STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235600	A. Building B. Wing	06/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Montrose Inc	9317 West Vienna Road Montrose, MI 48457

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. This Citation pertains to Intake Number MI00153369. Based on observation, interview and record review, the facility falsified the completion of staffs' online education, which had the potential to affect a census of 112 residents residing in the facility. Findings Include: On 6/10/25 at 8:50 AM, an interview was conducted with Nurse B. When asked about education, the Nurse reported that they started a new education (online education) but could not get into the program and had not completed the education though the facility wanted to have it done. The Nurse reported having issues with getting in the system and had not completed the education. On 6/10/25 at 12:45 PM, an interview was conducted with CNA (Certified Nursing Assistant) I. When asked if they have had their education completed with the new online education, the CNA indicated she had not completed it. The CNA reported they could complete it at home but was unable to and stated, I have not done it yet. On 6/10/25 at 1:53 PM, an interview was conducted with CNA (Certified Nursing Assistant) T. When asked about the completion of education, the CNA reported that they had not received log in information and after they sent the password, the CNA stated, I logged in and it was all completed. The CNA indicated that they had not been on to do any of the education but when they did get on, the CNA stated, It was all done. I never did them. On 6/10/25, an interview was completed with a Confidential Staff W regarding completion of education. The Confidential Staff revealed that the facility had completed courses online for anyone who had not had it completed and stated, They did the courses for anyone that was not done. On 6/10/25 at 2:56 PM, an interview was conducted with the Staff Development Nurse (SDN) N regarding completion of staff education. The SDN reported that he had worked there for about 4 months and the one online education had been stopped prior to him coming to work at the facility and they had a newer online education program for staff. The SDN reported there had been issues with staff getting on to work the modules but that the monthly ones were all up to date. The SDN reported that they could do it here at the facility or could complete the modules at home. The SDN reported it was mandatory for the staff to complete, and he had asked staff to get it done. A review of the following staff was reviewed. (continued on next page)

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

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-CNA D with 23 of 24 sections that were documented as completed on 6/5/25. -LPN (Licensed Practical Nurse) X had 8 sections completed on 6/5/25. -Nurse B had 28 of 29 sections completed on 6/5/25. -CNA T had 23 of 24 completed section on 6/5/25. -CNA I had 23 of 24 completed sections on 6/5/25. -LPN BB had 17 of 34 sections completed on 6/5/25. -CNA G had 5 of 26 sections completed on 6/5/25. -CNA CC had 5 of 24 sections completed on 6/5/25. -Nurse Aide Non-Certified DD had 7 of 20 sections completed on 6/5/25. The SDN was queried regarding the completion of the education all on the same day. When asked if he had access to when the staff had gone on to the program to complete the education to verify, they had all completed the education on that day, the SDN reported he would not be able to pull that up, if there was a way, he did not know how to do it. When asked about CNA T not having a password then once she acquired the password, the CNA went on the program to find that it said it was completed. The SDN reported that they did not know how that would have happened. The SDN looked up when that staff member got their password and reported it had been on 6/5/25. The SDN reported that he had to put in education for others on orientation and by error completed all the education on everyone but reported he had not been aware if that had occurred. A review of CNA Qs online education Test Report was reviewed that had 23 of 24 sections completed. The CNA was working that day. On 6/10/25 at 3:50 PM, an interview was conducted with CNA Q regarding the online education. The CNA was asked if she completed the education and the CNA informed the surveyor, she was not able to get into the program and had not completed the education. The SDN had stopped to talk to the DON and then approached to find out the CNA had not been on the program to complete the education. When asked if she had completed the education on June 5th as the Tests Report document indicated, the CNA reported she could not have because she had not been able to get on. The CNA and SDN were asked to log in to see the education. An observation was made, after a couple of tries to log into the computer education program, of the SDN and CNA able to log in. An observation was made of the education program that indicated CNA Q had 0 assignments and had 24 completed sections. The CNA stated, I never did it. I don't know why it says it is completed, and reported it was their first time into the program for education. On 6/10/25 at 4:05 PM, an interview was conducted with the DON and SDN N regarding the education documentation as completed when staff were reporting not going onto the program to complete the education. The SDN reported that it might have occurred in error when recording other education. The DON was asked who had access to the education system. The DON reported that she would have to investigate to find out who had made the documentation. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the online education Tests Report of staff listed above included Sections of education titled: Infectious Disease for All Staff; emergency Preparedness; Pneumonia; Fraud, Waste & Abuse; Skills for Addressing Challenging Behavior; Trauma Informed Care; Preventing and Caring for Pressure Ulcers for Nursing; What is Abuse; Substance Use Disorder; Enhanced Barrier Precautions for all Staff; Effective Communication; HIPAA for Long Term Care Employees; Dementia; End of life; Hazardous Communication and Safety Data Sheets; Resident Rights; Blood borne Pathogens Training; Assisting with Meals; Dietary Considerations; and Infection Control: Basics; Fall Prevention. A review of facility policy titled, Nursing Services and Sufficient Staff, reviewed/revised 1/1/22, revealed, Policy: It is the policy of this facility to provide sufficient staff with appropriate competencies and skill sets to assure resident safety and attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident . 3. The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for resident's needs as identified through resident assessments and described in the plan of care . 5. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care .

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This Citation pertains to Intake Numbers MI00153369 and MI00153563. Based on observation, interview and record review, the facility failed to ensure resident safety with a lack of timely documentation of Resident #13 exiting the building unattended by staff. The facility also failed to update and/or revise care planning to include exit-seeking behavior and ensure that staff signed out pagers that notify staff of the resident call system and door activation for one resident (Resident #13) of three residents reviewed for elopement. Findings include: Resident #13: A review of Resident #13's medical record revealed an admission into the facility on 1/22/25 with diagnoses that included dementia, metabolic encephalopathy, bipolar disorder, altered mental status, depression, adjustment disorder with anxiety, muscle weakness, unsteadiness on feet, restlessness and agitation. A review of the Resident's Minimum Data Set assessment dated [DATE], revealed a Brief Interview of Mental Status score of 00/15 that indicated severely impaired cognition and the Resident needed substantial/maximal assistance with bathing, lower body dressing, putting on/taking off footwear, needed partial/moderate assistance with toileting hygiene, personal hygiene, lying to sitting on side of bed and supervision or touching assistance with transfers. On 6/5/25 at 12:12 PM, an interview was conducted with the Director of Nursing (DON) and the Administrator (NHA). The DON and NHA were asked if there had been a Resident that had eloped from the facility and was found to be outside the building. The DON and NHA agreed they did not have a Resident that had left the facility. On 6/6/25 at 12:16 PM, a phone call was made to Nurse B regarding call light pager system being accessible for the nightshift. The Nurse reported that if a pager was not signed out at the start of shift that they would be locked after a certain time and not accessible. The Nurse reported that they had been written-up due to not having a pager on their person. When asked when this occurred, the Nurse was unsure of the date but indicated they thought it was when a Resident was found outside the building instead of eating dinner. The Nurse was not aware who the Resident was or the date of the occurrence. On 6/6/25 at 1:05 PM, an interview was conducted with Nurse GG regarding Resident's with exit seeking behaviors and elopements. The Nurse indicated that Resident #13 had been found outside the facility but was unsure of the date and reported no injuries occurred. The Nurse indicated Resident was confused at times and reported should not be outside without staff assistance. On 6/6/25 at 1:20 PM, a review of Resident #13's progress notes in the medical record revealed no documented occurrence of the Resident found outside the building. A review of Resident #13's medical record revealed the following: (continued on next page)

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	235600	A. Building B. Wing	06/11/2025

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Dated 2/23/25 at 5:24 PM, Pertinent Charting-Behavior: Behavior Displayed: Resident exhibited exit seeking behaviors throughout shift, approaching emergency exits throughout facility. When staff approaches to redirect, resident becomes agitated and aggressive with staff . Intervention results: unsuccessful . -Dated 2/24/25 at 4:38 AM, Resident has been exit seeking and asking can I go out this door? Can I go out any of these doors? Resident was told no and became aggravated and aggressive with staff, walking in the hallways with no O2 and no shirt on . -Dated 3/26/25 at 4:47 AM, .resident continues to remove oxygen and ambulating in hallway. -Dated 4/6/25 at 12:36 AM, wandering in w/c (wheelchair) continues, patient takes off oxygen often, self transfers, and unable to use call light for assist. Incontinent and does not tell staff he needs assist. -Dated 5/13/25 at 2:53 PM, Social Services Progress Notes, Left VM (voice message) for son. He was going to pursue guardianship for (Resident #13). No paperwork has been filed to this date. (Resident #13) is deemed unable to make his own decisions . -Dated 5/20/25 at 10:02 AM, walking through out long term side with out assistance and without wheelchair. Has O2 off, O2 off of wheelchair and stated I didn't buy that. Talking about going to the hospital and how he is in severe back pain, attempted to give Tylenol, refused multiple times. Attempted to exit seek, this nurse was there to redirect him . -Dated 5/20/25 at 6:24 PM, pmr progress note, .Interval History: Pt (patient) seen and examined. The patient was seen in WC next to nursing station. Pt is now intermittently taking his O2 off and refusing to put it back on. Pt also has very poor safety awareness and will randomly get up from his wheelchair and walk around. Pt apparently over the weekend had a fall and was sent to the hospital . Pt seen pushing his wheelchair around as well and needs lots of redirection and safety education. Pt will need to be watched closely and needs strict fall precautions . -Dated 5/20/25 at 7:42 PM, BH (Behavior Health)-Psychology Follow-up Visit, .Staff report concerns of worsening cognition .Encourage appropriate behavior and interpersonal boundaries, particularly in light of reported increased adverse behaviors including verbal aggression and exit seeking behaviors . -Dated 5/20/23 at 8:23 PM, In wheelchair being pushed around facility by staff member as he is exit seeking stating he needs to go the gas station on the corner and the hospital. Not making statements based on reality or facts at this time . (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/6/25 at 1:58 PM, an interview was conducted with the DON regarding an interview conducted on 6/5/25 with Human Resource Personnel (HR) HH of staff disciplinary actions. The HR had indicated that Nurse B had not had any disciplinary documentation but to check with DON. The DON was asked for the staffing disciplinary documentation. The Surveyor was given a document, but the document was not for not having the pager signed out. The DON was asked again, and the document titled Performance Improvement Form was reviewed with the DON of the Employee Comments: Pagers locked 1 hour after shift starts, correction for pager is after elopement . and was signed on 5/21/25. When asked about Resident #13 out of the facility, the DON reported the Resident had been out with staff prior to the incident, he had gone out the front door, he was sitting on the front porch, went out for 4 to 5 minutes. When asked how they knew the time he had been out, the DON reported they had watched the cameras and stated, He didn't go off the property, he was just on the porch. He was his own person. It was identified that family were working on guardianship for him, the DON stated, Now they are. The DON reported she had driven up to the facility and stated, I found him sitting on the porch. The DON reported it was identified that some of the staff had not had pagers on them and that staff had not responded to the door alarming. The DON reported that when the door was opened, the door alarm would sound and then it goes to the call light pagers that the CNA's and Nurses were to have them at the beginning of their shift. The DON reported she had done education with the staff. When asked how many staff did not have pagers, the DON indicated 6 of 12 did not have a pager on them. On 6/6/25 at 2:27 PM, a phone interview was conducted with Nurse II regarding Resident #13's behaviors. When asked if the Resident was safe to go out of the facility on their own, the Nurse stated, Absolutely not. The Nurse did not remember hearing the door alarm on 5/20/25 and reported they did not know he was out until he was brought back in. The Nurse reported that staff did not all have pagers on them and they all got write-ups for it. When asked why they had not signed out a pager, the Nurse reported getting to the facility before the shift started and would not get one until day shift leaves, and reported there was not enough pagers for both shifts to get/have one. On 6/6/25 at 3:14 PM, an observation was made with the NHA of the video footage at the time the Resident breeched the front doors of the facility. At approximately 7:20 PM on 5/20/25, visitors were seen leaving thru the door in the lobby. Resident #13 is near the doors seated in a wheelchair. The Resident was observed to be pushing on the door and then goes through the door. The NHA is asked if the door was alarming at this time and reported it would have been sounding. The Resident was in the vestibule at 7:21 PM. At 7:22 PM the Resident was observed on the video going through the second set of doors. A car was seen pulling up to the front porch area. The DON was observed to be bringing the Resident back in at 7:24 PM. The NHA reported that at the time the visitors went out, the door was triggered and it should alert the pager system, but staff had not responded to the door alarm. The NHA reported they had done a past non-compliance on this. On 6/6/25 at 3:29 PM, an interview was conducted with CNA JJ regarding Resident #13 exit seeking behavior on 5/20/25. The CNA reported having a pager and that it had gone off and stated, I was busy with another resident, could not check the door. When I got done, he was back in. The CNA was asked about the availability of the pagers and reported that they try to get a pager and walkie when just starting the shift but sometimes there is not enough pagers. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/10/2 at 4:35 PM, a review was conducted with the DON of the staffing documentation and the Pager Log. The DON indicated that the Nursing Staff were to sign out the pagers at the start of their shift on the Pager Log when they get their pager. The DON was asked if the staff signs out the pager, they should have one on them and if they did not sign then staff had not gotten a pager, they sign when they get the pager, and the DON indicated that was correct. A review of Tuesday, June 3, 2025, was reviewed with two staff on day shift and two staff on night shift that had not signed out pagers. For Sunday, June 8, 2025, a comparison of the staffing sheet and the Pager Log revealed four staff on day shift and three staff on night shift had not signed out pagers. For Saturday, June 7, 2025, the comparison of the staffing sheet and the Pager Log revealed four staff did not sign out pagers on day shift and four on night shift. The DON reported there were extra pagers and opened the drawer with some pagers available. On 6/10/25 at 4:55 PM, an interview was conducted with the Social Services Director (SSD) O and Social Services (SS) P regarding Resident #13's exit seeking behaviors. The SSD reported she was unaware the Resident had been outside or had exit seeking behaviors and reported the Resident was not in the elopement book. The SSD reported that the nurse would do an elopement assessment and then their department would make sure the resident was in the elopement book and make sure it was care planned. A review of the care plan lacks documentation of exit seeking behaviors and reported they would update the care plan. SS P reviewed the tasks for documenting behaviors and reported it had not been identified as a behavior to be monitored. SSD was in Resident #13's medical record and stated, There is a task now if he is trying to wander. The Social Service Staff reported it would be a behavior that would need to be monitored. When asked if the Resident was appropriate to go outside by himself, the SS stated, Definitely not. A review of Resident #13's progress notes revealed a progress note for 5/20/25 at 7:30 PM, Nurses' Notes: Late Entry: Note Text: Resident was observed on porch at approx. 722pm. Resident stated he was waiting for a ride to the store and getting some fresh air. Resident was redirected back into facility and assessed for injury. No injuries observed. When questioned who let him out the resident stated the door was opened for me. Further review of the progress notes revealed an IDT-Interdisciplinary Progress Note, dated 6/9/25 at 3:26 PM, IDT met to discuss resident with recent LOA. Resident went to the front porch of the facility to sit and get fresh air while waiting for his ride to the store. Resident was redirected back into facility and assessed for any injuries as he did not have foot pedals on his chair and was self propelling wheelchair with feet. No injury observed and resident was taken back to his unit for further evaluation/observation for any changes. Resident was able to go out through the doors as they were alarming and opened by family prior with no receptionist at desk at that time. Resident was asked if he signed out and he stated no. Verbal education/reminder to sign out when leaving the facility. Resident stated he was sorry and wound not do it again. A review of the facility policy titled, Code Yellow Drill (Elopement), revealed, Purpose: The purpose of the mock Code Yellow Drill is to evaluate staff competency in the management of a missing resident/elopement . Process for drill: .Upon return to the facility, the Director of Nursing or Charge Nurse should: examine the resident for injuries, Contact the attending physician and report what happened, Contact the resident's responsible party and inform him/her of the incident, Make appropriate notations in the resident's medical record, Complete an incident report . (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility policy titled, Unsafe Wandering and Elopement Prevention, reviewed/revised 1/1/22, revealed, Policy Explanation and Compliance Guidelines: .2. The resident's care plan will be modified to indicate the resident is at risk for elopement episodes. Staff will be informed at shift change of the modifications to the resident's care plan. 3. Interventions for unsafe wandering and elopement attempts will be entered onto the resident's care plan and medical record. 4. Should an elopement episode occur, the contributing factors, as well as the interventions' tried, will be documented on the nurses' notes . Upon return of the resident to the facility, the Director of Nursing Services or Charge Nurse should: .g. Add Resident elopement Risk Identification from with picture to the elopement risk binder .

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This Citation pertains to Intake Number MI00153563. Based on observation, interview and record review, the facility failed to ensure infection control practices were followed and emergency equipment was available for residents with tracheostomy status for four residents (#14, #15, #16 and #17) of four residents reviewed for tracheostomy and oxygen care. Findings include: Resident #15: On 6/10/25 at 11:45 AM, an observation was made with the Director of Nursing (DON) of Resident #15 lying in bed in her room. The Resident did not respond when her name was called. The Resident's head of the bed was elevated and the Resident had oral secretions coming out of her mouth. The Resident had a tracheostomy, and a collar with oxygen. A review of the emergency equipment at the head of the bed revealed an obturator in a bag that was taped to the wall above the head of the bed. When asked where a replacement trach was in the resident's room, the DON was unsure, looked through supplies but did not find the emergency equipment. The oxygen tubing was observed on the floor were the DON and this surveyor were standing, possibly standing on the tubing and oxygen supply was not connected to the trach collar/mask. The Resident was not getting oxygen at the time. The DON was asked to get an oxygen saturation. Two CNA's, CNA Q and CNA FF came to Resident #15's room and applied personal protective equipment (PPE). Unit Manager and this surveyor applied PPE to observe oral care for the Resident and to obtain an oxygen saturation. The DON left to get tubing for the replacement of the oxygen that was on the floor. Unit Manager, Nurse EE came into the room to obtain the oxygen saturation. The CNA's had been in the room. The Unit Manager proceeded to take the oxygen saturation and when asked, reported the oxygen tubing was connected and had been connected since she had come into the room. CNA FF reported that she had placed the oxygen tubing that was on the floor back onto the Residents trach tubing for oxygen supply. The O2 saturation fluctuated in the low to mid 90%. The DON had returned and indicated the tubing had been on the floor and should not be placed back on once it was on the floor. Unit Manager, Nurse EE looked through supplies but was unable to find extra tubing to replace the tubing that was on the floor. Meanwhile, the emergency equipment was looked for and was found on a shelf in the corner positioned behind the phone. When asked about the placement of the emergency trach on the shelf, the Unit Manager reported it would be ok to have it on the shelf due to this side of the Resident's bed was where all the equipment for suctioning and oxygen was. Resident #14: (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/10/25 at 12:15 PM, an observation was made with the Director of Nursing of Resident #14 lying in bed, awake and answered simple questions. The Resident confirmed to come in and seemed to drift off to sleep while we were in his room. An observation was made with the DON of no emergency equipment for the resident at the head of the bed. The DON was asked if there was any in the trach supplies and after inspection of the contents in the area, could not find emergency equipment. The DON stated, I would like to say yes, but indicated emergency equipment for dislodgement of the trach tube was not available at the bedside. The O2 tubing was kinked over and potentially obstructing oxygen supply from entering the corrugated tubing and to the Resident. The DON adjusted the tubing so it was not bent over on itself, reported the tubing had recently been changed and will get educate the person changing the tubing. The distilled water for oxygen equipment use was not dated with an open date. The DON indicated that the water, once opened, should be dated. The canister for suction had discolored secretions in it and did not have a date on the canister. The DON indicated the canisters were to be dated. Resident #16: Resident #16's room was observed. The Resident had been transferred out to the hospital and an observation was made of supplies and equipment remained in the room. The suction canister had secretions inside and there was no date on the canister. The distilled water was opened and stored on the windowsill, opened a partially used. There was not an open date on the distilled water. Resident #17: Resident #17's room was observed. The Resident was not in the room at the time. An observation was made of the oxygen tubing laying in a basin that was on the floor. When asked about facility policy for storage of oxygen tubing, the DON reported the tubing should have a bag available and when not in use, put the tubing in the bag. An observation was made of a lack of a storage bag available for use with the oxygen tubing. Resident #14: A review of Resident #14's medical record revealed an admission into the facility on 2/14/25 and readmission on [DATE] with diagnoses that included acute and chronic respiratory failure with hypoxia, chronic obstructive pulmonary disease, heart disease, kidney disease, stroke, and tracheostomy (trach) status. A review of the Resident's MDS (Minimum Data Set) assessment revealed the Resident was cognitively intact and needed substantial/maximal assistance with toileting hygiene, bathing, lower body dressing and needed partial/moderate assistance with bed mobility and transfers. The Resident had a tracheostomy. A review of Resident #14's medical record revealed a lack of documentation for the size of the trach that the Resident had in the care plan. An order was written on 6/10/25 with a start time of 1:00 PM for Trach Change. Trach brand: shiley Trach size: 6. Directions: every day shift every 3 month(s) starting on the 1st for 1 day(s) for Routine Trach Care and as needed for Trach Change. Nursing Evaluation Summary, dated 2/15/25 revealed the resident admitted on [DATE] with a 6UN75H. A review of Resident #14's orders for oxygen dated 6/3/25, revealed, Oxygen: Run @ (0.5-6)L/min via (route was not specified and hours per day, PRN or continuous was not identified in the order). Resident #15: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235600	A. Building B. Wing	06/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Montrose Inc	9317 West Vienna Road 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)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident #15's medical record revealed an admission into the facility on 5/30/25 with diagnoses that included diffuse traumatic brain injury with loss of consciousness, acute respiratory failure with hypoxia, weakness, need for assistance with personal care and tracheostomy status. A review of Resident #15's care plan revealed the resident was a 2 person assist for bathing, bed mobility, dressing, and toileting and was dependent with 2 person assist and use of mechanical lift for transfers. Further review of Resident #15's care plan revealed a focus for impaired cognitive function related to TBI (traumatic brain injury), encephalopathy and is non-responsive. The care plan for a focus of impaired pulmonary/respiratory status related to tracheostomy status, respiratory failure lacked information of the size of the Resident's trach. The Resident had an order for Oxygen: Run @ 0.5-5L/min via mask, trach, 24 hours per day, continuous, every day and night shift, created on 6/2/25. Resident #16: A review of Resident #16's medical record revealed an admission into the facility on 5/22/25 and was transferred to the hospital on 6/9/25. The Resident had diagnoses that included metabolic encephalopathy, dementia, acute respiratory failure with hypoxia, obstructive sleep apnea and tracheostomy status. A review of the MDS for Resident #16 revealed a Brief Interview of Mental Status score of 13/15 that indicated intact cognition and was dependent on helper for activities of daily living, bed mobility and transfers. Resident #17: A review of Resident #17's medical record revealed an admission into the facility on 5/20/25 and readmission on [DATE] with diagnoses that included metabolic encephalopathy, chronic respiratory failure with hypoxia, and tracheostomy status. A review of facility policy titled, Oxygen Administration, revealed, Policy Explanation and Compliance Guidelines: . 5. Other infection control measures include: .Change oxygen tubing and mask/cannula weekly and as needed if it becomes soiled or contaminated . Keep delivery devices covered in plastic bag when not in use . A review of facility policy titled, Ventilator Unit- Accidental Tracheal Decannulation, revealed, .Procedure: 1. A replacement tracheostomy tube of same size or one size smaller must be readily available .