the catheter is inserted through the urethra. This is the tube that carries urine from the bladder to the outside of the body. Sometimes, the provider will insert a catheter into your bladder through a small hole in your belly. This is done at a hospital or provider's office . A catheter is most often attached to a drainage bag. Keep the drainage bag lower than your bladder so that urine does not flow back up into your bladder. (https://medlineplus.gov > Medical Encyclopedia)Resident #101: Review of an admission Record revealed Resident #101 was a male with pertinent diagnoses which included acute kidney failure, kidney disease, retention (holding back of substances in the body that are normally excreted) of urine, and benign prostatic hyperplasia (enlarged prostate gland) with lower urinary tract symptoms. Review of current Care Plan for Resident #103, revised on 5/15/2025, revealed the focus, .Resident has a need for an indwelling catheter related to: urinary retention, mechanical complication of foley cath. with the intervention .Observe for signs and symptoms of UTI (Urinary Tract Infection) and report to the Physician: blood in urine, cloudiness, foul smell, fever, change in mental status.Document output.Report signs of peri-area redness, irritation, skin excoriation/breakdown to the Nurse. Report signs of peri-area redness, irritation, skin excoriation/breakdown to Physician/NP/PA.Assist resident with indwelling catheter care.Change catheter and drainage system as clinically indicated per order(s). Observe for signs/symptoms of obstruction (leakage, increased sediment, etc.), infection, or if closed system was compromised.Irrigate foley catheter as indicated.Maintain drainage bag below the bladder level.Privacy cover to catheter drainage bag.Review of Order dated 4/28/25 revealed, .Monitor urine from indwelling catheter for color, cloudiness, odor, and decreased output. Notify provider as needed of any changes.every day and night shift. Review of Order dated 4/28/25, revealed, .Catheter: ensure anchor secured in place. every day and night shift. Review of Order dated 4/28/25, revealed, .Change indwelling Foley catheter 16Fr; balloon 10cc as clinically indicated: s/s (signs/symptoms) of obstruction (leakage, increased sediment, etc.), infection, or if closed system was compromised.as needed.Review of Order dated 4/28/25, revealed, . Maintain indwelling foley catheter every day and night shift related to OTHER RETENTION OF URINE (R33. 8).During an observation on 08/05/25 at 8:50 AM, Resident #101 was observed lying sideways in his bed. Noted his catheter bag was hanging from the left side of the bed, there was not a privacy bag which covered it, and it was lying on the floor. During an observation on 08/05/25 at 09:50 AM, Resident #101 was observed lying in his bed, his catheter bag was placed on the floor on the left side of the foot of the bed. No privacy bag/cover was over it. During an observation on 08/05/25 at 11:42 AM, Resident #101 was observed lying in his bed, his catheter bag was lying on the floor next to the right side by the privacy curtain side. During an observation on 08/05/25 at 12:58 PM, Resident #101 was observed lying in his bed. His catheter bag was lying flat on the floor, the connection to the bag/tube area was not on the floor. During an observation on 08/05/25 at 2:19 PM, Resident #101 was seated upright, and he was eating his lunch. Resident #101's catheter bag was hung at the left side of his bed, but it did not have a privacy bag/cover over it. During an observation on 08/06/2025 at 09:00 AM, Resident #101 was observed in his room, lying in his bed, he had his breakfast tray but had not begun to eat it yet. The catheter bag was hung at the side of the bed, but it did not have a privacy bag. Review of Nurse's Notes dated 7/4/2025 at 10:19 PM, revealed, .Note Text: Foley bag had milky/green foul odor urine, reported to NP (Nurse Practitioner) (Name of NP) who ordered UA C&S (culture and sensitivity).Review of Pertinent Charting-Infections/Signs Symptoms dated 7/7/2025 at 4:59 PM, revealed, .Event Date: 07/04/2025.Site of infection: UTI .Reason on antibiotics/new signs & symptoms: Foley bag had milky/green foul odor urine, reported to NP (Name of NP) who ordered UA C&S.Intervention(s): Administer medications and treatments to treat infection and/or symptoms as ordered; observe for adverse effects.Encourage fluids unless contraindicated. Observe and report to Physician/NP/PA signs/symptoms of dehydration (poor skin turgor, dry mucous membranes, increased heart rate, sunken eyes, decreased urinary output, difficulty breathing, hypotension) Evaluate for verbal and non-verbal signs of pain. Administer