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	05/14/2026

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

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake # 2790303 & 2968884.Based on interview, and record review, the facility failed to ensure timely response to call lights to meet resident needs in 4 of 5 residents (Resident #8, #14, #58, & #119) reviewed for dignity, and 6 of 13 residents from the confidential group interview, resulting in long call light wait times for incontinence care, frustration, and impaired self-worth.Findings include:Resident #8 Review of a Face Sheet revealed Resident #8 was a female, with pertinent diagnoses which included heart failure, obstructive lung disease, morbid obesity, diabetes, high blood pressure, depression, and anxiety. Review of a Minimum Data Set (MDS) assessment for Resident #8, with a reference date of 3/6/26, revealed a Brief Interview for Mental Status (BIMS) score of 15 out of a total possible score of 15, indicating she was cognitively intact. Further review revealed Resident #8 was always incontinent of bowel and bladder. In an interview on 5/12/26 at 9:49 AM, Resident #8 reported concerns with long call light wait times, and staff coming to the room and turning off her call light before her need was met. Resident #8 reported call light response times on first shift are generally between 20-30 minutes but sometimes .it takes them (the staff) an hour . to respond to her call light and assist her with incontinence care. Resident #8 reported call light response times on second shift (in the afternoon) were generally longer, and she had to wait approximately 45 minutes at times for incontinence care and to get her brief changed. Resident #8 reported waiting a long period of time for incontinence care .Makes you feel like (expletive) .(Like) you are not worth anything. You don't mean anything . Resident #14 Review of a Face Sheet revealed Resident #14 was a female, with pertinent diagnoses which included heart failure, heart disease, obstructive lung disease, morbid obesity, chronic pain, anxiety, high blood pressure, muscle weakness, reduced mobility, diabetes, and a history of falls. Review of a Minimum Data Set (MDS) assessment for Resident #14, with a reference date of 4/28/26, revealed a Brief Interview for Mental Status (BIMS) score of 15 out of a total possible score of 15, indicating she was cognitively intact. Further review revealed Resident #14 was always incontinent of bowel and bladder. In an interview on 5/14/26 at 11:43 AM, Resident #14 reported concerns with long call light wait times. Resident #14 reported she experienced a call light wait time of approximately two hours last (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	week for incontinence care during the morning shift. Resident #14 stated .I was soaked and it was burning my behind . Resident #14 reported waiting for an extended period of time for incontinence care makes her feel .bad . Review of the policy/procedure Call Lights: Accessibility and Timely Response, dated 1/1/2022, revealed .The purpose of this policy is to assure the facility is adequately equipped with a call light at each residents' bedside, toilet, and bathing facility to allow residents to call for assistance. Call lights will directly relay to a staff member or centralized location to ensure appropriate response .All staff members who see or hear an activated call light are responsible for responding. If the staff member cannot provide what the resident desires, the appropriate personnel should be notified . Resident #58 Review of a Face Sheet revealed Resident #58 was a male who originally admitted to the facility on [DATE] and had pertinent diagnoses which included: muscle weakness, history of falling, and hemiplegia and hemiparesis following cerebral infarction affecting right dominant side (weakness or paralysis of the right side of the body following a stroke). Review of Care Plan for Resident #58 revealed focus/goal/interventions : Resident has an ADL (activities of daily living) self-care performance deficit.ADL needs will be met.dressing 1 person assist.personal hygiene 1 person assist.toileting 1 person assist.transfer 1 person assist.encourage resident to use call light when assistance is needed.with initiation dates of 9/26/2023. In an interview on 5/12/26 at 9:45 AM, Resident #58 reported third shift staff would take over an hour to answer his call light. Resident #58 reported last week he had an accident, he urinated on himself, when he was waiting for the call light to be answered by the third shift staff. Resident #58 reported he was mad, frustrated, and embarrassed when that happened. Resident #58 stated The wait is ridiculous and it shouldn't happen.Someone could be dying waiting for them to answer the call light. Resident #119 Review of a Face Sheet revealed Resident #119 was a male who originally admitted to the facility on [DATE] and had pertinent diagnoses which included: pressure ulcer of the sacral region stage 4 (most severe form of the pressure ulcer, characterized by a deep, open wound that extends through the skin, underlying tissue, muscle, and bone), sepsis (a life-threatening condition caused by the body's extreme response to an infection), and paraplegia (paralysis of the legs and lower body). Review of Care Plan for Resident #119 revealed focus/goal/interventions : Resident has an ADL (activities of daily living) self-care performance deficit.ADL needs will be met.dressing 1 person assist.personal hygiene 1 person assist.bed mobility 1 person assist.eating 1 person assist.transfer Hoyer lift x 2 staff assistance.encourage resident to use call light when assistance is needed.prefers to have call light attached to his wrist with a rubber band.with initiation dates of 2/16/26. In a telephone call on 5/13/26 at 9:41 AM, Family Member (FM) XX reported Resident #119 waited a long time for his call light to be answered. FM XX reported she witnessed Resident #119's call light on for over 20 minutes when she was visiting before staff responded. FM XX reported staff would turn off the call light, ask Resident #119 what he needed, and then they would not come back. FM XX reported Resident #119 would call her in the middle of the night, tell her his call light had been on for a long time, and no one would answer it. FM XX reported she would then call the facility and ask for the (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	staff to check on Resident #119. FM XX reported her and another family member had to call the facility to get their attention several times. FM XX reported Resident #119 was bed bound and required a lift for transfers; he was unable to get out of bed on his own. In an interview on 05/13/2026 at 10:20 AM, 6 out of 13 participants from a confidential group meeting reported staff members were turning off call light before their needs were met, turning off the call light and not returning to complete the residents request, and long call light wait times for resident assistance.

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake #2968884, #3004071, and #3000720Based on observation, interview and record review the facility failed to ensure resident received appropriate care for skin breakdown and pressure ulcer development in 2 of 3 residents (Resident #119 and Resident #5) reviewed for pressure ulcers, resulting in Resident #119 developing a pressure ulcer infection and Resident #5 developing pressure ulcers.Findings include:Resident #119 Review of a Face Sheet revealed Resident #119 was a male who originally admitted to the facility on [DATE] and had pertinent diagnoses which included: pressure ulcer of the sacral region (the lower part of the back, base of the spine just above the buttock) stage 4 (most severe form of the pressure ulcer, characterized by a deep, open wound that extends through the skin, underlying tissue, muscle, and bone), sepsis (a life-threatening condition caused by the body's extreme response to an infection), and paraplegia (paralysis of the legs and lower body). In an interview on 5/13/26 at 9:04 AM, Registered Nurse (RN) DD reported Resident #119 had orders for a wound vac (wound vacuum- a medical device that uses negative pressure to promote wound healing) when he was admitted to the facility. RN DD reported Resident #119's wound vac care was difficult on occasion and his wounds had so much drainage. RN DD reported Resident #119 had an order for a wet to dry dressing (involves placing a piece of gauze, moistened with sterile saline or water directly into the wound opening) when the wound vac was not working and he was waiting to be seen by the wound clinic. RN DD reported Resident #119's wound dressings were changed a couple of times a week. In a telephone interview on 5/13/26 at 9:14 AM, Family Member (FM) XX reported Resident #119 had a bad wound in his sacral area and had orders for a wound vac and the facility did not put the wound vac on as it should have been and Resident #119's wound was exposed to blood, pus, and urine when the facility did not have the wound vac in place. FM XX reported she had visited Resident #119, and the wound vac was not in place. FM XX reported Resident #119's wound was to be kept clean and dry. FM XX reported she was told by facility staff that the facility did not have the right staff to place a wound vac. FM XX stated if Resident #119's care was too complex for the facility to handle; they should have not accepted him. Review of Home Discharge Instructions for Resident #119 dated 2/16/26 revealed .Wound Care Discharge Instructions wound vac for sacral wounds x 4.change wound vac every Monday and Thursday.Nursing Notes History dated 2/12/26.all wounds have improved with this dressing change.R (right) trochanter (hip area/end of the femur near the hip joint) .no drainage with this assessment.R ischial (area of the hip/the curved bone forming the base of pelvis) wound. partially debrided (removal of dead tissue from wound bed).left side wound are all pink, clean, and granular (new tissue growth).will continue with NPWT (negative pressure wound therapy/wound vac) dressings biweekly (two times a week). Review of Braden Scale for Predicting Pressure Ulcer Risk Evaluation for Resident #119 from 2/16/26 revealed .Braden score 14. (13-14 moderate risk for the development of pressure ulcers). Review of Nursing Evaluation Summary for Resident #119 dated 2/16/26 at 15:49 (3:49 pm) revealed .Resident has wound vac on his coccyx. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of Skin Issues for Resident #119 dated 2/16/26 at 16:23 (4:23pm) revealed .Skin issue #001.rear right trochanter.Stage 3(serious skin injury characterized by full thickness skin loss, exposing the fatty tissue beneath).no signs and symptoms of infection.painful yes.length 8.49 cm(centimeters) width 8.96 cm depth 2.8 cm.exudate (drainage) moderate amount, serosanguineous (drainage that is contains a mixture of clear and bloody) mixture of serous (clear watery fluid) and sanguineous (resembling/containing blood) fluid, typically pale, red, and watery.no odor after cleaning.primary dressing.negative pressure wound therapy.secondary dressing. no secondary dressing applied.Skin issue #002.rear left trochanter.Stage 3.no signs and symptoms of infection.painful yes.length 3.7 cm width 2.67 cm depth 0.2 cm.exudate (drainage) moderate amount, serosanguineous (drainage that is contains a mixture of clear and bloody) mixture of serous (clear watery fluid) and sanguineous (resembling/containing blood) fluid, typically pale, red, and watery.no odor after cleaning.primary dressing.negative pressure wound therapy.secondary dressing. no secondary dressing applied.Skin issue #003.Right gluteus (buttock).Stage 3.no signs and symptoms of infection.painful yes.length 6.26 cm width 7.61 cm depth 2.9.exudate (drainage) moderate amount, serosanguineous (drainage that is contains a mixture of clear and bloody) mixture of serous (clear watery fluid) and sanguineous (resembling/containing blood) fluid, typically pale, red, and watery.no odor after cleaning.primary dressing.negative pressure wound therapy.secondary dressing. no secondary dressing applied.Skin issue #004.Left gluteus.Stage 3.no signs and symptoms of infection. painful yes.length 6.41 cm width 4.37 cm depth 1.7 cm.exudate (drainage) moderate amount, serosanguineous (drainage that is contains a mixture of clear and bloody) mixture of serous (clear watery fluid) and sanguineous (resembling/containing blood) fluid, typically pale, red, and watery.no odor after cleaning.primary dressing.negative pressure wound therapy.secondary dressing. no secondary dressing applied. Review of Transcribed Physician Progress Note for Resident #119 dated 2/17/26 at 13:33 (1:55 pm) revealed .chief complaint Gluteal, lower extremity wounds.was transferred to this facility for continued physical rehab, has wound VAC in place. Review of Nurses' Notes for Resident #119 dated 2/18/26 at 03:50 (3:50 am) revealed .reinforcement successful. Wound vac running.No leaks. Review of Skin Issues for Resident #119 dated 2/18/26 at 22:11 (10:22 pm) revealed .Skin issue #002 has not been evaluated.location right gluteus.Skin issue #005 has not been evaluated.location rear left trochanter.Skin issue #009 has not been evaluated.location left gluteus.Skin issue #012 has not been evaluated. location rear right trochanter. Review of Nurses' Notes for Resident #119 dated 2/18/26 at 22:41 (10:22pm) revealed .Wound vac.was noted to be leaking.night shift nurse attempted to patch it but was unsuccessful.it began to leak after repositioning.order obtained to apply a wet-to dry dressing until tomorrow. Review of Nurses' Notes for Resident #119 dated 2/19/26 at 12:28 pm revealed .a voicemail was left with (Name Redacted) wound clinic to see if the resident is to follow-up with them for his multiple wounds; the resident is adamant he is seen by them. Review of Nurses' Notes for Resident #119 dated 2/20/26 13:18 (1:10 pm) revealed .due to the wound vac repeatedly not functioning properly due to the extent and location of his wound on his bilateral hips and ischium a seal cannot be maintained. Replacing and reinforcing the wound vac therapy has been attempted multiple times by multiple different people. Okay per (Name Redacted) NP to use a wet to dry dressing at this time. She is aware that we are waiting to get him into the wound clinic. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of Skin Issues for Resident #119 dated 2/23/26 at 10:01 am revealed .Skin issue #002.right gluteus.progress: stable.previously deteriorating wound characteristics plateaued.unstageable ulcer due to slough (dead nonviable tissue in a wound, yellow or white that can impede healing) and/or eschar (a thick dry dead layer of tissues that forms over a wound often appearing black).no signs and symptoms of infection.painful no.length 6.97 cm width 7.76 cm depth 3 cm.exudate moderate amount, serosanguineous.no odor after cleaning.dressing saturation moderate 26-75% .primary dressing.wet soak.Other secondary dressing ABD (abdominal) pad tape.Skin issue #005.rear left trochanter. progress: stable.previously deteriorating wound characteristics plateaued.Stage 3.no signs and symptoms of infection.painful no.length 3.9 cm width 3.01 cm depth 0.2 cm.exudate moderate amount, serosanguineous.no odor after cleaning.dressing saturation moderate 26-75% .primary dressing.wet soak.Other secondary dressing ABD pad tape.Skin issue #009.Left gluteus. progress: stable.previously deteriorating wound characteristics plateaued.Stage 3.no signs and symptoms of infection.painful no.length 6.08 cm width 6.08 cm depth 1.5.exudate moderate amount, serosanguineous .no odor after cleaning. dressing saturation moderate 26-75% .primary dressing.wet soak.Other secondary dressing ABD pad tape.Skin issue #012.Rear right trochanter. progress: stable.previously deteriorating wound characteristics plateaued.unstageable ulcer due to slough and/or eschar.signs and symptoms of infection none.painful no.length 12.63 cm width 7.97 cm depth 2.1 cm.exudate moderate amount, serosanguineous.no odor after cleaning. dressing saturation moderate 26-75% .primary dressing.wet soak.Other secondary dressing ABD pad tape. Skin issues #002, #005, and #009 were noted documented with an increase in wound size indicating a decline not a stable plateau. Review of Appointment/Transportation Note for Resident #119 dated 2/24/26 at 13:47 (1:47pm) revealed .(Name Redacted) wound clinic resident scheduled for 3/3/26 at 1030. It was noted that the facility contacted (Name Redacted) wound clinic to schedule an appointment for Resident #119, seven (7) days after he admitted to the facility. Review of Skin Issues for Resident #119 dated 3/2/26 at 9:33 am revealed .Skin issue #008.rear left trochanter.progress: stable.previously deteriorating wound characteristics plateaued.stage 3.length 3.18 cm width 3.11 cm depth 0.2 cm.Other primary dressing calcium alginate.other secondary dressing applied super absorbent. frequency of dressing every day shift and PRN (as needed). Skin issue #012.left gluteus.progress: stable.previously deteriorating wound characteristics plateaued.Stage 3.length 4.09 cm width 5.04 cm depth 0 cm.exudate heavy amount, serosanguineous.Other primary dressing calcium alginate.other secondary dressing applied super absorbent. frequency of dressing every day shift and PRN .Skin issue #016.Right gluteus. progress: stable.previously deteriorating wound characteristics plateaued.Stage – unstageable.length 5.5 cm width 6.85 cm depth 0.exudate moderate amount, serosanguineous .Other primary dressing calcium alginate.other secondary dressing applied super absorbent. frequency of dressing every day shift and PRN.Skin issue #020.Rear right trochanter. progress: stable.previously deteriorating wound characteristics plateaued.unstageable ulcer.length 5.27 cm width 8.52 cm depth 0.5 cm.exudate heave amount, serosanguineous. Other primary dressing calcium alginate.other secondary dressing applied super absorbent. frequency of dressing every day shift and PRN. Skin issues #008 and #020 were noted documented with an increase in wound size indicating a decline not a stable plateau; and skin issues #008, #012, #016, and #020 were noted to have no documentation regarding an assessment for signs and symptoms of infection. Review of Nurses' Notes for Resident #119 dated 3/3/26 at 12:16pm revealed .(Name Redacted) wound clinic called and stated that they are sending resident (Resident #119) to the ED (emergency room) d/t (due to) fever and wounds needing to be debrided (removal of dead, damaged, or infected (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	tissue to promote healing). Review of Progress Note Details for Resident #119 provided by wound clinic, dated 3/3/26 revealed .male.decreased mobility presents with multiple wounds from (Name Redacted) facility.was last seen on 1/15/26.was hospitalized 1/27-2/16/26 .while hospitalized he had an excisional debridement of.bilateral gluteal abscesses.was discharged to (Name Redacted) facility with a wound vac. However, he had no dressing on his wounds or wound vac supplies when he arrived at the wound clinic.He also had a 100.7 degree F temperature.Right hip wound with necrotic tissue draining copious amounts of purulent draining and probing down to the bone (a clinical tool used to diagnosis osteomyelitis (an infection of the bone) by detecting whether bone can be palpated through the wound with a sterile blunt metal probe). In a telephone interview on 5/14/26 at 8:49 AM, Wound Clinic Nurse Practitioner (WCNP) RR reported Resident #119 arrived at the clinic for his appointment on 3/3/26 with no dressings on his wounds and no wound vac or wound vac supplies. WCNP RR reported she would never recommend that a wound be left uncovered. WCNP RR reported Resident #119 had a low-grade fever and an infection in a wound and she sent him to the emergency room for treatment. WCNP RR reported Resident #119 was an established patient and the wound clinic should have been contacted by the facility regarding the difficulties experienced with Resident #119s wound vac. WCNP RR reported the facility had not contacted the wound clinic regarding Resident #119's wounds, dressing instructions, the wound vac malfunctioning, or for alternate treatment for his wounds. WCNP RR reported the facility had contacted the wound clinic via telephone on 2/23/26 regarding the need for a follow up appointment for Resident #119. Review of Treatment Administration Record (TAR) for Resident #119 for the month of February 2026 revealed .Bilateral hips/ischial wounds: cleanse & pat dry. Apply skin prep to surrounding tissue. Apply wound vac dressing, bridging all four wounds. Maintain continuous pressure at -125 mmhg (millimeters of mercury) every day shift every Mon, Thu for pressure wounds with a start date of 2/19/26 and a D/C (discontinue) date of 2/23/26. In a telephone interview on 5/14/26 at 2:41 PM, Wound Nurse/Registered Nurse (WN/RN) D reported Resident #119's wound vac was never discontinued. WN/RN D reported there was a time when the staff were struggling to get the dressing and the wound vac to seal, and they were given an OK to use a wet to dry dressing. WN/RN D reported she was able to get the wound vac to seal a couple of days at a time, and that her and Education Training Director/RN (ETD/RN) N were the two nurses managing Resident #119's wound care. WN/RN D reported she did not contact the wound clinic for alternate treatment options for Resident #119's wounds when the wound vac would not seal. WN/RN D reported she was on vacation from 2/24/26 and returned on 3/3/26 and when she is out of the building, ETD/RN N was the nurse who covered for her. In an interview on 5/14/26 at 3:08 PM, ETD/RN N reported she only covered for WN/RN D one day during her week vacations. ETD/RN N reported Resident #119 should have had dressings on his wound when he went to the wound clinic on 3/3/26, and she had no idea why they weren't covered. ETD/RN N reported Resident #119's wound vac was not discontinued; they were struggling to get it to seal correctly. ETD/RN N reported there was a day that she spent over an hour trying to secure the wound vac dressing for Resident #119 and was unsuccessful and had to contact the on call provider for an order to place a wet to dry dressing instead. ETD/RN N reported there should have been other nurses to assist with Resident #119's wounds, she was not the only one to cover when WN/RN D was off. ETD/RN N reported there was a standing order for a wet to dry dressing for wounds when they (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	could not get a wound vac dressing secured. When queried, ETD/RN N reported she did not contact the wound clinic regarding alternate wound treatments for Resident #119's wounds when they experienced difficulties with the wound vac seal. In an interview on 5/14/26 at 3:15 PM, Director of Nursing (DON) B reported ETD/RN N was responsible for covering for WN/RN E when she was out of the building. In an interview on 5/14/26 at 3:21 PM, Nursing Home Administrator (NHA) A reported Resident #119's wound vac wound not seal and at one point Resident #119 had to be sent to the hospital for it to be placed. NHA A reported the wound vac was never discontinued, but it was placed on hold because it would not seal. In an interview on 5/14/26 at 3:22 PM, Corporate Clinical Nurse (CCN) E confirmed Resident #119's wound vac order was discontinued on 2/23/26. In an interview on 5/14/26 at 3:25 PM, NHA A reported she did not have documentation regarding the discontinuation of Resident #119's wound vac, continuation for the use of a wet to dry dressing in place of the wound vac, discussions with in house provider regarding Resident #119's wound care, nor discussions with wound clinic staff regarding Resident #119's wound care. Resident #5: Review of an admission Record revealed Resident #5 was a female with pertinent diagnoses which included heart failure, chronic pain, respiratory failure, peritoneal abscess (collection of infected fluid or pus in the abdominal cavity) JP drain infection (Jackson Pratt drain is a flexible, bulb-shaped surgical drain used to remove excess fluids (blood, serous fluid) from a wound site) and stroke. Review of Resident #5's activity of daily living (ADL) care plan included an intervention, revised 4/16/26, which stated, BED MOBILITY: 1 person assist; utilizes bilateral grab bars. Review of a current Care Plan for Resident #5 revised on revealed a focus .Resident is a risk for impaired skin integrity as evidenced by weakness, heart failure, chronic pain, impaired vision. Resident admitted with left arm skin tear, left buttock MASD (Moisture Associated Skin Damage-inflammation, softening, and erosion of the skin caused by prolonged exposure to bodily fluids), left flank indentation/redness, medial abdomen abscess (a walled-off pocket of pus and infection fluid inside the belly often caused by bacterial infections), bilateral feet dry skin, low back JP (drain) pain.New: Left heel pressure ulcer.Left calf red discoloration. with the intervention .APM (alternating pressure mattress) to bed; check for proper machine functioning & mattress inflation.Apply protective barrier cream after incontinent episodes.Encourage & assist resident to turn and reposition q (every) 2-3 h (hour) and PRN (as needed) .Encourage/assist as needed to elevate heels off the mattress as tolerated. Review of Braden Scale for Predicting Pressure Sore Risk dated 5/3/26 at 8:02 PM, revealed a BRADEN Score: 16.0 which indicated a mild risk for skin breakdown. Review of New Follow UP Note (Electronic Medical Record) dated 4/16/26 at 11:22 PM, revealed, .PLAN: 04/16/2026 - . Encourage out-of-bed activity multiple times per day. Requires ongoing skilled therapy progression and monitoring.Bowel and Bladder: Incontinent.The patient requires assistance with functional mobility and ADLs and has safety issues requiring further management. - Needs to (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	continue intensive subacute rehabilitation therapy in order to ensure a safe discharge plan. Review of the document Skin Issue: #003 revealed Resident #5 had a new deep tissue pressure ulcer identified on the left heal, acquired 5/8/26 in house that was painful intermittently and burning. The wound measured Length (cm): 4.19 Width (cm): 3.89 Depth (cm): 0 Area (cm2): 13.36 Undermining: No. Tunneling: No. Epithelial: 100%. Exudate amount: None. Resident #5 was to have the wound cleaned and skin prep applied twice daily. Review of the document Skin Issue: #004 revealed Resident #5 had a new on the left lateral calf that was facility acquired and identified on 5/8/26. The wound measured Length (cm): 0.81 Width (cm): 4.89 Depth (cm): 0 with 100% epithelial tissue and no exudate. The wound was to be cleaned daily and as needed with skin prep applied. Review of Skin and Wound Note dated 5/11/26 at 4:21 PM, revealed Resident #5's wounds were .Left heel. Size: 5 cm x 4 cm x 0 cm (which was an increase in size) and the Left calf.Size: 8 cm x 1 cm x 0 cm. The treatment plan for the heel included: Treatment Recommendations: 1. Cleanse with wound cleanser.2. apply Skin Prep to base of the wound.3. leave open to air .4. apply skin prep every shift. The treatment plan for the left calf included Treatment Recommendations: 1. Cleanse with wound cleanser.2. apply Skin Prep to base of the wound.3. leave open to air 4. apply skin prep every shift.PREVENTATIVE MEASURES: Group 2 support surface - powered pressure reducing air mattress or non-powered advanced pressure reducing mattress, Offload heels per Facility Protocol, Offload pressure / reposition patient frequently.Additional Recommendations: Pain control: 30 min prior to wound treatment, please administer PRN pain medication and/or topical anesthetic. Pressure Relief: Repositioning, offloading, Specialty mattress.Dietary Interventions: protein supplement with meals twice daily until wound closure. Review of Order dated 5/8/26, revealed, .Encourage & assist resident to wear bilateral pressure redistribution boots at all times while in bed. every day and night shift. Review of Standard of Care Meeting dated 5/13/26 at 11:25 AM, revealed, .Reasons for Standards of Care review Wound: Reinforce current care plan updated: - APM to bed; check for proper machine functioning & mattress inflation.- Encourage & assist resident to turn and reposition q.2-3h and PRN.Assist as needed.- Encourage/assist as needed to elevate heels off the mattress as tolerated. During an observation on 05/12/2026 at 9:38 AM, Resident #5 was observed lying in her bed feet out in front of her, lying on her back, the head of her bed was at approximately 60 degrees, she did not have her feet on a pillow or bolster. No boots were noted on her feet. During an observation on 05/12/2026 at 10:04 AM, Resident #5 was observed lying in bed feet out in front of her, on her back and had the head of the bed at approximately 60 degrees. Review of Resident #5's medical record revealed no refusals noted for repositioning/turning and wearing pressure redistribution boots. In an interview on 05/14/2026 at 1:45 PM, Licensed Practical Nurse (LPN) W reported if a resident was susceptible to developing a pressure ulcer wound, and the resident refused turning and repositioning a progress note would be created in the medical record to document the refusal as well as the CNA (Certified Nursing Assistant) would document in their area in the medical record the refusal. (continued on next page)

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	05/14/2026

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 0686 Level of Harm - Actual harm Residents Affected - Few	In an interview on 05/14/2026 at 1:52 PM. Registered Nurse (RN) CCC reported if a resident was dependent for cares and the resident refused assistance with turning and re-positioning that as the nurse she would enter a note into the medical record to document any refusals of care. In an interview on 05/14/25 at 3:04 PM, Director of Nursing (DON) B reported staff should document in the medical record if a resident was refusing pressure ulcer interventions.