

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235600	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/08/2025
NAME OF PROVIDER OR SUPPLIER Medilodge of Montrose Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 9317 W Vienna Rd Montrose, MI 48457	

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)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37771</p> <p>This Citation pertains to Intake Numbers MI00151406 and MI00151580.</p> <p>Based on observation, interview and record review, the facility failed to ensure that residents' rights and/or dignity were maintained by failing to answer residents' call lights in a timely manner, ensure that call lights were in reach, ensure that meals and/or snacks were provided and followed the residents' preferences, and provide adequate lighting in a resident's room for five residents (#2, #3, #6, #8, and #9) of five residents reviewed for food and call lights, resulting in long call light wait times, incontinence, and frustration.</p> <p>Findings include:</p> <p>Resident #2:</p> <p>A review of Resident #2's medical record revealed an admission into the facility on [DATE] and readmission on 11/22/24 with diagnoses that included Parkinson's disease, diabetes, unsteady on feet, muscle weakness, epilepsy and chronic obstructive pulmonary disease. A review of the Minimum Data Set (MDS) assessment revealed a Brief Interview of Mental Status (BIMS) score of 15/15 that indicated intact cognition, and the Resident needed partial/moderate assistance with eating, oral hygiene, toileting hygiene, bathing, and personal hygiene.</p> <p>On 4/8/25 at 9:00 AM, an observation was made of Resident #2 lying in bed, awake. The Resident was interviewed, answered questions and engaged in conversation. The Resident reported he liked to get up out of bed at lunch time. The Resident was asked where his call light was located and if it was in reach. The resident stated, Nope, I don't have it, and did not know where it was. The call light was observed to be clipped to the call light cord that hung on the wall behind the head of the bed. The call light was not reachable by the Resident. The Resident stated, They forget sometimes to put it in reach. When asked what he does when he needs assistance, the Resident stated, I got to yell for them. When asked do they hear you, the Resident stated, Eventually. When asked about the hand bell on the table that was not in reach for the Resident, the Resident stated, They can't hear that one. When asked if the Resident had other concerns, the Resident reported that he would really like to have the light above the bed to be working. The light was tested and did not go on. An observation was made of wires bunched together that had caps on and there was no bulb. The Resident expressed he would like for the light to work and then I can do it myself.</p> <p>(continued on next page)</p>

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 235600
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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 4/8/25 at 9:15 AM, CNA (Certified Nursing Assistant) H was interviewed regarding facility policy on call lights. The CNA reported that call lights were to be in reach for the resident, answered ASAP, right away. When asked if you answered a light but were unable to meet the resident's needs at that time? The CNA reported you would leave the light on, don't turn it off until the need was met. The CNA had gone into Resident #2's room, seen the call light clipped to the cord, reported it should be in his reach and then positioned the call light, so the Resident had access to the device.</p> <p>Resident #3:</p> <p>A review of Resident #3's medical record revealed an admission into the facility on [DATE] with diagnoses that included chronic obstructive pulmonary disease, seizures, and need for assistance with personal care. A review of the Minimum Data Set (MDS) assessment revealed a Brief Interview of Mental Status (BIMS) score of 14/15 that indicated intact cognition, and the Resident needed partial/moderate assistance with bathing, and putting on/taking off footwear and needed supervision or touching assistance with toileting hygiene, upper body dressing, sit to stand, chair to bed transfer, toilet transfer and walk 10 feet.</p> <p>On 4/4/25 at 11:11 AM, a call was made to Confidential Person (CP) M regarding the care received by Resident #3 from the facility. The CP reported that on March 6th she had gone to the facility in the evening to visit Resident #3. The CP reported that the Resident was seated in her wheelchair half dressed. The CP reported that the Resident had told her she had not had a shower or got washed up since coming to the facility. The CP reported that she had given the Resident a sponge bath, lotioned her up, clothed her, teeth cleaned, and the Resident complained that she was starving, and had not eaten dinner. The CP reported it was then about 8 PM, there was no food tray that was in the Resident's room, and no one had come with her meal. The CP reported the facility never gave her any snacks and that the Resident had hidden food in a towel so she could have something to eat later in the evenings. The CP reported that when the Resident arrived at the facility, she was 95 pounds, was transferred to another facility, had weighed in at 82 pounds and had lost 13 pounds since being at the facility for 10 days. The CP reported the Resident had told her she had missed meals for two days while at the facility.</p> <p>A review of Resident #3's meal intake revealed data dated 3/4/25 to 3/10/25 with no documentation of meal intake for the evening meal on 3/6/25 and 3/8/25. A review of the Task: Nutrition-HS (nighttime) Snack: Routine, from 3/6/25 to 3/10/25 revealed two entries marked on 3/7/25 and 3/9/25 as Not Applicable, with lack of documentation on the other days that the Resident had received HS snacks.</p> <p>Resident #6:</p> <p>A review of Resident #6's medical record revealed an admission into the facility on [DATE] and readmission on 11/5/21 with diagnoses that included multiple sclerosis, diabetes, foot drop, muscle weakness and depression. A review of the Minimum Data Set (MDS) assessment revealed a Brief Interview of Mental Status (BIMS) score of 14/15 that indicated intact cognition, and the Resident needed substantial/maximal assistance with toileting hygiene, bathing, and dressing and dependent on helper for transfers.</p> <p>(continued on next page)</p>		

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 4/3/25 at 2:18 PM, an observation was made of Resident #6 sitting in a wheelchair in their room next to the bed. The Resident was interviewed, answered questions and engaged in conversation. The Resident was asked if she had any concerns with her care provided by facility and staff. The Resident reported the facility was short staffed and that call lights were not answered timely. The resident reported some call light response time recently being more than 30 minutes before staff come down. When asked if she has had to wait more than an hour, the Resident stated, more than an hour? Yes, depends on who is here, indicating which staff was on or how many staff were on. The Resident was asked how the meals were, and the Resident reported that you don't always get what you ask for, and explained that if you order it, it may not come as you ordered, the meal, drinks and that sometimes it is cold and stated It's a surprise when the lid is opened. I should get what I asked for.</p> <p>Resident #8:</p> <p>A review of Resident #8's medical record revealed an admission into the facility on [DATE] with diagnoses that included lupus, heart failure, muscle weakness, adult failure to thrive, dementia chronic pain and depression. A review of the Minimum Data Set (MDS) assessment revealed a Brief Interview of Mental Status (BIMS) score of 11/15 that indicated moderately impaired cognition, and the Resident was dependent on a helper for toileting hygiene, bathing, dressing lower body and chair/bed-to-chair transfer.</p> <p>On 4/3/25 at 2:35 PM, an observation was made of Resident #8 lying in bed, awake. The Resident was interviewed, answered questions and engaged in conversation. The Resident was asked about any concerns with care and the Resident reported that call lights had a long wait time to be answered. The Resident expressed that the facility needs more workers. When asked how long a wait she had to have her call light answered, the Resident reported she has had to wait over 30 minutes at times. The Resident expressed frustration with meals and stated, They take my order, but you don't get what you ordered, and explained I ask for orange juice, and I get some peach colored juice, I ask over and over for the orange juice, I don't want that peach colored juice, and reported she would get the peach colored juice sometimes. The Resident said pleadingly, Please give me wheat bread, but I still get white, so disappointed. I have told them over and over. The Resident reported that she took a lot of pills in the morning and needed something on her stomach so she wouldn't get sick and did not like white toast, asked for wheat toast but sometimes got the white toast anyway.</p> <p>On 4/8/25 at 8:35 AM, an interview was conducted with Resident #8. The Resident was asked about her breakfast, and she reported getting wheat toast today and stated, It was burnt toast, and reported she ate one and a half anyway. The Resident was asked if she requested other toast, reported that she had eaten it anyway and stated, So disgusted. Why would they give me burnt toast.</p> <p>On 4/8/25 at 8:38 AM, an interview was conducted with CNA N regarding Resident #3's preference for wheat toast and not white toast. The CNA stated, She gets whatever they are serving.</p> <p>On 4/8/25 at 3:34 PM, an interview was conducted with Dietary Manager (DM) D regarding Resident #8's preferences for wheat toast. The Dietary Manager had gone to check the meal ticket and with Resident #8 and returned. The Dietary Manager reported that the dietary staff knew the Resident did not like white bread and they would put it on the menu, but it was not going on her dislikes. The DM reported that it needed to go on her dislikes and stated, every once in a while, she would get someone that did not know her preference and she would get the white bread. The DM reported that education was provided to staff and that the request for No [NAME] Bread was added to the meal tickets.</p> <p>(continued on next page)</p>		

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Resident #9:</p> <p>A review of Resident #9's medical record revealed an admission into the facility on [DATE] with diagnoses that included stroke, seizures, contracture of left hand, lupus, depression, anxiety disorder, hemiplegia and hemiparesis affecting the left non-dominant side. A review of the MDS assessment revealed a BIMS score of 15/15 that indicated intact cognition, and the Resident needed substantial/maximal assistance with toileting hygiene, bathing, lower body dressing and needed partial/moderate assistance with mobility and transfers.</p> <p>On 4/4/25 at 1:20 PM, Visitor L of Resident #9 motioned the surveyor into the Resident's room. The Visitor reported to be a family member of Resident #9. The Visitor reported that the Resident had issues with the call light not being answered timely. The Visitor reported that they had complained at care conference and filled out orange (grievance) forms, but that the staff continued with not answering the call light timely. The Visitor reported they had put the call light on about 15 minutes ago and no staff had come in yet. The Visitor stated, you can see she has to go to the bathroom. The Resident was sitting on the edge of the bed and indicated she had to use the bathroom. The Visitor stated, This is frequent, more then not, wait too long for light to be answered. The Resident and Visitor was asked about their meal. The Resident indicated it was late and cold. The Resident reported that she did not like baked fish or zucchini and stated, I still get it even though it is on sheet. The slip with the lunch meal indicated dislikes fish and zucchini. When asked if they don't follow the resident's preferences, the Resident reported if they were having fish, they would serve it to her for the meal.</p> <p>On 4/4/25 at 1:30 PM, an observation was made of a staff member going into Resident #9's room and then came back out. Resident #9's room was approached again. The Visitor was still in the room and the Resident was sitting in the same position on the side of the bed. The Visitor was asked if the Staff had assisted the Resident. The Visitor stated, No, but she turned off the call light and said she would send someone down.</p> <p>On 4/4/25 at 1:36 PM, a staff member was observed to be entering Resident #9's room.</p> <p>On 4/4/25 at 1:38 PM, Visitor L came out of Resident #9's room. When asked if the staff was assisting the Resident to the bathroom, the Visitor stated, They came in, but it was too late, she already relieved herself in bed.</p> <p>On 4/8/25 at 2:24 PM, an interview was conducted with the Director of Nursing (DON) and Unit Manager regarding the concern of call light wait times, call lights not in reach, food preferences not honored and ensuring meals and snacks were provided. The Unit Manager reported that the facility uses call light system pagers, a call light will go to the CNA first immediately, 3-5 minutes to the nurse's pager. The DON reported she was at 15 minutes. The DON reported that if the staff could not provide the care, the light was to be left on until the needs were met. The DON reported that education will be provided to the staff.</p> <p>A review of facility policy titled, Frequency of Meals, revised/reviewed 1/1/2022, revealed, Policy: The facility will ensure that each resident receives at least three meals daily without extensive time lapses between meals . 1. The facility has scheduled three regular mealtimes, comparable to normal mealtimes in the community, per day and has scheduled three regular snack times .</p> <p>(continued on next page)</p>		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of facility policy titled, Promoting/Maintaining Resident Dignity, reviewed/revised 10/26/23, revealed, Policy: It is the practice of this facility to protect and promote resident rights and treat each resident with respect and dignity as well as care for each resident in a manner and in an environment, that maintains or enhances resident's quality of life by recognizing each resident's individuality . 2. During interactions with residents, staff must report, document and act upon information regarding resident preferences .		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37771</p> <p>This Citation pertains to Intake Number MI00151746.</p> <p>Past Non-Compliance (PNC) was identified at the facility during investigation of the allegation and was accepted by the survey team upon exit from the facility for this citation. Following discussion with the State Manager, Past Non-Compliance was accepted with a Compliance Date of 3/24/2025.</p> <p>Based on interview and record review, the facility failed to immediately report to the Abuse Coordinator allegations of sexual abuse and report timely to the State Agency abuse allegations for one resident (#1) of four residents reviewed for abuse, resulting in a delay in the investigation and the potential lack of resident safety to go undetected and abuse to continue to occur.</p> <p>Findings include:</p> <p>Resident #1:</p> <p>A review of Resident #1's medical record revealed an admission into the facility on [DATE] and readmission on 3/25/25 with diagnoses that included cerebral palsy, dysphasia, adult failure to thrive, hydrocephalus, dementia, anxiety disorder, and adjustment disorder with mixed disturbance of emotions and conduct. A review of the Minimum Data Set assessment revealed the Resident had severely impaired cognitive skills for daily decision making and was dependent on staff for activities of daily living, mobility and transfers.</p> <p>A review of the investigation report for Resident #1 revealed the summary of incident that revealed the following:</p> <p>-On 3/23/25, Resident #1(R1) was sent out to the hospital for vaginal bleeding. On 3/24/25 approximately 11:48 AM, a call was place with Resident #1's legal guardian to follow up on the status of R1's hospital admission from the prior day. During discussion, legal guardian confirmed that R1 was admitted to the facility for vaginal bleeding and seemed to be stable however, a pelvic exam was ordered by the hospital to rule out sexual abuse. Administrator reported the allegation and began investigation.</p> <p>A review of R1's investigation report of Statement of Witness, revealed the following:</p> <p>-Dated 3/24/25, Witness and Position of Witness: (Confidential Person R), Statement of Witness (R1) will be discharging back to (facility name). I spoke with the Doctor yesterday and had to sign paperwork for a rape test to be completed. The hospital notified (area police) for a possible case. When I spoke to the Doctor today, he said there was a scratch on the inside of her labia. I feel that (R1) is safe at the facility, and just waiting on the results are back .</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Dated 3/24/25, Witness Nurse B revealed, .I noticed scattered amount of blood on her labia. Since (R1) is contracted, I attempted to open her legs a little to get a better view. Her labia appeared to be swollen, and I notice (R1) was more hysterical than usual when trying to assess her peri area. Normally that is how she communicates during her normal routine by yelling out, but this time due to the intensity of her yelling, I stopped attempting to assess her . I didn't know what was wrong with her, so I went an told (DON) what I saw in the room. Do to (R1) not being non-verbal. I didn't know at the moment what caused this and I didn't want to rule out any possibility. I explained to (DON) what I found and asked if this a reportable event. DON said to send (R1) out for evaluation and contact the on call provider EMS arrived . (A male resident) came to the doorway asking is she okay? And (Nurse P) told him that he had to leave and exit the room. The resident left the room. EMS placed (R1) on the stretcher and (Nurse P) said to them to make sure to take all the bedding. (Nurse P) told EMS we don't know if something happened to her and would like her evaluated and if something did happen, we could suspect who did it. EMS said they would advocate for (R1) when they got to the hospital.</p> <p>A review of Resident #1's medical record of the SBAR Communication Form and progress note dated 3/23/25 at 11:25 AM revealed, .4. Nursing Notes .Upon changing resident to provide perineal care, resident was guarded and began screaming out. Resident was observed to have blood of brief by staff, and it was reported to nurse. Upon nursing entered room to assess peri area, resident began screaming and crying, notified DON and on call NP, recommended transfer to hospital to evaluate .</p> <p>On 4/4/25 at 9:45 AM, an interview was conducted with the Administrator (NHA) regarding the investigation completed for R1. The NHA was asked when he became aware of allegations of sexual abuse. The NHA reported that when he had called the Confidential Person R regarding hospitalization of Resident #1, he was told of that the hospital had done rape testing and then they had started the interviews with staff and realized there was suspicion of abuse by the staff. NHA revealed that staff had not made it clear on 3/23/25 that they had suspected possible abuse with the lack of communication to him and the Director of Nursing (DON). The NHA reported that the police had been notified by the hospital and that if staff thought something happened here, we should have been the ones to call the police. The NHA reported he had not found out until the next day when talking with (Confidential Person R) that the ER (emergency room) was doing a rape assessment. The NHA reported that the State Agency was not notified until 3/24/25, the next day, and the investigation was delayed. The NHA reported they identified that reporting was delayed, completed education with the staff, myself and the DON to complete a past non-compliance. The NHA had the documentation for the past non-compliance. The NHA stated, We realized on the 24th that we were not in compliance and immediately started the education. We looked at the video and did not find another Resident in the room. The NHA reported that the video coverage of the hall will be given to the police who were coming today to pick it up to review.</p> <p>Past Non-Compliance:</p> <p>A review of the facility documentation titled, Facility Past Non-compliance Checklist revealed the following:</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>- Description of deficient practice (why and how did it happen): An incident of vaginal bleeding occurred on 3/23/2025 and resident was sent to the ER for evaluation. The police arrived to facility to conduct an investigation of potential sexual abuse. The administrator was not notified until the police were in the facility. The facility then started but failed to complete a thorough investigation timely which resulted in a delay in reporting an allegation of potential sexual abuse and the potential for harm to other residents as the allegation was not reported to the state agency until 3/24/2025.</p> <p>- Plan of Correction: Facility conducted a more thorough investigation on 3/24/2025 and reported the allegation of sexual abuse at that time based on further interviews. Like residents were assessed and education provided by DON/Designee was immediately started regarding abuse, reporting and investigating.</p> <p>- In-depth analysis of how the deficiency occurred: On 3/23/2025 resident was observed with vaginal swelling and bleeding in her brief by CNA during her routine check and change. Nurse notified the Director of Nursing and physician who agreed to send resident to ER for further evaluation of the cause of the bleeding. When staff went in to reassess resident she appeared to be very guarding, upset, yelling out and resistive to staff assessing her vaginal area. Resident was picked up by EMS and transported to the hospital for further evaluation and was told by staff to take the sheets with her. Administrator was not notified until the police arrived at the facility due to being called by the EMS Hospital for the suspicion of potential sexual abuse. Administrator and Director of Nursing arrived to the facility shortly after to start an investigation however the potential allegation was not reported to the state agency until 3/24/2025 after conducting further interviews with guardian. Like residents were also not assessed until 3/24/2025 for any other signs/allegations of abuse.</p> <p>- Corrective action to be taken: Administrator and Director of Nursing were re-educated on the Abuse, Neglect, and Exploitation Policy with emphasis on signs of potential sexual abuse. They were also educated on the Compliance with Reporting Allegations of Abuse/Neglect/Exploitation with emphasis that when there are signs of potential sexual abuse they need to contact the Regional Director of Clinical and Regional Director of Operations immediately, contact the police due the suspicion of a crime, report the potential abuse to the state agency and start a timely and thorough investigation immediately.</p> <p>- Staff were re-educated on the Abuse, Neglect, and Exploitation Policy by the Administrator and/or designee on 3/24/2025. A quiz was completed with staff to ensure staff understand the signs of sexual abuse and reporting potential for sexual abuse immediately to the abuse coordinator.</p> <p>- An Ad-HOC QAPI was completed on 3/24/2025 and the incident was reviewed with the Medical Director.</p> <p>- The police had already been notified on 3/23/2025 due to the suspicion of a crime.</p> <p>- The physician and Guardian were notified on 3/23/2025.</p> <p>- The Administrator/Designee reviewed video footage for the previous 24 hours from incident for any staff and residents that entered the resident's room and anyone that entered the room was interviewed for suspicion of potential signs of sexual abuse.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>- The Administrator/Designee interviewed staff that worked the previous 72 hours regarding any suspicion of potential signs of sexual abuse.</p> <p>-How facility monitors its corrective actions to ensure deficient practice was corrected and will not recur: Abuse quizzes will be completed by 10 staff weekly for 4 weeks then monthly thereafter to ensure staff understand the signs of sexual abuse including who and when to report to; Audits will be conducted by the Director of Nursing/Designee with 10 Residents weekly for 4 weeks then monthly thereafter to ensure residents do not show signs of sexual abuse, feel safe in the facility and know who to report concerns to; Incident reports will be reviewed by Director of Nursing/Designee weekly for 4 weeks then monthly thereafter to ensure there is a timely and complete investigation and that any suspicion of abuse was reported to the abuse coordinator immediately and reported to the state agency according to the regulation.</p> <p>The date of completion of the plan of correction was dated 3/24/2025.</p> <p>The State Surveyor verified the documentation provided by the facility and conducted interviews with facility staff. During the interviews with facility staff, staff reported that they had been educated on the facility policy for abuse, that included reporting of abuse and were knowledgeable about the facility policies.</p>		

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NAME OF PROVIDER OR SUPPLIER Medilodge of Montrose Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 9317 W Vienna Rd Montrose, MI 48457	
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)		
<p>F 0732</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>Post nurse staffing information every day.</p> <p>37771</p> <p>This Citation pertains to Intake Number MI00151580.</p> <p>Based on interview and record review, the facility failed to ensure that the required posting of daily nursing staff was accurate and updated, resulting in a lack of accurate documentation of daily staffing available to all 112 residents residing in the facility, the residents' representatives, staff and visitors.</p> <p>Findings include:</p> <p>On 4/8/25 at 12:00 PM, a review of the facility form titled BIPA, (Benefits Improvement and Protection Act of 2000 (BIPA) was conducted and the staffing schedules for the days requested were compared. The BIPA form was what the facility had as their mandatory posting of daily nursing staff that was posted at the front desk upon entrance to the facility.</p> <p>The BIPA dated 3/8/25 revealed 7 CNA's/76 hours from 6 AM to 6 PM with the staffing schedule having 8 CNA's/88 hours total. The BIPA had 5 CNA's/5 hours from 6 PM to 7 PM and 1 CNA/12 hrs. from 6 PM to 6 AM with the schedule reflecting 7 CNA/84 hrs. total. The Nurses for 6 PM to 6 AM on the BIPA was documented as 4 nurses/36 hours. The staff schedule revealed 6 nurses/60 hours.</p> <p>The BIPA dated 3/9/25 revealed 5 CNA's/60 hrs. from 6 AM to 6 PM with the staffing schedule with 7 CNA's/84 hrs. Nurses on BIPA 5 nurses/44 hrs. with the schedule of 7 nurses/68 hrs.</p> <p>The Administrator (NHA) was asked to review the BIPA forms and the staffing schedules with the surveyor. The NHA was asked if the staffing schedules were accurate to reflect who was on that day and reported they should be correct. A review of the dates 2/8/25, 2/9/25, 3/7/25, 3/8/25 and 3/9/25 revealed multiple errors on the BIPA form that was used as the mandatory daily posting of nursing staff. The Director of Nursing was asked to look at the forms and reported that she would look into it.</p> <p>On 4/8/25 at 2:35 PM, the Director of Nursing (DON) reported that the BIPA Form was not reflecting the correct staffing. The DON indicated that the new staff were not coded right and were not reflected on the staffing posting.</p> <p>A review of facility policy titled, Facility Required Postings, reviewed/revised 1/1/22, revealed, Policy: The facility will post required postings in an area that is accessible to all staff and residents . 2. The facility must also post the following: a. Staffing Information .</p>		