

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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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 05/14/2026
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 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 (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 0686 Level of Harm - Actual harm Residents Affected - Few	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. 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 &ndash; 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, (continued on next page)		

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F 0686 Level of Harm - Actual harm Residents Affected - Few	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 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 (continued on next page)		

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F 0686 Level of Harm - Actual harm Residents Affected - Few	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 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. (continued on next page)		

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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 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 (continued on next page)		

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 05/14/2026
NAME OF PROVIDER OR SUPPLIER Medilodge of Portage		STREET ADDRESS, CITY, STATE, ZIP CODE 7855 Currier Dr Portage, MI 49002	
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 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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NAME OF PROVIDER OR SUPPLIER Medilodge of Portage		STREET ADDRESS, CITY, STATE, ZIP CODE 7855 Currier Dr Portage, MI 49002	
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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** Based on observation, interview, and record review the facility failed to: 1.) ensure the safety of residents to prevent falls, 2) provide adequate supervision and assistance to prevent falls, and 3.) utilize footrests for wheelchair transport in 3 of 3 residents (Resident #40, #26, and #95) reviewed for accidents and hazards, resulting in Resident #40 having 22 falls over 2 months, Resident #40 and #95 being transferred without wheelchair footrests, and Resident #26 being improperly transferred. This deficient practice placed all 3 residents at risk for injury. Findings include: Resident #40: Review of an admission Record revealed Resident #40 was a male with pertinent diagnoses which included Alzheimer's disease, history of falling, dementia, insomnia, and kidney disease stage 3. Review of the medical record reviewed Resident #40 had 22 falls in two months between 3/11/26 and 5/12/26. Most of the falls indicated the root cause was the resident self-transferred and frequently needed toileting. During an observation on 05/12/2026 at 9:27 AM, Resident #40 was observed seated in his wheelchair in the doorway to his room. Resident #40 was observed to have a reddish/purple bruise directly under his middle left lower eyelid with a reddish-purple bruise that extended outward toward the corner of his left eye. During an observation on 05/13/2026 at 4:25 PM, Certified Nursing Assistant (CNA) Y was observed adjusting Resident #40 in his wheelchair, in front of him was the sit to stand transfer device. CNA Y had placed Resident #40 in the hallway and had him raise his legs while she pushed him out of the doorway into the hallway next to the rolling bedside table which was along the wall in the hallway. Resident #40 was observed attempting to prepare to stand up and CNA Y was able to intervene as she had been retrieving his foot pedals for his wheelchair in his room. CNA Y attached the foot pedals and was propelling Resident #40 down the hallway towards the dining room area as there was an activity occurring. Resident #40's right foot pedal fell off and CNA Y stopped and re-attached it, she continued down the hallway and Resident #40's left foot pedal fell off the wheelchair, and she continue to push him around the corner and into the dining room with the foot pedal being dragged under the wheelchair. In an interview on 05/14/2026 11:10 AM Unit Manager (UM) J reported Resident #40 has had a cognitive decline and when the falls began to happen, he was more higher functioning than he was now. UM J reported Resident #40 had had seizure activity and he had been receiving routine Busbar due to the chronic restlessness, but it was discontinued so she reported she wasn't sure if that correlated with the start of the falls Resident #40 had. UM J reported Resident #40 was able to stand and pivot and was now a hooyer transfer. UM J reported quite a few of Resident #40's falls revolved around him needing to use the bathroom and care plan interventions were developed to take him to the restroom prior to meals in the dining room and prior to placing him in bed. UM J reported the education provided to staff to follow the Kardex was provided verbally to the staff who were working the day it was determined education was needed. In an interview on 05/14/2026 at 2:52 PM, Nursing Home Administrator (NHA) A reviewed Resident (continued on next page)		

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 05/14/2026
NAME OF PROVIDER OR SUPPLIER Medilodge of Portage		STREET ADDRESS, CITY, STATE, ZIP CODE 7855 Currier Dr Portage, MI 49002	
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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	#40's medical record and reported for transfers he was a hoier lift with two staff assistance with transfers. NHA A reported it was not appropriate for Resident #40 to be transferred with a sit to stand and one person provided assistance. NHA A reported that when a resident had an incident involving a fall, the nurses were to implement an immediate intervention to keep the resident safe. NHA A reported the interdisciplinary team (IDT) reviewed the fall incidents and determined if the intervention initially implemented by the nurse was appropriate, if not, the intervention was revised in the incident report. NHA A reported this was not usually done on the day of the incident, especially if a fall incident happened over the weekend. NHA A reported a resident should not be transported in a wheelchair without foot pedals as the resident could place their feet down and create an injury. NHA A reported Resident #40 did not start restorative therapy until later due to falls that occurred after the fall where it was determined to start restorative therapy due to repeated falls and then eventual decline in resident's ability to self-ambulate. In an interview on 05/14/2026 at 1:33 PM, Licensed Practical Nurse (LPN) MM reported the nurse would develop and implement an immediate intervention following us fall to help prevent the next fall and provide for the safety for the resident. Review of the care plan for falls revealed Resident #40 was at risk for falls due to a history of falls, dementia, brain tumor and known to self-transfer/ambulate without asking for assistance. Interventions included: anti-roll backs to wheelchair Date Initiated: 11/21/2025 . Bed against wall to decrease environmental obstacles of room Date Initiated: 11/17/2025. Offer resident a HS snack at bedtime. Date Initiated: 01/21/2026 . Wheelchair to be locked at bedside when resident is in bed. Date Initiated: 11/17/2025 . Encourage & assist bed to remain at transfer height at all times. Date Initiated: 02/24/2026 Revision on: 03/11/2026 . No interventions were in place to prevent or mitigate risk for self-transfer/ambulation and toileting needs. Review of the incident/accident reports, care plans, and the initial fall evaluations revealed the following: 3/11/26 at 2:20 pm &ndash; fall out of bed. bed left high 3/30/26 at 00:00am- fall out of wheelchair. Self-transfer history and no toileting 5 hrs. Root cause: attempt to self-transfer. Review of Care Plan for Resident #40 revised on 5/1/26 revealed the added intervention of Resident to be referred to restorative program for strengthening. Date Initiated: 03/30/2026 . 4/4/26 at 3:50 am &ndash; fell from wheelchair. Not adequately monitored but had been redirected multiple times. Root cause: attempt to self-transfer. 4/4/26 at 8:20pm &ndash; fell in room on floor incontinent of urine. Wanted go to bathroom. Root cause: attempt to self-transfer. 4/10/26 at 4:37 am &ndash; fall in room. Was in bathroom, found vomit, stool and blood in bathroom. Root cause: attempt to self-transfer. 4/10/26 at 12:10pm &ndash; resident observed to stand up and walk unattended hitting his head. Root cause: attempt to self-transfer. (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

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 05/14/2026
NAME OF PROVIDER OR SUPPLIER Medilodge of Portage		STREET ADDRESS, CITY, STATE, ZIP CODE 7855 Currier Dr Portage, MI 49002	
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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Transcribed NP/PA Progress Note dated 4/10/26 at 2:58 PM, revealed, .Service date/time: 4/9/26 at 10:51 PM, revealed, this is an [AGE] year-old male seen today at (Facility) .he has been vomiting and having seizure-like activity.he has been hypotensive today we will discontinue his dose of Norvasc. Will start low-dose lorazepam twice daily in the hopes to reduce his likelihood of breakthrough seizure. Orders given for Compazine for nausea .The patient has been up a lot at night or needing to monitor my hope is that Ativan will help settle him during his increased agitation in the evening hours. 4/11/26 at 8:15 pm &ndash; fell in visitor bathroom. Root cause: attempt to self-transfer. 4/11/26 at 11:40 pm &ndash; fell in hall after standing from wheelchair. Root cause: attempt to self-transfer. Review of Care Plan for Resident #40 revised on 5/1/26 revealed the added intervention of Encourage & assist the resident to use the toilet prior to bed. Date Initiated: 04/11/2026 . Review of Transcribed Physician Progress Note dated 4/14/26 at 1:42 PM, revealed, .it appears patient has been having frequent falls.It appears patient has had low sugars in the past and glipizide was held. Patient is poor historian, denies any dizziness, palpitations, sweating, medical staff does not report any change in mentation from baseline.Assessment/Plan 1. Type 2 diabetes mellitus: Patient currently on 10 units of Premeal insulin with Lunch, 28 units of Lantus twice daily, Sugars have been fluctuating will adjust dose of long-acting insulin to 25 units at bedtime, change Premeal insulin to 5 units, monitor sugars and adjust accordingly.2. Hypoglycemia: will make insulin adjustments as above he is asymptomatic unreliable historian due to cognitive impairment, unsure if he has hypoglycemia awareness, will have to be liberal with sugar control.3. Cerebral mass: on dexamethasone. Review of Nurses' Notes dated 4/17/26 at 11:44 AM, revealed, .New order to decrease the resident's bedtime Lantus to 10 units at HS (bedtime) per (Medical Doctor) due to hypoglycemic episode this morning. 4/12/26 at 3:55pm - resident found on floor in hallway. Root cause: fell asleep in wheelchair. Review of Care Plan for Resident #40 revised on 5/1/26 revealed the added intervention of If resident appears sleepy/sleeping in his wheelchair, encourage & assist resident to lay down in bed. Revision on: 04/13/2026 . Offer & assist to play music (county) when unable to sleep. Date Initiated: 04/13/2026 . 4/14/26 at 1:00pm &ndash; resident fell in dining room after attempt to stand or dislodge his wheelchair from current location. Root cause: attempts to stand, impulsiveness, poor safety awareness. Review of Care Plan for Resident #40 revised on 5/1/26 revealed the added intervention of Encourage & assist resident to wear hipsters at all times except bathing as tolerated. Date Initiated: 04/14/2026 . 4/17/26 at 1:00pm &ndash; resident fell, found lying in bathroom floor. Root cause: self-transfer to toilet independently. Interventions: toilet prior to meals and concave mattress. (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

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 05/14/2026
NAME OF PROVIDER OR SUPPLIER Medilodge of Portage		STREET ADDRESS, CITY, STATE, ZIP CODE 7855 Currier Dr Portage, MI 49002	
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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Care Plan for Resident #40 revised on 5/1/26 revealed the added intervention of Assist resident to use the toilet then to the dining room for meals. Date Initiated: 04/17/2026 . During an observation on 05/13/26 at 4:00 PM, Resident #40 was propelled in his wheelchair by staff to the dining room without providing toileting prior to the meal after being transferred from his bed to the wheelchair. 4/18/26 at 00:50 am- resident found on floor sitting. Stated wanted to use restroom. Root cause: self-transfer to toilet independently. Intervention: fall mat to bedside. 4/18/26 at 9:10 am &ndash; resident sitting on floor in bathroom with soiled brief on. Root cause: self-transfer to toilet independently. Last toileted at 3:59 am. 4/18/26 at 12:00pm- resident found on floor in dining room after ambulating unassisted. Root cause: self-transfer Review of Care Plan for Resident #40 revised on 5/1/26 revealed the updated intervention of Educate staff to follow Kardex (care guide) to have resident toileted and then taken to dining room for meals Revision on: 04/20/2026 . 4/22/26 at 12:20 pm &ndash; resident found prone on bedroom floor. Had been waiting to be laid down. Root cause: self-transfer. Review of Care Plan for Resident #40 revised on 5/1/26 revealed the added intervention of Concave mattress to bed. Date Initiated: 04/22/2026 . 4/24/26 at 10:49am &ndash; found face down lying on bathroom floor. Skin tear observed. Root cause: self-transfer to bathroom. Intervention: continue current interventions. 4/26/26 at 11:50pm- resident observed lying on floor in room stated, trying to go to bathroom. Root cause: self-transfer to bathroom. 4/27/26 at 1:20am- resident found on floor in room with blood. Stated getting up to walk. Injury: skin tear left hand. Root cause: self-transfer/ambulate. Review of Care Plan for Resident #40 revised on 5/1/26 revealed the updated intervention of Bladder scan post void x3 with results to NP Date Initiated: 04/27/2026 . Fall mat to bedside floor when resident is in bed. Date Initiated: 04/27/2026 . 5/1/26 at 2:15am &ndash; resident found on floor in room. No new interventions. Root cause: self-transfer. 5/1/26 at 2:00pm &ndash; resident slid out of wheelchair in hallway and was lowered to floor by staff due to cushion being flat. Intervention: new cushion for chair. Review of Care Plan for Resident #40 revised on 5/1/26 revealed the updated intervention of Hospice contacted to order new pummel or anti-thrust cushion. Date Initiated: 05/01/2026 . 5/11/26 at 2:45pm &ndash; resident found on floor in doorway of room. No root cause identified. (continued on next page)		

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Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5/12/26 at 9:10pm- resident found on floor inside doorway of room. No root cause identified. During an observation 05/14/2026 at 10:17 AM, Resident #40 was observed lying in his bed. Review of the incident/accident reports and the initial fall evaluations for these falls revealed the facility did not add any supervision interventions to Resident #40's care plan following each fall. Review of Resident #40's falls had revealed he had 8 incidents which resulted in skin tears on his arms and hands. Review of Resident #40s' falls had revealed he had 6 incidents which resulted in a bloody nose, 3 falls with abrasion injuries, an eyebrow laceration, and laceration to his right elbow. Review of policy, Accidents and Hazards revised on 12/27/23, revealed, .Each resident will be assessed for accident risk and will receive care and services in accordance with their individualized care plan. Each resident will receive adequate supervision and assistive devices to prevent accidents. This includes: 2. Evaluating and analyzing hazard(s) and risk(s). 3. Implementing interventions to reduce hazard(s) and risk(s). 4. Monitoring effectiveness and modifying interventions when necessary.5. Supervision- Supervision is an intervention and a means of mitigating accident risk. The facility provides adequate supervision to prevent accidents. Adequacy of supervision is a. Defined by type and frequency .b. Based on the individual resident's assessed needs and identified hazards in their environment . Resident #26 Review of a Face Sheet revealed Resident #26 was a male who originally admitted to the facility on [DATE] and had pertinent diagnoses which included: acute respiratory failure, malignant neoplasm of esophagus (cancer of the esophagus that has spread to other areas of the body) and sepsis (a life-threatening condition caused by the body's extreme response to an infection). Review of Care Plan for Resident #26 revealed focus/goal/interventions : Resident has an ADL (activities of daily living) self-care performance deficit.ADL needs will be met.toileting 1 person assist bedside commode.transfer 1 person stand and pivot assist.encourage resident to use call light when assistance is needed.with initiation dates of 2/20/2026. On 5/12/26 at 1:39 PM, Certified Nurse Assistant (CNA) NN was observed assisting Resident #26 from her bed onto her bedside commode. CNA NN was observed holding Resident #26 under both arms (armpit area) during the transfer. CNA NN did not use a gait belt during the transfer. On 5/12/26 at 1:42 PM, CNA NN was observed assisting Resident #26 up from the bedside commode. CNA NN was positioned in front of Resident #26 who was sitting on the commode, CNA NN used her right hand under Resident #26's left armpit and assisted Resident #26 into a partial standing position. Resident #26 sat back down abruptly onto the commode, and asked CNA NN can you hold me under both arms? CNA NN was observed placing a hand into each armpit of Resident #26 and lifting her from the commode into the bed. CNA NN did not use a gait belt for the transfer. In an interview on 5/12/26 at 1:48 PM, Resident #26 reported the staff did not use a gait belt when they assisted her onto the commode, or for any transfer. (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 5/14/26 at 11:01 AM, CNA CC reported all transfers required the use of a gait belt. In an interview on 5/14/26 at 11:08 AM, CNA EE reported all transfers required the use of a gait belt. CNA EE reported gait belts offer safety and support for residents and staff when used during transfers. In an interview on 5/14/26 at 11:10 AM, Licensed Practical Nurse (LPN) MM reported Resident #26 was reevaluated on 5/12/26 after a difficult transfer to the commode and Resident #26's transfer status was downgraded for additional support. LPN MM reported that Resident #26 waxes and wanes with her strength, and staff should use a gait belt for safety during transfers. In an interview on 5/14/26 at 11:10 AM, CNA NN confirmed she did not use a gait belt when she transferred Resident #26 from bed to commode on 5/12/26 and said I should have especially with how weak she was the other day. Resident #95 Review of a Face Sheet revealed Resident #95 was a male who originally admitted to the facility on [DATE] and had pertinent diagnoses which included: neurocognitive disorder with lewy bodies (a progressive brain disorder characterized by the presence of abnormal protein deposits called Lewy bodies leading to cognitive decline and movement issues) and dementia (syndrome characterized by the decline in cognitive function, affecting memory, thinking, behavior, and the ability to perform everyday activities). Review of Care Plan for Resident #95 revealed focus/goal/interventions : Resident has an ADL (activities of daily living) self-care performance deficit.ADL needs will be met.transfer 2 person assist with Sara lift (a machine that assist an individual from a sitting to a stand position).impaired cognitive function.engage in simple, structured activities that avoid overly demanding tasks.with initiation dates of 4/28/2026. On 5/14/26 at 10:41 AM, Director of Nursing (DON) B was pushing Resident #95 in his wheelchair without footrests in place, down the B hall. DON B was observed standing behind and slightly to the side of the Resident #95's wheelchair, using her left hand on the right handle of Resident #95's wheelchair, and carrying a laptop in her right hand. DON B said pick your feet up to Resident #95 and as they passed this surveyor Resident #95's slippers could be heard scrapping on the floor as DON B continued to push Resident #95 in his wheelchair. DON B again reminded Resident #95 to pick your feet up. In an interview on 5/14/26 at 10:43 AM, DON B reported resident could be pushed without footrests as long as staff were walking beside them and could watch their feet and react if they put them down. DON B reported a resident could flip out of the wheelchair if they put their feet down while being pushed.		

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation and interview, the facility failed to maintain a safe, functional, sanitary, and comfortable environment. This resulted in an increased potential for contamination and a possible decrease in the satisfaction of living. Findings Include: On 5/12/26 at 11:01 AM, observation of the D hall closet containing resident slings, found that the slings were hung up by one side on the hangers and left to drag onto the floor. When asked if this is how the slings are normally kept, Housekeeping Manager M stated that it happens all the time and that staff need to hang both sides of the sling up to keep it off the floor. On 5/13/26 at 9:47 AM, observation of the love seat and chair, located on the far side of the dining room, were found with increased accumulation of debris, sand, wrappers, paper trash and a yellow push pin. Further review of the chair found a sheet of paper with resident's names and rooms numbers for the D hall and an intact plastic vile of Albuterol Sulfate. On 5/13/26 at 10:15 AM, an interview with Housekeeping Manager M found that the furniture in the dining room gets cleaned daily and that they get a lot of use from residents in that area. On 5/13/26 at 10:17 AM, observation of the B hall spa room found slings hung up on one side with the bottoms of the slings hanging on the floor of the shower room. On 5/13/26 at 10:25 AM, observation of the sling closet on B hall found slings hung up on one side leaving the bottom portions of the slings laying on the floor. On 5/13/26 at 2:03 PM, a perimeter tour of the facility observed numerous discharge pipes, for diverting rainwater from the roof away from the building, found broken at the bottom where water would exit away from the building. This was allowing diverted rainwater to consistently run down the brick outer layer causing added deterioration and erosion of the building in these areas. During an observation on 05/13/26 at 10:39 AM, observed Room A-05's bathroom floor, which had dirt and debris scattered across the floor, needed to be mopped, and the toilet had a black coating on the caulking around it which appeared to be mold/mildew. The bathroom walls on each side of the toilet had black marks on the walls, the doorframe had scrapes in the paint, black marks on the door frames and baseboards. The bathroom door thresholds leading to Room A-05 and A-03 appeared to be dirty needing to be mopped. In Room A-05 behind the bathroom door had dried liquid material. The shared floor space in Room A-05 needed to be swept and mopped, there were black scuff marks covering the floor. During an observation on 05/12/2026 at 10:50 AM, observed in Room D-01, Bed 2 had a grey fall mat next to the bed which was encrusted with what appeared to be dirt and had various splatters across the mat of dried brown liquid material. During an observation on 05/13/2026 at 12:40 PM, observed in Room C3, the wall on the right-hand side had scrapes and black streaks on the wall, the entry doorway frame had built up dirt and debris/ marks on the doorway, and the doorway had paint scrapped off the doorframe. During an observation on 05/13/2026 at 12:43 PM, observed in Room C5, the wall on the left as entered the room had black streaks on the wall, the bathroom door, and baseboards as well. There (continued on next page)		

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 05/14/2026
NAME OF PROVIDER OR SUPPLIER Medilodge of Portage		STREET ADDRESS, CITY, STATE, ZIP CODE 7855 Currier Dr Portage, MI 49002	
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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	were a couple of quarter size paint chips on the wall by the bathroom door. The door to the room had black marks and streaks on the bottom quarter of the door. During an observation on 05/13/2026 at 12:44 PM, observed in Room C8, there were black streaks and scrapes on the entry door, there was broken and missing piece of a tile at the transition from the hallway tile to the room tile near the door jamb. The hallway tile at the threshold had various cracks across them. During an observation on 05/13/2026 at 12:48 PM, observed in Room C8, the threshold from the room to the bathroom marble transition piece which would be under the bathroom door had the width of a door an area of dried liquid dirt where it would be under the door when closed. The door frame at the entry to the room had built up dirt and debris. The door to the room had black streaks/scrapes, and the door frame had missing paint/black scrapes. During an observation on 05/13/2026 at 1:01 PM, observed in Room C2 behind the entry door had the missing metal door stopper which was embedded in the floor and this created divot in the floor as well as appeared to be metal sticking up from the piece being broken off. During an observation on 05/14/2026 at 1:38 PM, observed on C Hallway outside of the Activity Supplies room door, there was a triangular piece of tile missing from the tile embedded there. Observed outside of the Personal Linens room door near Room C3, there was a half dollar size missing tile with cracks extending out from it. In an interview on 05/14/26 at 1:39 PM, Manager, Housekeeping M reported when the housekeeping staff observed broken items the housekeeping staff submitted a maintenance request in the facility maintenance request system. Manager, Housekeeping M reported the broken and missing tile in the hallway had been entered in the facility maintenance request system prior, but maintenance had not been able to complete the request yet.		

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide individualized activities designed to support the psychosocial well-being of 1 of 1 resident (R65) reviewed for activities, resulting in a potential for feelings of social isolation, loneliness, boredom, and depressed mood. Findings include: Review of R65's Minimum Data Set (MDS) dated [DATE], revealed the resident was unable to complete the BIMS (Brief Interview Mental Status) with a score of 99. Section B-Hearing, Speech, and Vision, stated R65 was absent of spoken words and rarely/never understood. Section GG-Functional Abilities revealed R65 was dependent on staff to provide ADLs (activities of daily living) including positioning and sensory stimulation. Section I-Active Diagnoses indicated R65's active diagnoses included stroke and traumatic brain injury. Review of R65's Care Plan, At Risk for Altered Activity Patterns/Pursuits related to cerebral infarction was dated 9/22/2023. The goal for the resident was revised on 3/17/2026 and included R65 accepting/interacting with others during 1:1 visit. To meet this goal, interventions included visiting with his son, listening to music-R&B (rhythm and blues), and short room visits. It was noted this intervention had not been revised since 12/17/2023 and there were no other activities listed to offer R65 including gardening and being outdoors. Review of R65's Activities Evaluation dated 3/2/26, indicated the resident was evaluated for activities he enjoyed which included family/friend visits, gardening/outdoor activities, movies/TV, and music/talk radio. A television was listed as needed for self-recreation material. A music machine was not listed as needed. R65 was indicated to have activities in his own room [ROOM NUMBER] on 1 throughout the day. R65 was stated to be rarely/never understood due to being unable to speak. As well as rarely/never understanding others. Special considerations to provide R65 with preferred activities indicated a television and radio were needed in his room. Review of R65's Activities Quarterly Progress Note dated 4/10/26, revealed, .needs assistance for most activities and transport. Resident enjoys music, watching sports and spending time with family, per son and observation. Will continue to assist resident with activities of interest and stimulation. Review of R65's Activities 1:1 Program dated 4/16/26 through 5/13/26 documented the resident listened/participated to music 7 times, refused once, and 12 times activities were not applicable to R65. It was noted not once during this period was R65 assisted in an outdoor activity that was previously stated he enjoyed. It was noted, R65's Care Plan did not have documentation that supported charting that the resident refused to participate in activities. Observed on 5/12/2026 at 2:44 PM, R65 was lying supine (on back) in bed staring at the privacy curtain to his left. To his right, the television was on. Behind R65 was a dresser with a stack of photographs out of his sight. No music machine was visible. There were no pictures or photographs on the walls in R65's bed area. It was noted that R65 was dependent on staff to turn, position him, and provide him with sensory stimulation. Observed on 5/12/26 at 1:05 PM, R65 lying supine in bed staring at a blank white ceiling. The television was tuned to a sitcom rerun. No music machine was visible in room. Observed on 5/12/26 at 3:00 PM, R65 was supine in bed staring at a blank white ceiling while a musical activity was being held in the main dining/common area. There was no music machine visible in resident's room. During an interview on 5/13/26 at 9:30 AM, Activity Director O stated, (R65) is unable to respond verbally to staff. He is unable to refuse activities because he cannot communicate. I bought a music machine for (R65) to listen to in his room. His short 1:1 visits are the music machine I got him. I don't know if staff turns it on for him or not. (R65's) brother has said he enjoys music. He likes R&B (rhythm and blues) per his brother. I have not been following CNAs (certified nursing assistant) charting about (R65). I did not know they were charting he was refusing activities because he cannot. I did not know (R65) was not up and listening to the music program yesterday. I dropped the ball on that. Review of R65's Care Plan indicated the resident enjoys listening to music, specifically R&B. Care plan interventions did not include the music machine Activities Director O obtained for him. (continued on next page)		

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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 05/14/2026
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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interventions do not include to keep television on, nor that R65 would enjoy listening to music programs offered by the facility as indicated by the Activities Director. During an observation on 5/13/26 at 9:45 AM, R65 was lying supine staring at the blank ceiling. A stack of family photographs was on the bedside dresser unable to be viewed by R65. Framed family photographs were lined up on furniture behind R65 and not within sight of resident. No music machine was visible in R65's bed area. A handwritten sign on the wall by the television was a request by family to always keep the television on. During an interview on 5/13/26 at 9:50 AM, Licensed Practical Nurse (LPN) W stated, (R65) does not have a music machine that I know of. His family has a sign on the wall to keep his television on. During an interview on 5/14/26 at 12:10 PM, CNA BB and LL stated R65 was unable to communicate his needs or wants. R65 could not refuse cares or what he wanted to do because he could not communicate. He does not have a choice in the music he listens to because his roommate listens to loud music all the time. R65 did not have a music machine they were aware of. They do not assist R65 in getting up for activities unless activities ask them to which was rare. According to nih.gov, Activities are vital for stroke residents in nursing homes, serving as a continuation of rehabilitation rather than just a way to pass the time. They prevent physical and mental decline, boost brain neuroplasticity, enhance everyday independence, and significantly reduce social isolation, depression, and fall risks. Call placed to R65's guardian, WW on 5/13/26 8:52 AM with a message left to call surveyor by end of survey 5/14/26. A call back was not received by end of survey 5/14/26 at 5:30 PM.		

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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. Based on observation, interview, and record review the facility failed to ensure a urinary catheter (tube placed in the body to drain and collect urine from the bladder) was maintained in a sanitary manner for 1 (Resident #122) of 2 residents reviewed for urinary catheters, resulting in the urinary catheter bag lying on the floor creating an opportunity for contamination and the potential for urinary tract infection. Findings include: Review of a current Care Plan for Resident #122 reflected a need for an indwelling catheter related to urine retention with interventions to 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. During an observation on 05/12/2026 at 10:12 AM, outside of Resident #122's door was a sign for enhanced barrier precautions (EBP). Resident #122 was observed seated in his wheelchair located in the hallway across from his room's doorway. Resident #122 had a catheter bag hanging under his wheelchair and the catheter bag was partially lying on the floor Resident #122 began to self-propel into his room and the catheter bag was dragging along on the floor. Licensed Practical Nurse (LPN) ZZ informed Resident #122 she had another attachment for him and she had him go into his room and she shut the door. LPN ZZ reported she replaced Resident #122's catheter tubing securement device. Review of Centers for Disease Control (CDC) poster for Enhanced Barrier Precautions, revealed, .Enhanced Barrier Precautions: Everyone Must .Clean Their Hands, including before entering and when leaving a room .Providers and Staff Must Also .Wear Gown and Gloves for the following High Contact Resident Care Activities .Device care or use: urinary catheter . Review of Nursing Evaluation Summary dated 5/7/2026 at 3:08 PM, revealed, .arrived at facility via ambulance. transferred to bed form (sic) wheelchair x 1 assist. recent hospital for stroke. has left side weakness in upper extremity. able to lift extremities away form (sic) body. unable to straighten arm completely .foley catheter in place 16 French (catheter sizing measurement) flexible medical tube with 10 ml (milliliters) balloon. was straight cath (catheter) at home independently prior to stroke .During an observation on 05/13/2026 at 12:08 PM, Resident #122 was self-propelling down the hallway, the catheter bag was observed to be under his wheelchair, and the bottom of the catheter bag was dragging on the floor. During an observation on 05/13/2026 at 12:54 PM, Resident #122 was seated in his wheelchair in the doorway to his room. The catheter bag was hanging under the wheelchair, the bottom of the catheter bag was dragging on the floor, and he was moving back and forth in the doorway. In an interview on 05/14/2026 at 11:15 AM, Unit Manager (UM) J reported Resident #122's catheter bag shouldn't be on the floor as that was an infection control issue and would contaminate the catheter bag. In an interview on 05/14/26 at 3:00 PM, Director of Nursing (DON) B reported Resident #122's catheter bag should not be on the floor as it is an infection control concern.		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents received oxygen as ordered in 1 resident of 1 resident (R9) reviewed for oxygen administration, resulting in the potential of respiratory health complications including exacerbation of COPD (chronic obstructive pulmonary disease) and/or retention of carbon dioxide (gas produced by cellular respiration in humans). Findings include: According to R9's Minimum Data Set (MDS) dated [DATE], she was cognitively impaired indicated by a BIMS (Brief Interview Mental Status) score of 8/15. Section GG-Functional Abilities indicated R9 was dependent on staff for transferring and mobility. Section I-Active Diagnoses stated debility due to cardiorespiratory conditions that included heart failure, respiratory failure with hypercapnia, Section O-indicated R9 used oxygen therapy continuously while a resident in the facility. Review of R9's Order Summary dated 3/29/2023, indicated oxygen rate was ordered to run at 2.5 lpm (liters per minute (amount of oxygen delivered via tubing)). Review of R9's Medication/Treatment Administration Record dated 5/1/26-5/31/26 revealed, 2.5L (liter) oxygen via nasal cannula (2-prongs that deliver oxygen via a tube into the resident's nose) continuous every day and night shift related to chronic respiratory failure whether with hypoxia (low oxygenation) or hypercapnia. Start date 3/29/2023. It was noted the night shift nurse documented R9's pulse oxygenation had been assessed at 94% and the resident was receiving 2.5 lpm. Review of R9's Care Plan, dated 9/12/2024, focused on altered respiratory status/difficulty breathing related to chronic respiratory failure with hypoxia, CHF, history of pleural effusion, current O2 dependence, SOB (shortness of breath). The goal for this specific focus centered on maintaining a normal breathing pattern by using interventions that included Oxygen use: continuous O2 (oxygen) via NC as ordered by MD/NP, see MAR. Observed on 5/12/2026 at 2:03 PM, R9's oxygen to be running at 3.5 lpm. Observed on 5/13/26 at 9:45 AM, R9's oxygen to be running at 3.5 lpm. During an observation and interview on 5/14/26 at 10:00 AM, Licensed Practical Nurse (LPN) W reviewed R9's physician order stating (R9) oxygen is ordered to be set at 2.5 lpm. LPN W observed R9's oxygen concentrator to be set at 4 lpm stating, Oh, I did not know it was set at that. If the night nurse changed the oxygen flow during the night with a new order, I should have been told when coming on shift. (R9) should not have been left at 4 lpm. It's not good for her to be left that high (concentration) for a long period of time. During an interview on 5/14/26 at 11:00 AM, Nursing Home Administration (NHA) A stated, Oxygen is a medication order. Review of the National Institute of Health (NIH.gov) revealed COPD (Chronic Obstructive Pulmonary Disease) is a progressive inflammatory lung disease that blocks airflow, making it hard to breathe. For residents with COPD, over-oxygenation occurs when supplemental oxygen raises blood saturation above safe levels, leading to dangerous carbon dioxide (CO2) retention (hypercapnia). Hypercapnia is an unhealthy buildup of CO2 in the bloodstream. It occurs when the body is unable to effectively expel XO2 through normal breathing.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to (1) ensure medications labeled/dated for 1 resident of 1 resident (R84) reviewed for medication labeling/dating, (2) ensure medications were stored in a secure manner in 2 of 2 treatment carts and 1 medication room/refrigerator (A Hall), resulting in the potential for residents to receive expired medications with altered potency and decreased efficacy, and residents, visitors, and/or staff access the medications, including narcotics, in the facility. Findings include: According to R84's Minimum Data Set (MDS) dated [DATE], the resident's BIMS (Brief Interview Mental Status) was 13/15 (cognitively intact). Section I-Active Diagnoses stated medically complex conditions including heart failure, arthritis (painful joints), non-Alzheimer's dementia (loss of memory), and bipolar disorder (recurring shifts in mood). During an observation, interview, and record review on 5/12/26 at 11:04 AM, R84 was awake in her bed. On a dresser next to R84's bed, was a tube of zinc oxide dated 3/16/26. The cap was off the tube with small particles of debris sticking to the white ointment around the brim of the opening. The top of the dresser was also covered in food crumbs, dirt, dust, and debris. R84 reported staff had used the zinc ointment on her bottom earlier that day and had left it on the dresser stating, Staff leave it there all the time. Antifungal powder was in a basin on the bedside table in front of R84 with no labeling or dating. Bio Freeze gel was on a shelf of a bookcase with no labeling or dating. On another bookcase shelf was a pair of clear disposable gloves. R84 stated, The powder goes under my boobs and belly. The green gel, I think it is bio something, goes on my knees when they hurt. Observed on 5/13/26 at 9:50 AM, R84 to have antifungal powder in a basin on a bedside table with no labeling or dating and a tube of Bio Freeze gel on a shelf of the bookcase with no labeling or dating. Review of R84's Order Summary, dated 6/25/25, revealed, Bio Freeze Cool the Pain External Gel 4% (Menthol (topical analgesic)). Apply to Bilateral knees topically three times a day related to PAIN. Review of R84's Order Summary, dated 11/3/25, revealed Zinc Oxide Bilateral buttocks: Apply Zinc. every day and night shift for blanchable redness AND as needed. Review of R84's Order Summary did not include an order for anti-fungal powder. Review of R84's Medication/Treatment Administration Record (MAR/TAR) dated 5/1/26-5/31/26, revealed from 5/1-5/14/26: - Bio Freeze Cool the Pain External Gel 4% (Menthol (topical analgesic)). Apply to Bilateral knees topically three times a day related to PAIN was applied as ordered. - Bilateral buttocks: Apply Zinc every day and night shift for blanchable redness. Start date: 11/3/25 was applied as ordered. It was noted; there was no documentation the antifungal powder had been applied. (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R84's Care Plan, revision date of 3/24/26, Focus Resident is at risk for impaired skin integrity related to (r/t) . history (hx) of excoriation to bilateral buttocks. Recurrent open wound r/t MASD/IAD (moisture associated skin disorder) to buttock. Hx stage III pressure ulcer to right gluteus. A goal of Resident will have intact skin . met by interventions that included Apply protective barrier cream after incontinent episodes (8/22/23). Further review of R84's care plan did not include a focus, goal, or interventions that contained antifungal cream or bio freeze gel. During an interview on 5/14/26 at 12:00 PM, Licensed Practical Nurse (LPN) W reported that no resident on A hall, including R84, self-administered medications. During an interview on 5/14/26 at 12:05 PM, Certified Nursing Assistants (CNAs) (BB and LL) reported R84 did not self-administer ointments, lotions, or powders on her own. CNA BB reported powders, ointments, or lotions should not be kept in resident rooms and should be kept in a medication cart. Neither CNA answered when asked if they had administered the zinc oxide ointment, Bio Freeze, or antifungal powder to R84. Observed on 5/14/26 at 12:05 PM, antifungal powder on the top shelf of a bookcase in R84's room. The container was not labeled or dated. On the second to bottom shelf of the same bookcase, was a tube of Bio Freeze gel. Next to the tube of gel was a pair of clear disposable gloves. The gloves were in the exact place as they had been when first seen on 5/12/26 at 11:04 AM. During an interview and record review on 5/14/26 at 12:45 PM, Infection Control Preventionist (ICP) C reviewed R84's medical chart while reporting medications including tubes of ointments and gels along with containers of antifungal powder should be labeled and dated for infection control purposes and their efficacy. Also, labeling ensures the correct resident receives the correct medication. ICP C stated after reviewing R84's medical chart that the resident was not assessed to nor could she administer ointments to her buttocks, or gel to her knees. R84 did not have an order for antifungal powder and should not have had it in her room nor applied to her skin. On 5/13/26 at 8:03 AM the refrigerator on the counter closest to the door, in the medication room on the A hall was observed unlocked. In an interview on 5/13/26 at 8:03 AM, Registered Nurse (RN) R reported the refrigerator, she gestured to while standing with this surveyor in the medication room, were used to store medications including narcotic medications. RN R made no attempt to secure the lock on the refrigerator. In an interview and observation on 5/13/26 at 8:23 AM, RN P reported there were narcotic medications stored in both refrigerators in the medication room on A hall. RN P entered the medication room with this surveyor and removed a plastic storage container from the refrigerator on the counter closest to the door. The plastic storage container was noted to be secured with a red plastic seal. RN P displayed the label on the box and indicated it contained a narcotic. RN P reported the refrigerators should be kept locked. In an interview and observation on 5/14/26 at 10:31 AM, RN T reported the refrigerator in the medication room on A hall should be kept locked. RN T reported narcotic medications were stored in the refrigerator and displaced the same plastic storage container with the red plastic seal and RN T reported the red plastic seal was removed with a pair of scissors when the medications stored inside (continued on next page)		

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Form Approved OMB
No. 0938-0391

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 05/14/2026
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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	it were accessed. In an interview on 5/14/26 at 10:40 AM, Director of Nursing (DON) B reported the refrigerators in the medication room on A hall should be locked at all times, there was no reason for the refrigerators to be left unlocked. DON B confirmed narcotic medications were stored in the refrigerators. Review of facility policy Medication Storage with a revision date of 1/30/2024 revealed .2. Narcotics and Controlled Substances. are stored under double lock and key.		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure accurate medical records for 1 (Resident #77) of 21 residents reviewed for accurate medical records, resulting in an inaccurate representation of Resident #77's current care needs and the potential for unmet care needs. Findings include: Resident #77 Review of a Face Sheet revealed Resident #77 was a female who originally admitted to the facility on [DATE] and had pertinent diagnosis which included: syndrome of inappropriate secretion of antidiuretic hormone (SIADH- a condition in which excessive antidiuretic hormone causes water retention and low blood sodium). Review of a Minimum Data Set (MDS) assessment for Resident #77, with a reference date of 4/25/26 revealed a Brief Interview for Mental Status (BIMS) score of 15/15 which indicated Resident #77 was cognitively intact. On 5/12/26 at 9:15 AM, Resident #77 was in her room, sitting at the bedside, with her breakfast tray in front of her. Noted on the meal tray ticket present on Resident #77's breakfast was instructions for fluid restriction. Observed on Resident #77's breakfast tray was a 4-ounce glass of water and a cup of coffee. Resident #77 was drinking from the coffee cup. Observed on Resident #77's over the bed table was an empty coffee cup, a partially consumed 4-ounce glass of water, 3 Styrofoam cups approximately 480 mL in size, all partially consumed, with varying levels of water, and a partially drank (Brand Redacted) soda pop bottle. Review of Medication Administration Record for Resident #77 for May 1 to May 13, 2026, revealed .Fluid Restriction 1000 mL/24hr (hours) 540 mL from dietary and 460 mL from nursing every day and night shift for hyponatremia (low blood sodium) start date 4/21/26. Review of Care Plan for Resident #77 revealed focus/goal/interventions : Resident is at risk for altered nutritional status. will have adequate nutrition to meet nutritional needs. fluid intake restriction as ordered 1000mL (milliliters) (540 mL from dietary, 460 ML from nursing with an initiated date 4/21/26. On 5/13/26 at 10:36 AM, a 480 mL cup of water with the date 5/12, partially consumed, a 4-ounce cup of water, partially consumed, two 12-ounce cans of soda pop, unopened, and a large metal cup with a handle, lid, and straw was observed in Resident #77's room. In an interview on 5/13/26 at 10:50 AM, Resident #77 reported occasionally my sodium gets low and they put me on a fluid restriction; I might even have to go to the hospital for salty fluids. Resident #77 reported she was not on a fluid restriction now since her salt was fine. Observed a partially consumed 16-ounce bottle of soda, and Resident #77 reported she had acquired it that morning, and she was drinking it. Resident #77 stated I am not retaining fluid right now, I can drink what I want, and I do. In an interview on 5/13/26 at 10:59 AM, Certified Nurse Assistant (CNA) AA Resident #77 was on a fluid restriction, and it was the responsibility of all the staff to monitor her compliance with the fluid restriction. In an interview on 5/13/26 at 11:18 AM, CNA X reported she was not familiar with Resident #77 but knew she was on a fluid restriction. CNA X reported she did not believe Resident #77 was compliant with following her fluid restriction considering the large number of cups she removed from her room that morning. Review of Medication Administration Record for Resident #77 for May 1 to May 13, 2026, revealed .Fluid Restriction 1000 mL/24hr (hours) 540 mL from dietary and 460 mL from nursing every day and night shift for hyponatremia, start date 4/21/26. 23/25 documented entries indicated staff acknowledged and followed the ordered fluid restriction for Resident #77. In an interview on 5/13/26 at 2:20 PM, Licensed Practical Nurse (LPN) MM reported Resident #77 was on a fluid restriction. LPN MM reported when she documented in the MAR regarding Resident #77's fluid restriction, she was documenting her acknowledgment that Resident #77 was on a fluid restriction, not if she was compliant with her fluid restriction. In an interview on 5/13/26 at 2:31 PM, Registered Dietitian (RD) L confirmed Resident #77 was ordered to be on a fluid restriction. In an interview on 5/13/26 at 2:39 PM, Nurse Practitioner (NP) YY reported Resident #77 should be on a fluid restriction, but she knew she would not be compliant, so she didn't order one. NP YY reported if Resident #77 was on a fluid (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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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 05/14/2026
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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	restriction and was not compliant the nursing staff needed to document that. NP YY stated, Yes, she should be on one, but it won't make a difference, she won't follow it, it will just fail.		