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	01/15/2026

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake #2709386.Based on observation, interview and record review, the facility failed to report an incident of neglect (a hot liquid burn) for 1 resident (Resident #101) of 5 residents reviewed for accidents/safety when Resident #101 did not have appropriate interventions in place based on an assessment related to hot liquid spills and did not receive the help she needed resulting in a second burn causing Resident #101 pain, distress and fear of getting burned again. Findings include:Review of the admission Record and Minimum Data Set (MDS) dated [DATE] revealed R101 originally admitted to the facility on [DATE] with pertinent diagnoses including nontraumatic intracerebral hemorrhage (serious stroke where bleeding occurs inside the brain and flaccid (lacking firmness, strength or stiffness; limp and flabby) hemiplegia (paralysis of one side) affecting left dominant side. Brief Interview for Mental Status (BIMS) on 1/12/2026 reflected a score of 13 out of 15 which indicated R101 cognition was intact. R101 went to the hospital on [DATE] and returned on 1/6/2026. In an email correspondence on 1/13/2026 at 10:20 AM, Family Member (FM) K stated on 12/27/2026 at 3 PM she found R101 was covered in dried coffee, and it was all over her bed and she had a burn from the coffee on her left forearm. FM K said R101's burn was red, swollen, skin peeled off in areas and she was complaining of pain. FM K stated that R101 had another burn on 12/30/2025 and she was notified about it when Unit Manager (UM) S called her and said R101 spilled coffee on her arm and all over the bed. FM K said R101 had a stroke, has left side paralysis and has only the use of her right arm which is her non-dominant hand. FM K stated that R101 needed assistance at meals and with drinks and she told staff that. Review of R101's Nursing admission Evaluation-Part -V9 dated 12/18/2025 indicated she was at risk from hot liquid spills due to weakness/paresis in upper extremities and loss of mobility/reduced movement in upper extremities. Review of R101's Care Plan revealed Focus: Resident has an ADL (Activities of Daily Living) self-care performance deficit related to intracerebral hemorrhage (bleeding inside the skull), major depressive disorder, multiple intracranial aneurysms (a weak, bulging spot on a blood vessel in the brain, often forming at artery junctions, that can leak or burst, causing a life threatening stroke) Left sided weakness . Date initiated 12/18/2025. Interventions. Eating: 1 person assist. Date initiated 12/18/2025. There was no information on R101 being at risk for hot liquid spills or any special equipment needed to diminish the risk of spills.Review of R101's Kardex (where staff can get information about the resident such as assistance levels) revealed .Eating: 1 person assist. Created date: 12/18/2025. There was no information on R101 being at risk for hot liquid spills or any special equipment needed to diminish the risk of spills. During an interview on 1/13/2026 at 11:05 AM, Registered Nurse (RN) O stated that R101 needed assistance with meals and lids and straws for drinks because she spilled her drinks.During an observation and interview on 1/13/2026 at 12:00 PM, R101 was sitting in the main dining room in a Broda chair (specialized wheelchair for limited mobility and to increase comfort and support) waiting for lunch. R101 stated (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: 235399	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/15/2026
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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	that she had 2 burns on her left arm/hand and the first burn was bad and almost a 3rd degree burn. R101 reported that she had blisters with the first burn and it was so painful. R101 said that the coffee lid was on the coffee cup both times but it fell off when she took a drink. R101 stated that she was left-handed and due to her left side neglect, she had to eat and drink with her right hand. R101 stated that she needed help with meals and drinks.Review of R101's Incident Report dated 12/27/2025 which was completed by Licensed Practical Nurse (LPN) I revealed .Nursing Description: This nurse was notified by staff that resident had spilled her coffee and burned herself. Upon assessments this nurse observed a skin injury to left lower forearm open skin with surrounding redness. Daughter was present during injury who stated she was not supposed to be left alone with hot drinks. Resident stated, I was drinking my coffee and it spilled and it hurts. During an interview on 1/14/2026 at 11:25 AM, CNA H stated that she worked on 12/27/2025 when R101 got her first burn. CNA H said that R101 was a one-to-one assist with meals because her right hand got shaky when drinking and feeding herself. CNA H stated that CNA U asked RN T if R101 could have coffee before giving it to her and then they left for the day. CNA H stated that she knew R101 needed assistance with meals/liquids. During an interview on 1/14/2026 at 10:30 AM, CNA U stated on 12/27/2025 she asked RN T if R101 could have coffee because she noticed that R101 spilled soda all over herself and the bed over the weekend and RN T said R101 could have it. CNA U said she gave her the cup of coffee with a lid and set it on R101's bedside table and R101 said she would let it cool before drinking it. CNA U indicated that the Kardex should indicate if R101 needed assistance with hot beverages. During an interview on 1/14/2026 at 10:43 AM, RN T stated on 12/27/2025 she couldn't remember if a CNA asked her if R101 could have coffee and then she was notified R101 had a burn. Review of R101's Incident Report (for second hot liquid spill) dated 12/30/2025 which was completed by UM S revealed Nursing Description: CNA went to resident's room because the resident's call light was on and resident informed CNA that she spilled her coffee. CNA came to my office to notify me of the incident. Went into resident's room and there was spilled coffee on the bed and the floor all over with the cup on the floor resident left hand noted to be red, blanching (white/pale). Resident description: I spilled my coffee. During an interview on 1/13/2026 at 3:00 PM, UM S stated that the hot liquid safety assessment was completed upon admission which indicated that she was at risk for hot liquid spills. UM S confirmed that the care plan and Kardex dated 12/18/2025 upon admission indicated R101 was an assist at meals and the CNAs would know that looking at the Kardex. UM S stated that she did not get a therapy to nursing communication form regarding any assisted devices for R101 from her first admission or after the first burn. During an interview on 1/14/2026 at 3:19 PM, UM S stated that the facility didn't do anything with hot liquid safety assessments when a resident was at risk for spills since all residents received a lid with hot liquids. When discussing how staff would be aware if a resident was at risk for a hot liquid spill and how this would be communicated, UM S said this wouldn't be communicated. When discussing interventions after R101's burn on 12/27/2025, UM S said that the nurse and on call manager should have put interventions in place initially and then it should have been discussed at the next IDT. UM S stated OT saw R101 after the second burn on 12/30/2025 and interventions were put in place at that time. UM S stated that the Kardex had whether resident needed assistance with meals/liquids and should be followed. UM S said that facility staff weren't educated after either burn. During an interview on 1/14/2026 at 3:39 PM, Nursing Home Administrator (NHA) A stated that the burn on 12/27/2025 wasn't reported since it wasn't an injury of unknown origin. This surveyor discussed reporting for neglect, when the care plan wasn't followed and interventions and education weren't in place after the first burn on 12/27/2025. NHA A stated that the hot liquid safety assessment was completed on all (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	residents and they didn't do anything for high-risk residents since every resident received lids on their cups and OT would see them if a referral was made. NHA A stated that she expected the Kardex would be followed by staff.Review of the Abuse, Neglect and Exploitation Policy with a revision date of 1/10/2024 revealed . Neglect means failure of the facility, its employees, or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress.III. Prevention of Abuse, Neglect and Exploitation.D. The identification, ongoing assessment, care planning for appropriate interventions, and monitoring of residents with needs and behaviors which might lead to conflict or neglect.IV. Identification of Abuse, Neglect and Exploitation.B. Possible indicators of abuse include but are not limited to.8. Failure to provide care needs such as comfort, safety, feeding, bathing, dressing, turning & positioning.VII. Reporting/Response.5. Taking all necessary actions as a result if the investigation, which may include, but are not limited to, the following. b. Defining how care provision will be changed and/or improved to protect residents receiving services.

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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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake #2709386.Based on observation, interview, and record review, the facility failed to provide adequate supervision with hot liquids for 1 resident (Resident #101) of 5 residents reviewed for accidents and safety resulting in Resident #101 receiving a second degree burn (causes pain and damages the outer and second layer of the skin) on her left arm on 12/27/2025 and a burn on her left hand on 12/30/2025 and the fear of receiving another burn. Findings include:Resident #101 (R101)Review of the admission Record and Minimum Data Set (MDS) dated [DATE] revealed R101 originally admitted to the facility on [DATE] with pertinent diagnoses including nontraumatic intracerebral hemorrhage (serious stroke where bleeding occurs inside the brain), flaccid (lacking firmness, strength or stiffness; limp and flabby) hemiplegia (paralysis of one side) affecting left dominant side, chronic pain and depression. Brief Interview for Mental Status (BIMS) on 1/12/2026 reflected a score of 13 out of 15 which indicated R101 cognition was intact. R101 went to the hospital on [DATE] and returned on 1/6/2026. In an email correspondence on 1/13/2026 at 10:20 AM, Family Member (FM) K stated on 12/27/2026 at 3 PM she found R101 was covered in dried coffee and it was all over her bed and she had a burn from the coffee on her left forearm. FM K said R101's burn was red, swollen, skin peeled off in areas and she was complaining of pain. FM K stated that R101 had another burn on 12/30/2025 and she was notified about it when Unit Manager (UM) S called her and said R101 spilled coffee on her arm and all over the bed. FM K said R101 had a stroke, has left side paralysis and has only the use of her right arm which is her non-dominant hand. FM K stated that R101 needed assistance at meals and with drinks and she told staff that. Review of R101's Nursing admission Evaluation-Part -V9 dated 12/18/2025 indicated she was at risk of hot liquid spills due to weakness/paresis in upper extremities and loss of mobility/reduced movement in upper extremities. Review of R101's Care Plan revealed Focus: Resident has an ADL (Activities of Daily Living) self-care performance deficit related to intracerebral hemorrhage (bleeding inside the skull), major depressive disorder, multiple intracranial aneurysms (a weak, bulging spot on a blood vessel in the brain, often forming at artery junctions, that can leak or burst, causing a life threatening stroke) Left sided weakness . Date initiated 12/18/2025. Interventions. Eating: 1 person assist. Date initiated 12/18/2025. There was no information on R101 being at risk for hot liquid spills or any special equipment needed to help diminish the risk of spills. Review of R101's Kardex (where staff can get information about the resident such as assistance levels) revealed .Eating: 1 person assist. Created date: 12/18/2025. There was no information on R101 being at risk for hot liquid spills or any special equipment needed to help diminish the risk of spills. Review of R101's MDS Section GG-Functional Abilities dated 12/24/2025 revealed . Eating: the ability to use suitable utensils to bring food and or liquid to the mouth and swallow food and or liquid once the meal is placed before the resident: Partial/Moderate assistance.During an interview on 1/13/2026 at 11:05 AM, Registered Nurse (RN) O stated that R101 needed assistance with meals and lids and straws for drinks because she spilled her drinks.During an observation and interview on 1/13/2026 at 12:00 PM, R101 was sitting in the main dining room in a Broda chair (specialized wheelchair for limited mobility and to increase comfort and support) waiting for lunch. R101 stated that she had 2 burns on her left arm/hand and the first burn was bad and almost a 3rd degree burn. R101 reported that she had blisters with the first burn and it was so painful. R101 said that the coffee lid was on the coffee cup both times but it fell off when she took a drink. R101 stated that she was left-handed and due to her left side neglect, she had to eat and drink with her right hand. R101 stated that she needed help with meals and drinks. R101 said she loved coffee but she only (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	drank chocolate milk now because she feared getting burned again. Review of R101's Progress Note dated 12/27/2025 revealed Skin Issues: Skin Issue: #001: New skin Issue. Location: Left inner forearm. Issue type: Burn. Progress: New: new wound. Wound acquired in-house. Painful: Yes. Wound pain (Frequency): Continuous. Pain description: Burning. Length (cm-centimeters): 4.77 Width (cm): 3.98 Depth (cm): 0 Area (cm2): 14.78.Review of R101's Progress Note dated 12/27/2025 revealed Nurses' Notes: New skin issues noted to the left lower forearm. resident c/o (complained of) pain Tylenol not effective on call provider notified who ordered 400mg TID (three times a day) for 2 days. The name of the medication ordered was not indicated in the progress note. Review of R101's Progress Note dated 12/30/2025 revealed Nurses' Notes: Late Entry: This DON{(Director of Nursing B} and Administrator {Nursing Home Administrator (NHA) A}met with resident after the spill and burn from hot liquid, to discuss with resident how we can prevent this from occurring again. Resident stated she actually preferred chocolate milk over coffee. We also discussed with resident using a sipper cup for hot liquids. Resident was in agreement with this, and (NHA A) and I updated the unit managers (UM S and UM MM) requesting to update her care plan to reflect these preferences.Review of R101's Incident Report dated 12/27/2025 which was completed by Licensed Practical Nurse (LPN) I revealed .Nursing Description: This nurse was notified by staff that resident had spilled her coffee and burned herself. Upon assessments this nurse observed a skin injury to left lower forearm open skin with surrounding redness. Daughter was present during injury who stated, she was not supposed to be left alone with hot drinks. Resident stated, I was drinking my coffee and it spilled and it hurts. This nurse completed a skin assessment, notified appropriate parties, cleansed pat dry, applied triple antibiotic ointment, applied tefla (non stick wrap) and wrapped in stretch gauze.Level of Pain: 5.During an interview on 1/13/2026 at 2:42 PM, Wound Nurse (WN) Y stated that LPN I saw R101's wound after the burn on 12/27/2025, took a picture of it and started treatment. WN Y said she saw the first wound on 12/30/2025 and took a picture of it and UM S saw the second burn which occurred later, on 12/30/2025. WN Y reported that the first burn that she looked at on 12/30/2025 had granulation tissue, no blisters, was not raised and had a yellow appearance. WN Y stated that R101 needed assistance with meals since she couldn't use her left arm. During an interview on 1/14/2026 at 9:24 AM, LPN I stated that she completed the incident report on 12/27/2025 after the first burn. LPN I stated that a CNA (Certified Nursing Assistant) told her that R101 had a burn to her arm from spilling coffee. LPN I' stated that she saw redness with open skin and said some skin flapped over like the skin peels away during a skin tear. LPN I said she called the doctor and got an order for triple antibiotic cream and non-adherent pad (non-sticking) and to wrap it in in stretch gauze. During a second interview on 1/15/2026 at 9:21 AM, LPN I reported that she did not put cold water on R101's burn on 12/27/2026. She also stated that triple antibiotic ointment sounded like a good choice for treating a burn and the on-call provider {Nurse Practitioner (NP) JJ} said it was okay. According to the Burn Institute, first aid for burns includes the following steps, stop the burning process, remove the source of heat .remove all burned clothing .pour cool water over burned area, keep pouring the cool water for at least 3-5 minutes, never put ice or cold water on a burn as it lowers the body temperature and can make the burn worse .do not apply ointments, creams, or salves to wound .cover burn with a soft, clean, dry dressing, bandage or sheet. Seek medical attention as soon as possible. (www.burninstitue.org/fbp/factsheets/firstaid.html).According to the Mayo Foundation for Medical Education and Research, 1998-2012, when the first layer of skin has been burned through and the second layer of skin (dermis) also is burned, the injury is called a second-degree burn, blisters develop, skin takes on an intensely reddened, splotchy appearance and there is severe pain and swelling. If the second-degree burn area is no larger than 3 (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	inches (7.6 centimeters) in diameter, treat it as a minor burn. If the burned area is larger or if the burn is on the hands, feet, face, groin or buttocks, or over a major joint, treat it as a major burn and get medical help immediately. (www.mayoclinic.com/health/first-aid-burns)During an interview on 1/15/2026 at 8:56 AM, Nurse Practitioner (NP) JJ stated that she didn't see R101's burn and that NP KK was on call on 12/27/2025 when the first burn occurred. NP JJ stated that the standard of care for a burn would be to get something cold on it right away and to start Silvadene cream if skin was peeled or there were blisters. During an interview on 1/15/2026 at 9:29 AM, NP KK stated that the nurse (LPN I) called her on 12/27/2025 after she found R101 had a burn. NP KK said LPN I put R101's arm under cold water and put triple antibiotic ointment cream on it since it was a brand-new burn, there were no blisters and the skin was intact, then it was covered with a non-stick pad. When discussing the standards of care for a burn, NP KK stated to run the burn under cold water for 15 minutes, wash with soap and water, cover with dry nonstick pad to keep infection out. NP KK said if the skin was open then Silvadene should be applied.Review of R101's burn photograph dated 12/27/2025 revealed Length (cm-centimeters): 4.77. Width (cm): 3.98. Depth (cm): 0. Area (cm2): 14.78. The picture showed the area on her left arm area was red, shiny, and open.Review of R101's burn photograph dated 12/30/2025 from the burn on 12/27/2025 revealed Length (cm-centimeters): 4.27. Width (cm): 3.56. Depth (cm): .1. Area (cm2): 12.34. The picture showed the left arm area was blistered as evidenced by raised skin, yellow exudate (discharged fluid substance), red exposed skin in middle of blistered area and it was red around the edges. Review of hospital notes on 12/31/2025 revealed .Type-Wound 1: Blister, Location: Wrist, Left, Description: Blistered, Surrounding tissue: Red, Drainage: Serosanguinous (fluid from wound), Drainage Amount : Scant (a little bit). Review of the 2022 Cleveland Clinic Guidelines revealed . Second degree burns cause skin discoloration: deep red to dark brown, blisters, shiny and moist skin, pain or discomfort, swelling, layers of skin peeling away. A common prescription cream to treat second-degree burns is silver sulfadiazine (Silvadene).During an interview on 1/15/2026 at 12:30 PM, UM S stated for a burn, staff should get ice water and dump it on the burn and then call the doctor. UM S stated that triple antibiotic cream should not be used, Silvadene should be used instead. During an interview on 1/15/2026 at 1 PM, Director of Nursing (DON) B stated her expectation for a burn was to put cool water on it, not ice and use Silvadene cream. She stated that triple antibiotic cream shouldn't be used because it was petroleum based and held heat in.Review of R101's Medication Administration Record (MAR) for December 2025 revealed Left Lower Forearm: Cleanse, Pat Dry, apply triple antibiotic ointment, apply tefla (telfa-sterile, non-adherent wound pad with a perforated film on both sides that prevents it from sticking to healing tissue), wrap with stretch gauze. every day shift. Start date 12/28/2025. D/C date (discontinued date) 12/29/2025. The MAR showed it was applied on 12/28/2025 and 12/29/2025 and LPN I applied it on 12/27/2025 right after the burn.Review of the 2024 American Heart Association Guidelines revealed Burns can come from a variety of sources such as hot water (scalds).It is known that applying ice directly to a burn can cause tissue ischemia (restricted blood supply leading to shortage of oxygen which can lead to tissue damage). Don't apply ice directly to a burn, it can produce tissue ischemia. Cool thermal burns with cool or cold water potable water as soon as possible and for at least 10 minutes. If cool or cold water is not available a clean cool or cold, but not freezing compress can be useful as a substitute for cooling burns.Review of the 2026 American Burn Association Guidelines revealed .First aid facts.Don't apply ice-it can worsen damage, don't use butter, oils or ointments-they trap heat.During an interview on 1/14/2026 at 11:25 AM, CNA H stated that she worked on 12/27/2025 when R101 got her first burn. CNA H said that R101 was a one-to-one assist with meals because her right hand got shaky when (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	drinking and feeding herself. During an interview on 1/14/2026 at 10:30 AM, CNA U stated on 12/27/2025 she asked RN T if R101 could have coffee because she noticed that R101 spilled soda all over herself and the bed over the weekend and RN T said R101 could have it. CNA U said she gave her the cup of coffee with a lid and set it on R101's bedside table and R101 said she would let it cool before drinking it. CNA U indicated that the Kardex should indicate if R101 needed assistance with hot beverages. During an interview on 1/14/2026 at 10:43 AM, RN T stated that R101 loved coffee and was always asking for it. RN T stated on 12/27/2025 she couldn't remember if a CNA asked her if R101 could have coffee and then she was notified R101 had a burn. RN T said she looked at the burn briefly and only noticed red areas but LPN I completed the incident report and treatment. Review of R101's Incident Report dated 12/30/2025 (date of R101's second burn incident) which was completed by UM S revealed Nursing Description: CNA went to resident's room because the resident's call light was on and resident informed CNA that she spilled her coffee. CNA came to my office to notify me of the incident. Went into resident's room and there was spilled coffee on the bed and the floor all over with the cup on the floor resident left hand noted to be red, blanching (white/pale). Resident description: I spilled my coffee. Staff poured cool water on area immediately after seeing the spill. Care plan updated: Encourage and assist resident to the dining room for meals. Sippy cups with lids and straws for all liquids, divided plate. Statements: (CNA J): I went into resident's room to answer call light and resident informed me that she spilled her coffee. I poured water on area and got nurse to assess area.During an interview on 1/13/2026 at 3:00 PM, UM S stated that on 12/30/2025 CNA J got her when she noticed R101 had another burn on her left hand by her knuckles. UM S said that CNA J put water on it and got her. UM S stated that R101 had red knuckles and coffee was spilled on her bed and mostly on the floor. UM S said that the hot liquid safety assessment was completed upon admission which indicated that she was at risk for hot liquid spills and they didn't know R101 needed help with eating at first. UM S confirmed that the care plan and Kardex dated 12/18/2025 upon admission indicated R101 was an assist at meals and the CNAs would know that looking at the Kardex and it should be followed. UM S stated that she did not get a therapy to nursing communication form regarding any assisted devices for R101 from her first admission or after the first burn. During an interview on 1/14/2026 at 9:55 AM, RN Q stated that R101 needed assistance with meals due to left sided weakness. RN Q stated that CNA P took R101 coffee on 12/30/2025 when she was on lunch and when she got back, she was told that R101 received a burn. During an interview on 1/14/2026 at 10:02 AM, CNA P stated on 12/30/2025 R101 got her attention when she was in the hallway and asked her for a cup of coffee. CNA P stated that she didn't know R101 had a burn a few days before. CNA P indicated that the Kardex would have if assistance was needed by a resident.During an interview on 1/14/2026 at 12:37 PM, CNA J stated on 12/30/2025 she answered R101's call light and noticed she spilled her lunch plate and coffee on her and the floor. CNA J said R101's hand was red and she got UM S and UM S put cold water on R101's hand. CNA J reported that she was aware that R101 was a 1:1 assist at meals and that UM S said that R101 shouldn't have been eating and drinking by herself due to having a burn before. CNA J stated she was unaware of the first burn until UM S told her after she received the second burn. During an observation on 1/15/2026 at 12:00 noon, R101 received her lunch tray in the main dining room, was eating with her right hand and shaking. She had a cup with a plastic lid for her drink and staff was nearby to assist her.During an interview on 1/13/2026 at 11:40 AM, Occupational Therapist (OT) AA stated that she saw R101 on 12/30/2025 after her second burn before she went to the hospital from a fall. OT AA said that she did a full feeding assessment and filled out a communication form for nursing related to R101 needing a Kennedy cup (adaptive, spill-proof drinking cup with a secure lid), (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Medilodge of Portage		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0689 Level of Harm - Actual harm Residents Affected - Few	divided plate and lids on hot liquids and for her to go to the dining room for meals. OT AA stated that R101 needed assistance with food and fluids. During a phone interview on 1/13/2026 at 2:31 PM, Therapy Rehabilitation Director (TRD) Z stated that he thought nursing completed the hot liquid safety assessment and then the speech therapist or OT would look at the resident if a referral was made. During an interview on 1/13/2026 at 3:20 PM, OT CC and this surveyor could not locate the therapy to nursing communication form in the therapy department for when R101 was first admitted on [DATE] until her second burn occurred on 12/30/2025 when OT AA assessed her. During an interview on 1/13/2026 at 4:20 PM, Dietary Account Manager (DAM) D stated that the kitchen staff checked the temperature of hot coffee but not hot water before it left the kitchen at meals and it was documented on the log and that lids were put on all hot liquids. DAM D said she would let therapy know if she thought a resident needed assistive devices with eating/drinking or they would let her know. DAM D stated that therapy ordered sippy cups for R101 because she got burned.Review of the Service Line Checklist for December revealed that breakfast, lunch and dinner only had 1 line for hot beverages and the staff checked coffee temperatures before serving the meal and did not have a line for other hot beverages such as hot water for tea and hot chocolate. During an interview on 1/14/2026 at 7:50 AM, Assistant Manager (AM) E checked the temperature of the coffee pot for the main dining room and it was at 164.2 degrees Fahrenheit. During an interview on 1/14/2026 at 9:15 AM, DAM D said the temperature of the coffee that came off of the coffee machine was usually around 180 degrees Fahrenheit, then the dietary staff put the coffee in pots which was usually around 160 degrees Fahrenheit, and when it was poured into cups for the dining room it was around 140 degrees Fahrenheit.The temperature of room tray coffee was 99.8 degrees Fahrenheit and the hot water temperature was 152 degrees Fahrenheit.During an interview on 1/14/2026 at 9:34 AM, Director of Clinical Operations (DCO) L who is also a Registered Dietitian stated IDT can determine who needs assistive devices. When a resident was at risk for hot liquid spills, DCO L said that OT would evaluate for specialty equipment and put an order in. DCO L stated that the dietary staff makes sure hot liquids aren't too hot and to minimize risk for burns they like to maintain hot liquids at or below 165 degrees Fahrenheit when serving. During an interview on 1/14/2026 at 3:19 PM, UM S stated that the facility didn't do anything with hot liquid safety assessments when a resident was at risk for spills since all residents received a plastic lid (used to keep heat in) with hot liquids. UM S said they wouldn't have done anything different with R101. When discussing how staff would be aware if a resident was at risk for a hot liquid spill and how this would be communicated, UM S said this wouldn't be communicated. When discussing interventions after R101's burn on 12/27/2025, UM S said that the nurse and on call manager should have put interventions in place initially and then it should have been discussed at the next IDT. UM S stated OT saw R101 after the second burn on 12/30/2025 and interventions were put in place at that time. UM S stated that she did not get a therapy to nursing communication form regarding any assisted devices for R101 from her admission on [DATE] or after the first burn on 12/27/2025. UM S said that facility staff weren't educated after either burn. UM S also stated that the nurses interchanged the location of where the first burn was and said either left forearm/left wrist. During an interview on 1/14/2026 at 3:39 PM, Nursing Home Administrator (NHA) A stated that R101's burn was an isolated incident and they didn't think there was a systemic issue so they didn't do full staff education. NHA A stated that the hot liquid safety assessment was completed on all residents and they didn't do anything for high-risk residents since every resident received lids on their cups and OT would see them if a referral was made. NHA A also stated that there were no interventions put in place after R101's first burn on 12/27/2025. NHA said that it was her expectation that staff followed the Kardex.Review of the (continued on next page)

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	235399	A. Building B. Wing	01/15/2026

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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 0689 Level of Harm - Actual harm Residents Affected - Few	Hot Liquids/Food Assessment Policy with a revision date of 10/26/2023 revealed Policy: Hot Liquids will be provided to residents as indicated on the facility menu, resident preference and to meet the individualized needs of each resident, while providing safety. Hot liquid assessments will be completed on admission, quarterly and with acute change of condition. Policy Explanation and Compliance Guidelines: Fluids will be served to residents per the physician order(s).1. If the resident is identified as having concerns regarding the ability to handle hot liquids, a hot liquids safety evaluation should be completed to determine if the resident is at higher risk for spills.assistance with meals, weakness, shaking. 2. If a resident is identified with any of the above or other symptoms that would warrant further evaluation the following actions should be conducted as applicable; Immediate interventions to prevent spills such as; Lids, Cooling of liquids before served (adding ice, letting set (sit) 10 minutes before serving, or avoidance of hot liquids until formal evaluation complete: Therapy evaluation, Interdisciplinary team review, Immediate plan of care. 5. All interventions should be added to the plan of care and Kardex/nurse aide plan of care. 6. The care plan should be reviewed and updated at least quarterly and with significant change in status.Review of the Use of Assistive Devices Policy with a revision date of 10/26/2023 revealed Policy: The purpose of this policy is to provide a reliable process for the proper and consistent use of assistive devices for those residents requiring equipment to maintain or improve function and/or dignity. Policy Explanation and Compliance Guidelines: 1. Assistive devices are tools, products, types of equipment, or technology that help individuals perform tasks and activities. They may help the individual move around, see, communicate, eat, or get dressed. Assistive devices include: .g. eating utensils. The facility will provide assistive devices for residents who need them. Nursing, dietary, social services, and therapy departments will work together to ensure availability of devices, such as for ordering and/or replacement. 4. Facility staff will provide appropriate assistance to ensure that the resident can use the assistive devices. This may include education or therapy sessions for training on the use of the device, set up assistance, supervision, or physical assistance as needed. 5. Direct care staff will be trained on the use of the devices as needed to carry out their roles and responsibilities regarding the devices. Training will also include when to refer to other departments for changes in condition or problems with the device. 6. The resident's assigned nurse will monitor for the consistent use of the device and safety in the use of the device. Refusals of use, or problems with the device, will be documented in the medical record. Modifications to the plan of care will be made as needed.