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	07/09/2025

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 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 Numbers 1205063 and 1205084.Based on observations, interview and record review, the facility failed to ensure that call lights were answered timely and assist with care needs, snacks, and incontinence care in a timely manner for four residents (6, 7, 14, and 18) of eight residents reviewed for call light responses, a Confidential Resident and a Confidential Group of Residents. Findings include: Resident Council: FACILITY According to the group of confidential residents, as of July 1, 2025, during the Resident Council (RC) meeting held between 1:30 PM and 2:30 PM, 15 of 15 Resident Council attendees opted to remain anonymous and asked to keep their identities confidential. One confidential resident stated that the issues brought up by the council do not get resolved and said, Some issues do not go anywhere. All 15 of 15 residents in the confidential group expressed that the call light response time was too long. During the RC Meeting, some residents indicated that grievance forms are filled out, but no one seems to find a solution. Among many grievances brought up by the confidential group of residents, The following were mentioned concerning call lights, consistency of HS snack distribution and ADLs (Activities of Daily Living) assistance not provided: Showers were not received consistently by staff, shower schedules were not followed, and schedule preferences were not honored. One resident reported that he has not received any showers since his return from the hospital. It has been over a month since he last had a shower. Call light response and call light function were an issue. The Resident Council revealed that the main reason for the delayed response is the staff's attitude. Most confidential group of residents (but not all) indicated that staff are L-A-Z-Y (residents spelled it out instead of saying the word). The residents described that staff were mainly busy on their phones, and some prioritized socializing with other staff over responding to the residents' needs. One of the confidential group of residents indicated issues with Incontinence care. She received a delayed call light response and was soaked in urine for 3 hours. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235600	A. Building B. Wing	07/09/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the Monthly RC Meeting Minutes from January through June 2025 revealed the following issues noted as unresolved: February 2025 Date of the RC Meeting: 2/11/25 at 3:30 PM The following unresolved Old Business issues were discussed: Night and day shift CNA staff on cell phones. (no status/update). (The names of the people responsible for each issue were written) Some nursing staff members' approach is rude. (no status/update). (The names of the people responsible for each issue were written) March 2025 Date of the RC Meeting 3/11/25 at 3:32 PM The following unresolved Old Business issues were discussed Water Pass not consistent- Unresolved. (Names of the people responsible for each issue were written) Staffing has been a challenge- Unresolved. (Names of the people responsible for each issue were written) April 2025 Date of the RC Meeting 4/8/25 at 3:27 PM The following unresolved Old Business issues were discussed: HS Snack not available and not distributed. Water Pass not consistent- Unresolved since February. (Names of the people responsible for each issue were written) Staffing has been challenging- unresolved since February. (Names of the people responsible for each issue were written) May 2025 Date of the RC Meeting 5/20/25 at 3:34 PM The following unresolved Old business issues discussed were: HS Snacks are not available consistently - Status: Unresolved since March. (Names of the person responsible for each issue were written) Water Pass Not consistent- unresolved since February. (Names of the people responsible for each issue were written) June 2025 Date of the RC Meeting 6/17/25 at 3:34 PM The following unresolved Old Business issues were discussed: (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	07/09/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	HS Snack unavailable and not distributed in Maple- Status: Unresolved since March (the name of the person responsible for each issue was written) Not seeing the Manager on Weekends- Status: Unresolved since April. (Names of the people responsible for each issue were written) Sandwiches and Juice are not available and not distributed in HS- Unresolved. (Names of the people responsible for each issue were written) The Administrator was interviewed on July 9, 2025, at 11:05 AM. Each of the concerns was discussed and a walk-through was done. R#14 Call Lights A review of R14's Electronic Medical Record (EMR) revealed R14 left Against Medical Advice (AMA) on 6/27/25. R14 was [AGE] years old and was admitted to the facility on [DATE], with a Peripherally Inserted Central Catheter (PICC) placed in the left upper arm for intravenous (IV) antibiotic access to treat local skin and subcutaneous tissue infections. R14 was admitted at the facility with a diagnosis of burns involving 10-19 % of body surface with 0% to 9% third degree burns, Burn of second degree of multiple sites of left wrist and hand, Burn of third degree of right lower leg, Burn (third degree) of the left lower leg and reduced mobility, and need for assistance with personal care in addition to other diagnoses. R 14's Minimum Data Set (MDS) assessment dated [DATE], revealed his Brief Interview of Mental Status (BIMS)Score was 15/15 and Section GG with an assessment date of June 11, 2025 indicated that he required supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes the activity. Assistance may be provided throughout the activity or intermittently), especially in toileting, showers, upper and lower body dressing including putting on and taking off socks or footwear, bed mobility, transfers, and walking 10 feet. R14's Plan of Care was reviewed, reflecting his IV PICC Line for Antibiotic infusion, Wound Care, Monitoring, and treatment regimen. The facility's Quality Assurance (QA) Form was reviewed on July 2, 2025, at 3:00 PM. The QA Form, also known as the grievance form or orange form, was filled out by R14, received by the facility on June 9, 2025. It revealed: Resident (R14) communicated to staff that: I'm gonna kick her out of my room. I don't want her touching me. Resident (R14) described: My beeping was going off for 55 mins. The nurse was not to be found. So, I got fed up with it and took matters into my own hands and figured it out myself. I'm not even certified in that field. I even told her to change my wrap, Nope, not my job. Thinking about Leaving this facility and going to some place that cares!!! (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	07/09/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Nurse S interview by phone initiated on July 2, 2025, at 2:45 PM and followed up on July 10, 2025, at 4:00 PM revealed that Resident (R14) was received at about 12:15 AM on 6/10/25. R14 was still hooked up to his IV medication when I entered the room. The IV was started by Nurse U at 10:15 PM. Nurse S indicated that he unhooked the resident and flushed the PICC line. Nurse S recalled R14 stating that he felt neglected by Nurse U. R14 further described why he felt neglected: R14 stated because he had been asking for his leg dressing changed and the nurse assigned told him that it wasn't her job to change the dressing. Regarding the pump alarm, Nurse S stated that R14 played with the machine until he figured out how to shut it off. R14 complained about having to listen to the beep for 55 mins. Another Nurse (Nurse T) did his wound treatment after NurseS unhooked R14 off his IV tubing. They (Nurse S and Nurse T) worked together to complete the task. Resident was upset and frustrated and stated The treatment had to be done. Furthermore, Nurse S revealed that Nurse U was sent home (walked out) at around 2:00 AM and did not finish her shift on the night of 6/9/25 and 6/10/25, per our Administrator's instruction. All of Nurse U 's residents were reassigned to other nurses. Nurse JJ kept R14 until the end of my shift that evening so I can keep an eye on his concerns and call light response time. Nurse S interview by phone initiated on July 2, 2025, at 2:45 PM and followed up on July 10, 2025, at 4:00 PM revealed that Resident (R14) was received at about 12:15 AM on 6/10/25. R14 was still hooked up to his IV medication when I entered the room. The IV was started by Nurse U at 10:15 PM. Nurse S indicated that he unhooked the resident and flushed the PICC line. Nurse S recalled R14 stating that he felt neglected by Nurse U. R14 further described why he felt neglected: R14 stated because he had been asking for his leg dressing changed and the nurse assigned told him that it wasn't her job to change the dressing. Regarding the pump alarm, Nurse S stated that R14 played with the machine until he figured out how to shut it off. R14 complained about having to listen to the beep for 55 mins. Another Nurse (Nurse T) did his wound treatment after Nurse S unhooked R14 off his IV tubing. They (Nurse S and Nurse T) worked together to complete the task. Resident was upset and frustrated and stated The treatment had to be done. Furthermore, Nurse S revealed that Nurse U was sent home (walked out) at around 2:00 AM and did not finish her shift on the night of 6/9/25 and 6/10/25, per our Administrator's instruction. All of Nurse U 's residents were reassigned to other nurses. Nurse JJ kept R14 until the end of my shift that evening so I can keep an eye on his concerns and call light response time. Nurse T Interview: During the interview, Nurse T stated that she had come to see R14 because she was told to assist with the resident's wound dressing. The wound dressing changes were to be done every shift. Resident (R14) preferred his IV medication and treatment done sooner so he can rest and go to sleep early at night. Meanwhile, Nurse S was nowhere to be found at night. We were paging her and communicating through walkie-talkie, but she was not responding to any of the calls. Nurse S is notorious for missing for prolonged periods during her shift and not responding. A phone call was initiated on June 2, 2025, at 12:30 PM to confirm the statement with the staff, and a follow-up telephone reply was received on July 10, 2025, at 3:48 PM. An attempt to interview Nurse U on June 2, 2025, at 12:55 PM. Nurse U did not return the call. A written statement by CNA W was reviewed on 7/8/25 at 1:35 PM. (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	07/09/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	CNA W statement was based on the Administrator's interview on 6/12/25. According to the written statement, it revealed that on 6/9/25, the CNA did not provide care for R14, but did, however, answer his call light because his IV pump was beeping when CNA went in. CNA W admitted to the Administrator that she turned off R14's call light and told Nurse U over the walkie-talkie. The CNA W received on-the-spot in-service training on June 12, 2025. Description of Education: Call light can not be turned off until resident's needs have been met. A review of CNA V statement dated 6/10/25 was conducted on 7/2/25 at 12:00 PM. CNA V responded to R14's call light, which was going off, and noted in her written statement that R14 was upset about his nurse. He called the facility phone and his call light. CNA V wrote in her statement that she spoke with him on the facility phone and also responded to his call light. R14 was very upset with his nurse. R14 didn't want his nurse in his room. R14 wanted his leg dressing changed and had to wait all night. CNA V reported it to other nurses (Nurse S and Nurse T). R14 calmed down in his room after the dressing change was completed. On 6/9/25-6/10/25 shift at approximately 2:00 PM was sent home for suspension pending investigation. Per the administrator's decision. The Suspension Form was reviewed on 7/2/25 at 245PM. It was noted for Nurse U dated 6/9/25 (Performance Improvement Form) was reviewed on July 2, 2025, at 12:00 PM. It revealed that the reason for counselling or corrective action was: Suspension pending investigation. The entire form was empty. The surveyor did not find the following: Counselling session/corrective action Expected Level of Performance Corrective action plan Time Frame for Improvement Follow-up Review Date NO signature and date from the employee The Administrator admitted that the suspension occurred and did not receive any disciplinary or in-service training regarding what happened. The Administrator revealed that not every staff received any additional education regarding the incident reported on 6/9/25. Resident #6: A review of Resident #6’s medical record revealed admission into the facility on 5/20/25 and re-admission on [DATE] with diagnoses that included chronic respiratory failure with hypoxia, dysphagia, heart failure, and tracheostomy status. A review of the Resident’s Minimum Data Set (MDS) assessment revealed a Brief Interview of Mental Status (BIMS) score of 13/15 that indicated intact cognition, and the Resident was dependent with activities of daily living, mobility and transfers. (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	07/09/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/1/25 at about 1:20 PM, an observation was conducted of Resident #6 sitting in the common area looking out the window. The Resident was interviewed, answered questions and engaged in conversation. The Resident had a tracheostomy. The Resident was asked about call light response times when he uses the call light. The Resident reported he has had to wait a long time for staff to answer. When asked if had to wait longer than 30 minutes, the Resident indicated yes. Resident #7: A review of Resident #7’s medical record revealed an admission into the facility on 4/2/25 with diagnoses that included fracture of the lumbar vertebra, fall, dementia, vertigo, muscle weakness, and need for assistance with personal care. A review of the MDS revealed a BIMS score of 13/15 that indicated intact cognition and needed substantial/maximal assistance with bathing self, dependent on assistance with lower body dressing and toileting hygiene and needed partial/moderate assistance with upper body dressing, transfers and mobility. On 7/1/25 at 1:30 pm, an observation was made of Resident #7 lying in bed and a visitor sitting in a chair across the room. Both the Resident and the visitor had their eyes closed and appeared to be sleeping. The Resident did not respond to a knock on the door and her name spoken. An observation was made of a call light draped over a cord for the bed controls. The head of the bed was elevated and the call light cord hung down over the other cord with the push apparatus touching the floor. The call light was not within reach of the resident. On 7/1/25 at 1:50 PM, an interview was conducted with Resident #7 and Resident Visitor “X” who were both awake and Resident #7 was seated in a wheelchair. The Resident and Visitor were asked about concerns regarding care received at the facility. When asked about call light response times, the Resident reported issues with long call light wait times but was unsure when. When asked if had to wait over 30 minutes, the Resident indicated yes. A review of the facility document titled, “Quality Assistance Form,” dated 5/29 revealed a concern written by a family member for Resident #7. The details revealed, “Mom was left with no call light. She was yelling and crying she had to go to bathroom very bad. You could hear her from [NAME] (Coffee/Deli area) calling for help. Nurse and Aide within ear shot. In care plan to always have call light attached to clothes.” Resident #18: A review of Resident #18’s medical record revealed an admission into the facility on 6/24/24 and readmission on [DATE] with diagnoses that included Parkinsonism, irritable bowel syndrome, dementia, depression, and macular degeneration. A review of Resident #18’s MDS revealed a BIMS score of 15/15 that indicated intact cognition, and the Resident was dependent for toileting hygiene, shower/bathe self, lower body dressing, transfer chair/bed-to-chair, and tub/shower transfer. (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	07/09/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/1/25 at 10:44 AM, an observation was made of Resident #18 lying in bed with the head of the bed elevated. The Resident answered questions and engaged in conversation. The Resident was asked about concerns with call light response times. The Resident reported that his call light does not always work, and he had asked for a new one, but no one has brought one in. When asked to explain, the Resident reported he would show me, picked up his call light and pressed the call light apparatus down, the call light did not go on. The Resident asked if the call light on the wall had a red light. The red light was not on. The call light cord was plugged into the wall and the call light cord was intact. The Resident made another attempt and pressed the call light multiple times, again the call light did not go on. The Resident tried two more times by pressing the call light, there was no call light on over the resident’s door and the red light on the wall hook-up did not show red. On the fifth try, the light turned red at the wall to indicate it was activated. The call light cord plugged into the wall was behind the resident’s head and the resident reported not being able to see it to know that it was activated. The Resident reported calling the front desk at times to let them know he needed assistance, and the Resident stated, “They tell me to put my call light on, and I try but they don’t come… I can’t get someone to help me because it does not work.” The Resident reported that when he had called when the call light was working, he has had to wait “2 hours 45 minutes, 2 and a half hours, sometimes 45 minutes,” and that he has waited for an hour at times. The Resident was asked what he calls for and reported he would call to have his brief changed. The Resident was asked if staff ask him about every two hours to check to see if he needed his brief changed. The Resident stated, “No one asks to change, I have to tell them.” The Resident reported at night being soaked, “sheets wet, shirt wet, I am soaked.” The call light that had been activated at the beginning of the interview with the Resident had been activated for approximately 17 minutes per the clock in the Resident’s room and had not been answered by staff. An observation was made from the hallway at 11:08 of the call light answered. The Nurse Practitioner came out of the Resident’s room and when queried if the Resident had asked for a functioning call light, the NP reported that he had not and was informed of the call light not working properly. Confidential Resident “Y”: On 7/1/25 at 11:10 AM, a Resident was observed in their room sitting in a wheelchair. The Resident was interviewed, answered questions and engaged in conversation. The Resident reported issues with call light response times of staff when she used the call light while having to wait over thirty minutes. The Resident reported having to wait in the bathroom for almost 50 minutes and had a problem sitting on the toilet that long. The Resident reported they knew I was in there, I was waiting for a brief and to get off the toilet and had a hard time after sitting that long. A review of the facility documents titled, “Alarm Event Report” revealed the following call lights/bed exit alerts/bathroom alerts for the room and the documented response times or the amount of time the event was on that were greater than 30 minutes. Room of Resident #18: 6/7/25 11:12 AM Bed A 1hr and 5 minutes; 12:27 PM Bed A 36 minutes; 2:01 PM Bed A 32 minutes; 4:59 PM Bed B 55 minutes; 6:42 PM Bed A 48 minutes; 9:01 PM Bed A 51 minutes. (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	07/09/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6/8/25 10:13 AM Bed A 30 minutes. 6/9/25 10:34 AM Bed A 1hr and 47 minutes. 6/10/25 2:26 PM Bed B 39 minutes. 6/12/25 at 8:23 AM, Bed A, 42 minutes; Bed A 9:31 AM 45 minutes; Bed A 10:27 AM 46 minutes. 6/13/25 9:04 AM Bed B 1 hour (hr) and 4 mins; Bed B 12:50 PM 1 hr and 23 min. 6/14/25 9:22 AM Bed A 57 mins.; 1:01 PM Bed A 41 mins.; 1:07 PM Bed B 47 minutes; 1:59 PM Bed A 41 minutes; 4:17 PM Bed A 56 minutes; 4:33 PM Bed A 56 minutes; 4:33 PM Bed B 39 minutes; 5:55 pm Bed B 1hr and 38 minutes; 6:34 pm Bed A 57 minutes. 6/16/25 10:43 AM Bed B 1hr and 22 minutes; 11:27 AM Bed A 39 minutes; 4:06 PM Bed A 44 minutes; 5:51 PM Bed A 1hr and 49 minutes; 7:56 PM Bed A 51 minutes; 8:11 PM Bed B 39 minutes. Confidential Resident room Alarm Event Report: 6/22/25 6:41AM Bed exit 30 minutes; 11:05 AM Bath Call 35 minutes; 6:22 PM Bed B exit 57 minutes. 6/24/25 10:26 AM Bath Call 33 minutes. 6/26/25 11:28 AM Bed B Exit 1 hr 12 minutes; Bath Call 42 minutes; Bed B Exit 49 minutes. On 7/9/25 at 2:55 PM, an interview was conducted with the State Ombudsman Z regarding issues identified from visits at the facility. The Ombudsman reported being out to the facility in the month of June and receiving complaints of call light response issues and that staff were going into the room to shut off the call light but were unable to meet the Resident's needs and they would shut off the call light, now the resident would have to wait for someone else to come in and stated, They are not getting the response they need. On 7/9/25 at 2:55 PM, an interview was conducted with Unit Manager Q regarding facility policy on call light response times for staff to answer. The Unit Manager reported a target time was less than 3 minutes. The call light system was reviewed, and the call system alert goes to the CNAs pager immediately, then if not responded to the Nurse would get the alert and then at seven minutes, it would go to the Unit Manager. A review of facility policy titled Call Lights: Accessibility and Timely Response, dated reviewed/revised 12/28/23, revealed, Policy: The purpose of this policy is to assure the facility is adequately equipped with a call light at each resident's 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 . 1. Staff are educated in the proper use of the resident call system, including how the system works and ensuring resident access to the call light . 6. Ensure the call system alerts staff members directly or goes to a centralized staff work area. 7. Any staff member who sees or hears an activated call light is responsible for responding. If the staff member cannot provide what the resident desires, the appropriate personnel should be notified.

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	07/09/2025

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. (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	07/09/2025

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	This citation pertains to intake numbers: 1205082 and 1205084. Based on interview and record review, the facility failed to provide prompt efforts to resolve complaints pertaining to prolonged call light response time, food palatability, bedtime (HS) snack distribution, Weekend Manager on Duty (MOD) availability and accessibility for residents, staff attitude in providing quality of care, availability and assistance and to ensure the process to address grievances was understood for confidential group of 15 residents, resulting in unresolved grievances and potential for further frustration. Findings include: Resident CouncilFACILITYAccording to the group of confidential residents, as of July 1, 2025, during the Resident Council meeting held between 1:30 PM and 2:30 PM, they revealed that the Resident Council meets once a month. They requested to remain anonymous and to keep their identities confidential. One confidential resident stated that the issues brought up by the council do not get resolved and said, Some issues do not go anywhere. Some concerns are not followed up on, and no one gets back to us. All 15 of 15 residents in the confidential group expressed that the call light response time was too long. During the RC Meeting, some residents indicated that grievance forms are filled out, but no one seems to find a solution.The following were grievances brought up by the confidential group of residents during the meeting held on 7/1/25 between 1:30 AM and 2:30 PM:Showers were not received consistently by staff, shower schedules were not followed, and schedule preferences were not honored. One resident reported that he has not received any showers since his return from the hospital. It has been over a month since he last had a shower.The call light response and call light function were an issue. The Resident Council revealed that the main reason for the delayed response is the staff's attitude. Most confidential group of residents (but not all) indicated that staff are L-A-Z-Y (residents spelled it out instead of saying the word). The residents described that staff were mainly busy on their phones, and some prioritized socializing with other staff over responding to the residents' needs.The confidential group of residents mentioned that a staff member had an attitude and was incompetent, such as medication errors. Residents also felt that the same staff member they suspected of being under the influence while at work. They have reported the issue to the Administrator, but no action has been taken. This particular nurse still works at the facility.The confidential group of residents, when asked regarding abuse, revealed that they were not fearful at the facility but reported a couple of residents who may potentially cause harm (verbally, physically, or even inappropriate sexual behaviors). Two members of the council revealed that they had reported these incidents to the Administrator but felt they were being swept under the rug.The grievance/concern forms were filled out and submitted, but the issues seemed unresolved. One resident indicated issues with Incontinence care. She received a delayed call light response and was soaked in urine for 3 hours.A review of the Monthly RC Meeting Minutes from January through June 2025 revealed the following issues noted as unresolved:January 2025 Date of the RC Meeting 1/14/2025 at (no time was indicated)The following unresolved Old Business issues were discussed:ABC Station not coming in-status continues. (The names of the people responsible for each issue were written)Fitted sheets are either too small or too large - this remains a concern. (The names of the people responsible for each issue were written)The 700 Shower Room is very cold. (The names of the people responsible for each issue were written)The Internet is not working consistently. (The names of the people responsible for each issue were written)February 2025 Date of the RC Meeting: 2/11/25 at 3:30 PMThe following unresolved Old Business issues were discussed:Night and day shift CNA staff on cell phones. (no status/update). (The names of the people responsible for each issue were written)Some nursing staff members' approach is rude. (no status/update). (The names of the people responsible for each issue were written)March 2025 Date of the RC Meeting 3/11/25 at 3:32 PMThe following unresolved Old Business issues were discussed:Internet connection remains slow. (Names of the people responsible for each issue were written)Water Pass not consistent- Unresolved. (Names of the people responsible for each issue were written)Menu selection not followed- Unresolved. (Names of the people responsible for each issue were written)Staffing has been a challenge- Unresolved. (Names of the people responsible for each issue were written)April 2025 Date of the RC Meeting 4/8/25 at 3:27 PMThe following unresolved Old Business issues were discussed:HS Snacks not available - Unresolved since March. (Names of the people responsible for each issue were written)Water Pass not consistent- Unresolved since February. (Names of the people responsible for each issue were written)The menu selection was not followed. Unresolved since February. (Names of the people responsible for each issue were written)Staffing has been challenging- unresolved since February. (Names of the people

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	07/09/2025

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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	07/09/2025

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake #1205082.Based on interview and record review, the facility failed to protect a resident from abuse and neglect for one resident (R#14) when a nurse on midnight shift neglected to respond to the call light promptly, and did not provide nursing care during IV infusion while the resident's PICC (Peripherally Inserted Central Catheter) machine alarm was sounding for prolonged periods and wound care as needed of a total sample of 3 residents reviewed for abuse and neglect. Findings include:A review of the Facility's Incident Report dated 6/9/25 at 2:00 AM revealed that the resident (R14) alleges that the assigned nurse (Nurse U) neglected to ensure his IV meds were completed timely. The assigned nurse (Nurse U) was suspended, and an investigation was initiated. Further review of the Facility Incident Report, Concluded and wrote: That they cannot substantiate any abuse or neglect for the following reasons:Residents assigned to Nurse U were interviewed. They denied any issues with their nurse, and no concerns were identified.The Nurse U employee file was reviewed, with no prior occurrences noted, and the current license and background checks were verified. No concerns have been validated.R14's care and clinical needs were met with no harm sustained.Met with resident, and he has not sustained any resulting injury or harm. R14's care plan has been reviewed by the IDT team and updated.During the Resident Council Meeting held on July 1, 2025, at 1:30 PM, a group of 15 confidential residents raised concerns and reported that a staff member (Nurse U) was suspected of working under the influence and making medication errors, and questioned her competency as a safe nurse. The confidential group af residents also stated they have reported Nurse U to the Director of Nursing, but Nurse U is still currently employed, and nothing has been done. The confidential group of residents is concerned for their safety and the safety of others who may be affected and harmed.A review of the staff member's (Nurse U) Performance Improvement Form was conducted on July 9, 2025, at 12:00 PM. It was revealed that Nurse U was suspended pending investigation on June 9, 1925, as signed by the Director of Nursing. The details, including the employee's name, Department, Position, and date of Hire, were filled in. The rest of the 2-page form was empty. No counselling, corrective action plan, follow-up, or comments from the employee were found. There was only the DON's signature, signed on June 9, 1925. The entire form was not filled out (empty) except for the employee's details at the top of the page, and it was suspended pending investigation. However, a policy was carefully stapled to the suspension form, titled Substance Abuse and Testing Policy (dated September 22, 2020).The facility's Quality Assurance (QA) Form, also known as the Orange Form or the Grievance Form was reviewed on 7/2/25 at 3:00 PM. The facility received R14's grievance form dated June 9, 1925. (Time of grievance received was not noted.). It revealed: Resident (R14) communicated to staff that: I'm gonna kick her out of my room. I don't want her touching me.Resident (R14) described: My beeping (PICC machine alarm) was going off for 55 mins. Thenursee was not to be found. So, I got fed up with it and took matters into my own hands, figuring it out on my own. I'm not even certified in that field. I even told her to change my wrap. Nope, not my job.Thinking about leaving this facility and going to some place that cares!!!The Quality Assistance Form dated June 9, 2025, was not reviewed by staff after R14 was submitted. The Potential Department Involved and Findings boxes were empty. No Plan/Actions. No signature and Date of the Facility Staff who reviewed and handled the specific grievance.According to R14's discharge progress notes, reviewed on July 9, 2025, at noon, R14 left the facility Against Medical Advice (AMA) on June 27, 2025 The R14 phone interview occurred on June 10, 2025, at 4:0,0 PM, after the surveyor called the number listed in his face sheet on June 9, 2025, at 12:30 PM. R14 explained that he intended not to include his actual phone number in the facility record because he changes his phone number frequently. He instead placed his mother's phone number. R14 acknowledged responding because the surveyor left a voicemail. on 7/9/2025. R14 recalled the incident on 6/9/25. R14 indicated that the nurse assigned to him left after his IV medication was hooked at around 10:00 PM; he did not come back. She (Nurse U) was nowhere to be found.The call light was activated, and the PICC machine pump was sounding according to the resident. R14 stated he even called the nurse's station using his phone, looking for his nurse, but staff could not find his nurse either. She did not respond. Other staff members did try to find her, but were unsuccessful. R14 further stated, All that was needed were two things: 1.) PICC alarm was sounding for an hour, and 2.) my dressing change on my leg. Other staff members were also frustrated because she did not reply, despite being reached using the walkie-talkie. They said she was out of the building. The PICC Pump was sounding for 55 minutes between 11:00 PM and 12:00 Midnight. R14

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	07/09/2025

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to Intake Numbers 1205063, 1205080 and 1205084.Based on observation, interview and record review, the facility failed to provide necessary assistance to honor residents' preferences, choices, or requests to maintain bathing, grooming, nail care and personal hygiene for 6 residents (Resident's #1, #3, #6, #7 #18 and #22) of 7 residents reviewed for Activities of Daily Living/ADL care, resulting in the loss of personal dignity and individuality.Facts and Findings include:Review of the face sheet, physician orders dated 5/26/2025 and Activities of daily living/ADL care plan initiated on 4/16/2025 revealed, Resident #1 was [AGE] years old, alert with a BIMS (cognitive assessment) of 15, admitted to the facility on [DATE] and dependent on staff for supervision and assist of 1 for ADL's including shaving. The resident's diagnosis included, heart disease, respiratory failure with hypoxia, mood disorder, Chronic lung disease, anxiety, and need for assistance with personal care, schizophrenia. On 7/1/25 at 10:45 - Resident #1 Observed resident sitting in wheelchair watching TV. He is unshaven with ~ ¼ inch facial hair throughout neck, chin and upper lip area. The resident states his daughter shaves him when she comes in, she brings in electric razor. He stated the facility told him they don't have enough razors here to shave him. On 7/2/25 at 9 am - Resident #1 Observed in bed watching TV, he was still unshaven (neck, chin and upper lip area). On 7/9/25 at 8:11 am - Resident #1 Observed in bed watching TV, still unshaven ~1/2 inch facial hair throughout chin, neck and upper lip areas. The resident said his daughter has not been in and he is unsure when she is coming next, he would like to be shaved and the Certified Nursing Assistant/CNA came around a few days ago and asked if he would like to be shaved, he told them he wanted to be shaved but they did not come back to do it for him. He was unsure of which CNA he spoke to. Record review of the facility Activities of daily Living/ADL policy states A Resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.Record review of the facility physician orders dated 5/26/2025 and 6/18/2025, stated Clarification: Skilled Occupational Therapy/OT services 5 x times a week x 30 days, neuro re-ed, ADL training, group therapy and wheelchair management for muscle weakness and need for assistance with personal care.Record review of resident's ADL care plan initiated on 4/16/2025, stated ADL interventions; Bathing 1 person assist; Personal hygiene supervision and set up. Resident Council FACILITY According to the group of confidential residents, as of July 1, 2025, during the Resident Council meeting held between 1:30 PM and 2:30 PM, All of the Resident Council attendees (15 total) requested to remain anonymous and to keep their identities confidential. All 15 of 15 residents in the confidential group revealed that the call light response time was too long. During the RC Meeting, some residents indicated: Showers were not received consistently by staff, shower schedules were not followed, and schedule preferences were not honored. One resident reported that he has not received any showers since his return from the hospital. It has been over a month since he last had a shower. (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	07/09/2025

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The call light response and call light function were an issue. The Resident Council revealed that the main reason for the delayed response is the staff's attitude. Most confidential group of residents (but not all) indicated that staff are L-A-Z-Y (residents spelled it out instead of saying the word). The residents described that staff were mainly busy on their phones, and some prioritized socializing with other staff over responding to the residents' needs. One resident indicated issues with Incontinence care. She received a delayed call light response and was soaked in urine for 3 hours. A review of the Monthly RC Meeting Minutes from January through June 2025 revealed the following issues noted as unresolved: January 2025 Date of the RC Meeting 1/14/2025 at (no time was indicated) The 700 Shower Room is very cold. (The names of the people responsible for each issue were written) February 2025 Date of the RC Meeting: 2/11/25 at 3:30 PM The following unresolved Old Business issues were discussed: Night and day shift CNA staff on cell phones. (no status/update). (The names of the people responsible for each issue were written) Some nursing staff members' approach is rude. (no status/update). (The names of the people responsible for each issue were written) March 2025 Date of the RC Meeting 3/11/25 at 3:32 PM The following unresolved Old Business issues were discussed: Water Pass not consistent- Unresolved. (Names of the people responsible for each issue were written) Staffing has been a challenge- Unresolved. (Names of the people responsible for each issue were written) April 2025 Date of the RC Meeting 4/8/25 at 3:27 PM The following unresolved Old Business issues were discussed: HS Snacks not available and not distributed - Unresolved since March. (Names of the people responsible for each issue were written) Water Pass not consistently distributed- Unresolved since February. (Names of the people responsible for each issue were written) Staffing has been challenging- unresolved since February. (Names of the people responsible for each issue were written) (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	07/09/2025

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	May 2025 Date of the RC Meeting 5/20/25 at 3:34 PM The following unresolved Old business issues discussed were: HS Snacks are not available consistently and not distributed - Status: Unresolved since March. (Names of the person responsible for each issue were written) Water Pass Not consistently distributed- unresolved since February. (Names of the people responsible for each issue were written) June 2025 Date of the RC Meeting 6/17/25 at 3:34 PM The following unresolved Old Business issues were discussed: HS Snack unavailable and not distributed at Maple- Status: Unresolved since March (the name of the person responsible for each issue was written) Sandwiches and Juice are not available and not distributed in HS- Unresolved. (Names of the people responsible for each issue were written) The Administrator was interviewed on July 9, 2025, at 11:05 AM. Each of the concerns above was discussed, including a walk-through with the Administrator on finding the posting of the Manager of the Day (MOD) information. The posted names were hidden in the activities calendar, and the text size was too small for residents to read. The names did not indicate their designation as the MOD (Manager of the Day) or why the names were listed, and no contact information was provided in case residents need to report issues during the weekend if the concerns cannot wait until regular office hours. Resident #6 A review of Resident #6’s medical record revealed admission into the facility on 5/20/25 and re-admission on [DATE] with diagnoses that included chronic respiratory failure with hypoxia, dysphagia, heart failure, and tracheostomy status. A review of the Resident’s Minimum Data Set (MDS) assessment revealed a Brief Interview of Mental Status (BIMS) score of 13/15 that indicated intact cognition, and the Resident was dependent with activities of daily living, mobility and transfers. On 7/1/25 at about 1:20 PM, an observation was conducted of Resident #6 sitting in the common area looking out the window. The Resident was interviewed, answered questions and engaged in conversation. The Resident was asked if he had any problems with the care received while at the facility. The stated, “I have only had three showers the whole time I been here. Had one today.” The Resident reported they don’t always take him for a shower on the days he is supposed to get a shower. When asked about a bed bath the Resident reported he did not want any sponge baths and that he wanted to take a shower. An observation was made of the Resident’s nails long and some not well cleaned underneath the nail bed. The Resident reported he did not have clippers, and he could not do them. When asked if the staff had offered to clip his nails when he received his shower today, the Resident reported they have never offered to clip his nails and stated, “I don’t like them this long, never offered at my shower, they were in a hurry, they didn’t clean them, they didn’t clip them.” (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	07/09/2025

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident #6’s medical record of the Task: Bathing, Showers on Tuesday/Friday AM shift for a look back of 30 days revealed a lack of documentation of bathing/shower completed on 6/20 and 6/27. On 7/2/25 at 3:15 PM, Unit Manager “Q” was asked for the bathing sheets for Resident #6 but was unable to find the paper documentation and the documentation was not received prior to the exit of the survey. Resident #7 A review of Resident #7’s medical record revealed an admission into the facility on 4/2/25 with diagnoses that included fracture of the lumbar vertebra, fall, dementia, vertigo, muscle weakness, and need for assistance with personal care. A review of the MDS revealed a BIMS score of 13/15 that indicated intact cognition and needed substantial/maximal assistance with bathing self, dependent on assistance with lower body dressing and toileting hygiene and needed partial/moderate assistance with upper body dressing, transfers and mobility. On 7/1/25 at 1:50 PM, an interview was conducted with Resident #7 and Resident Visitor “X” who were both awake and Resident #7 was seated in a wheelchair. The Resident and Visitor were asked about concerns regarding care received at the facility. The Visitor reported the Resident does not get bathed. The Resident was asked if they preferred a shower or bed bath and responded that she does not get under the shower but cleans up by sponge bath. The Visitor reported she was to get a sponge bath twice a week and stated, “She was supposed to get one on Sunday. I was here all day, no one came in to get her a sponge bath. She has not gotten a sponge bath twice a week.” The Resident reported that she was supposed to have one on the weekend, but no one came to give her one. When asked if staff came after her Visitor had left, the Resident reported no one came and stated, “I never got one.” Resident #18 A review of Resident #18’s medical record revealed an admission into the facility on 6/24/24 and readmission on [DATE] with diagnoses that included Parkinsonism, irritable bowel syndrome, dementia, depression, and macular degeneration. A review of Resident #18’s MDS revealed a BIMS score of 15/15 that indicated intact cognition, and the Resident was dependent for toileting hygiene, shower/bathe self, lower body dressing, transfer chair/bed-to-chair, and tub/shower transfer. On 7/1/25 at 10:44 AM, an observation was made of Resident #18 lying in bed with the head of the bed elevated. The Resident answered questions and engaged in conversation. The Resident was asked if staff ask him about every two hours to check to see if he needed his brief changed. The Resident stated, “No one asks to change, I have to tell them.” The Resident reported at night being soaked, “sheets wet, shirt wet, I am soaked.” The Resident was asked of any issues with getting showers or bed baths. The Resident stated, “I only got one shower last week… Friday, no bed bath or a shower.” The Resident reported their preference was to take a shower and stated, “They ask if I want a bed bath and I said no, I want a shower. They said they will put in for it and I never got it.” (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	07/09/2025

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An observation was made of the Resident’s fingernails being long. The Resident stated, “I don’t like them this long. They say, ‘we don’t have time’, supposed to have it done with my shower.” The Resident reported that staff will tell him they will do nail care when they have time and stated, “They say that ever week, but they never do anything.” A review of Resident #18 medical record for a look back of 30 days of the “Task: Shower/bathe Monday and Friday day shift. Prefers no facial hair. Ensure nails are clean and trimmed”, revealed a lack of documentation that bathing was completed on 6/16/25 and 6/27/25. A review of the progress notes revealed a lack of documentation of a refusal for showers on the days the showers were not documented as received. Resident #22 A review of Resident #22’s medical record revealed an admission into the facility on 6/28/25 with diagnoses that included cellulitis of right lower limb, kidney disease, diabetes, and pulmonary hypertension. 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 supervision or touching assistance with mobility and transfers. On 7/1/25 at 1:10 PM, an interview was conducted with Resident #22 who answered questions and engaged in conversations. The Resident was asked about any issues he had while at the facility. The Resident was asked about getting a shower and the Resident reported he had a shower earlier that day. An observation was made of the Resident’s fingernails that were long. When asked if staff had offered to clip their nails when he was showered earlier, the Resident stated, “No, they didn’t do them. Longer than I like. No, they did not offer.” On 7/2/25 at 12:06 PM, an interview was conducted with the Director of Nursing (DON) regarding a lack of documentation of showers for Resident #6, 7 and 18. The DON reported the Residents might have refused, the staff should follow up with them, offer a different date or time. The DON indicated that the Nurse was to follow up with any refusals and documents. A review of Resident #18’s medical record revealed a lack of documentation of the missed showers and lack of plan to follow up on the missed showers. On 7/2/25 at 3:15 PM, an interview was conducted with Unit Manager, Nurse “Q” regarding missed showers for Resident #6, 7, and 18. An observation was made of shower sheets near the Nursing work area and at the Unit Manager’s office area and the shower sheets were reviewed. The Unit Manager was unable to find a shower sheet for the missed showers for the residents. When asked about facility policy for showers, the Unit Manager reported the Resident should be offered two showers a week and if the Resident refuses the shower, the CNA should notify the nurse and make documentation and follow up with the Resident. On 7/9/25 at 12:15 PM, an interview was conducted with Regional Clinical Director, Nurse “D”. The Nurse was asked about facility policy on nail care. The Nurse reported that it would be the resident’s preference for what they prefer. When asked if the staff should offer during bathing/showers, the Nurse reported that they should be offering that on their shower days. A policy was requested. (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	07/09/2025

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of facility policy titled, “Nail Care,” revealed, “Policy: The purpose of this procedure is to provide guidelines for the care of a residents’ nails for good grooming and health… 3. Routine cleaning and inspection of nails will be provided during ADL care on an ongoing basis. 4. Routine nail care, to include trimming and filing, will be provided on a regular basis and as the need arises…” A review of facility policy titled, Activities of Daily Living (ADLs), date reviewed/revised 12/28/23, revealed, Policy Explanation and Compliance Guidelines: .3. A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene .

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	07/09/2025

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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. (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	07/09/2025

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 0686 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake 1205083 and 1205084.Based on interview and record review, the facility failed to Prevent 2 facility acquired stage II pressure ulcers/PU, for 1 resident (Resident #15) of 3 resident's reviewed for PU's, resulting in 2 facility acquired stage II pressure ulcers, pain, increased risk for infection, antibiotic usage and hospitalization.Findings Include:Review of the Face Sheet, Resident #15's facility care plans dated 3/24/25 through 4/1/25, Physician, Nurse Practitioner and nursing notes dated 3/24/25 through 3/27/25, revealed Resident #15 was [AGE] years old, unable to make own healthcare decisions, admitted to the facility on [DATE], after a severe car accident, had a tracheostomy, feeding tube (G-tube), urinary catheter, dependent on staff for all Activities of Daily Living/ADL's and was a full code. The resident's diagnosis included traumatic subdural hemorrhage, hemiplegia and hemiparesis, acute respiratory failure with hypoxia, tracheostomy status, gastrostomy status, acute kidney failure, and muscle weakness.Review of the facility Skin & Wound Evaluation for Resident #15 dated 4/4/25, stated New Stage 2 pressure (pressure ulcer/PU), in-house acquired.Review of the facility Braden Scale for Predicting Pressure Sore Risk dated 3/31/25, revealed the resident was a score of 10, at High Risk for the development of pressure ulcers upon admission.Review of the facility ADL documentation is as follows:Bed Mobility (Nursing Assistant/CNA documentation):-3/27/25: second and third shift blank (no documentation completed)-3/30/25: second and third shift blank-3/31/25: third shift blank-4/3/25: second shift blank -4/5/25: second shift blank-4/6/25: second shift blankReview of the Physician orders dated 4/4/25, stated L (left) Gluteus daily wound assessment document abnormal's in progress notes. R (right) Gluteus daily wound assessment document abnormal's in progress notes. No documentation of daily wound assessments was found in closed records, nor given to this surveyor by the Director of Nursing/DON.Review of the IDT (Interdiasplinary team) notes dated 4/7/25, stated Writer called to resident's room by floor nurse, stage II pressure ulcers noted to R (right) and L (left) gluteus.Review of the Physician orders dated 4/4/25, stated Cleanse L Gluteus with wound cleanser, pat dry, apply medihoney and cover with bordered gauze daily and PRN (as needed). Cleanse R Gluteus with wound cleanser, pat dry, apply medihoney and cover with bordered gauze daily and PRN.Review of Resident #15's electronic closed record revealed progress notes from Nurse Practitioner NP A, Physician, MD I and Nursing dated 3/24/25 through 4/4/25; no documentation was found of any pressure ulcers/PU assessments of PU's or PU monitoring.During an interview and record review done on 7/1/25 at approximately 12:15 p.m., Wound Nurse, LPN L said she had taken a picture of Resident #15's pressure ulcers on 4/4/25. She pulled up the pictures and showed this surveyor; Rt and Lt coccyx stage 2 pressure ulcers were shown.During an interview with the DON done on 7/2/25 at 11:20 a.m., no documentation of any PU assessments or monitoring (in the progress notes: nursing, nursing practitioner/NP, physician) was found by this surveyor or the DON during electronic closed record review.Review of Physician/Medical Director, MD I History and Physical and assessment dated [DATE], revealed no documentation of any PU's and stated Negative: Wounds, Erythema, Rash, Bruising.Review of the NP A progress notes dated 3/27/25 and 3/28/25, revealed no documentation of any PU's; and stated Case discussed with nursing, no acute concerns. Nurse to notify provider with any change in condition.Review of the Skilled Charting revealed the following:-On 4/1/25: Surgical wound (neck, trach wound)-On 4/2/25: Skin intact-On 4/3/25: Skin intact-On 4/4/25: Wound and Skin assessment, pressure ulcers documented, found.-On 4/4/25: Skilled, surgical wound (neck).Review of CNA task under monitor skin observation are as follows:-On 3/31/25: CNA no documentation of pressure ulcers found.-On 4/1/25: CNA no documentation of pressure ulcers found.-On 4/2/25: CNA no documentation of pressure ulcers found.-On 4/3/25: CNA no documentation of pressure ulcers found.-On 4/4/25: CNA no documentation of pressure ulcers found.Review of the resident's At Risk for Impaired Skin Integrity care plan initiated on 3/24/25, stated staff were to, complete skin inspection weekly, notify nurse of any new areas of skin impairment noted during bathing or daily care (redness, blisters, discoloration, impairment related to medical device/tubing). The care plan identified the resident's surgical: front neck trach stoma as impaired skin integrity on 3/24/25.Review of the resident's Impaired Skin Integrity care plan initiated on 3/24/25, with a revision done on 4/4/25 to include Pressure Stage II: R Gluteus, Pressure Stage II: L Gluteus. The IDT (Interdisciplinary Team) will review each pressure ulcer weekly for progress and changes. Review of the resident's Pressure Ulcer/Skin Breakdown policy dated 10/30/2022, stated Weekly skin evaluation/assessment by the licensed nurse on residents who have no current PU/PI's. Notify Physician and

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	07/09/2025

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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake #1205063.Based on observation, interview and record review, the facility failed to maintain a consistently operational and accessible call light system affecting 5 residents (R7, R10, R11, R18 and R22), Residents residing in the100 hall, 200 hall, 300 hall, 400 and 500 halls, resulting in extended call light times and unmet needs. Findings include: Resident #7 A review of Resident #7’s medical record revealed an admission into the facility on 4/2/25 with diagnoses that included fracture of the lumbar vertebra, fall, dementia, vertigo, muscle weakness, and need for assistance with personal care. A review of the MDS revealed a BIMS score of 13/15 that indicated intact cognition and needed substantial/maximal assistance with bathing self, dependent on assistance with lower body dressing and toileting hygiene and needed partial/moderate assistance with upper body dressing, transfers and mobility. On 7/1/25 at 1:30 pm, an observation was made of Resident #7 lying in bed and a visitor sitting in a chair across the room. Both the Resident and the visitor had their eyes closed and appeared to be sleeping. The Resident did not respond to a knock on the door and her name spoken. An observation was made of a call light draped over a cord for the bed controls. The head of the bed was elevated and the call light cord hung down over the other cord with the push apparatus touching the floor. The call light was not within reach of the resident. On 7/1/25 at 1:50 PM, an interview was conducted with Resident #7 and Resident Visitor “X” who were both awake and Resident #7 was seated in a wheelchair. The Resident and Visitor were asked about their concern regarding the call light not being in reach. The Resident reported that they had a problem before of the call light not in her reach and reported it was supposed to be clipped right on her. A review of the facility document titled, “Quality Assistance Form,” dated 5/29 revealed a concern written by a family member for Resident #7. The details revealed, “Mom was left with no call light. She was yelling and crying she had to go to bathroom very bad. You could hear her from [NAME] (Coffee/Deli area) calling for help. Nurse and Aide within ear shot. In care plan to always have call light attached to clothes.” Resident #18 A review of Resident #18’s medical record revealed an admission into the facility on 6/24/24 and readmission on [DATE] with diagnoses that included Parkinsonism, irritable bowel syndrome, dementia, depression, and macular degeneration. A review of Resident #18’s MDS revealed a BIMS score of 15/15 that indicated intact cognition, and the Resident was dependent for toileting hygiene, shower/bathe self, lower body dressing, transfer chair/bed-to-chair, and tub/shower transfer. (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	07/09/2025

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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/1/25 at 10:44 AM, an observation was made of Resident #18 lying in bed with the head of the bed elevated. The Resident answered questions and engaged in conversation. The Resident was asked about concerns with call light response times. The Resident reported that his call light does not always work, and he had asked for a new one, but no one has brought one in. When asked to explain, the Resident reported he would show the surveyor, picked up his call light and pressed the call light apparatus down, the call light did not go on. The Resident asked if the call light on the wall had a red light. The red light was not on. The call light cord was plugged into the wall and the call light cord was intact. The Resident made another attempt and pressed the call light multiple times, again the call light did not go on. The Resident tried two more times with pressing the call light, there was no call light on over the resident’s door and the red light on the wall hook-up did not show red. On the fifth try, the light turned red at the wall to indicate it was activated. The call light cord plugged into the wall was behind the resident’s head of the bed and the resident reported not being able to see it to know that it was activated. The Resident reported calling the front desk at times to let them know he needed assistance, and the Resident stated, “They tell me to put my call light on, and I try but they don’t come… I can’t get someone to help me because it does not work.” Resident #22 A review of Resident #22’s medical record revealed an admission into the facility on 6/28/25 with diagnoses that included cellulitis of right lower limb, kidney disease, diabetes, and pulmonary hypertension. 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 supervision or touching assistance with mobility and transfers. On 7/1/25 at 1:10 PM, an interview was conducted with Resident #22 who answered questions and engaged in conversations. The Resident was asked about any issues he had while at the facility. The Resident reported not getting lunch or dinner the day before. The Resident was asked if he had called on his call light and stated, “I tried but it wasn’t working.” The Resident complained that he would put the call light on, but no one would answer. When asked to explain about his call light, the Resident reported that he would press the button, but it would not turn on and it had been for a couple days after he arrived that he realized the call light cord was not working. The Resident reported the issue, and he had received a new call light cord. Facility Call Light During the Medication Administration observation conducted on July 1, 2025, at 10:30 AM, the Nurse was observed at 500 Hall passing the resident’s medication when one of the rooms at the end of 500 had a resident yelling out in their room. The surveyor noticed that the pager for the call light and walkie-talkie was on top of the medication cart. (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	07/09/2025

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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted on July 1, 202 at 10:35 AM, at 10:35 AM. Nurse ”R” was asked to explain what the call light system is like at the facility. Nurse “R” indicated that the CNA receives the signal from their pager once the call light is first activated. After a few minutes (if not answered), it continues to vibrate or sound an alarm and will go to the nurses. If not answered, it will be further escalated to the Nurse Managers and the DON (Director of Nursing). While explaining the process, Nurse “R” showed her pager, which indicated that it needed a battery change. Nurse “R” stated, “It needed a battery changed. I forgot to put in fresh batteries at the beginning of the shift. No wonder it was not going off the entire time.” On July 1, 2025, at approximately 11:00 AM, Nurse “R” completed her med pass, which was due, and went to the front office to replace the Hall 500 nurse’s pager batteries. (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	07/09/2025

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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #10R10 is [AGE] years old and admitted to the facility on [DATE] with diagnoses that include heart failure, left above the knee amputation, hypertension and atrial fibrillation. R10 has a Brief Interview for Mental Status (BIMS) score of 14, indicating they are cognitively intact.On 7/1/25, R10 was asked if the staff responded to the call light in a timely manner. R10 replied they can be slow and lately they have been really slow to respond.A review of call light times from 6/23/25-6/30/25 revealed multiple call light response times of 30 minutes or more.6/23/25- 47 minutes6/24/25- 41 minutes6/24/25- 36 minutes6/27/25- 51 minutes6/27/25- 1hr and 2 minutes6/27/25- 39 minutes6/28/25- 31 minutes6/28/25- 48 minutes6/30/25- 30 minutesResident #11R11 is [AGE] years old and admitted to the facility on [DATE] with diagnoses that include legal blindness, type 2 diabetes mellitus, chronic kidney disease and anxiety disorder. R11 has a BIMS score of 15, indicating they are cognitively intact.On 7/1/25, R11 was asked if the staff responded to the call light in a timely manner. R11 responded that on average it can take them about 20-40 minutes to get help. Two urinals were observed hanging from the edge of the garbage can next to the bed, they were both full of urine. R11 was asked if his urinals get emptied by the staff. R11 stated, it can take all day to get them emptied. I am legally blind, and I think they take advantage of that. They should have one person dedicated to answering call lights on every floor. I need help, I can't get up on my own, I need assistance.A review of call light times from 6/23/25-6/30/25 revealed multiple call light response times of 30 minutes or more. 6/23/25- 33 minutes6/25/25- 1hr 9 minutes6/26/25- 31 minutes6/28/25- 2hrs 32 minutes6/29/25- 40 minutes6/30/25- 34 minutes6/30/25- 42 minutesOn 7/1/25 an interview was conducted with Resident Aide (RA) A on the 700 hall. RA A was asked how the call light system works in the facility. RA A stated, the residents press a button, it shows up on a computer screen and also goes to the pagers to alert us it is on. RA A was asked if they had a pager on them. RA A stated, I don't currently have a pager on me but the aide I am training with has a pager on her.On 7/1/25 an interview was conducted with Licensed Practical Nurse (LPN) B on the 300 hall. LPN B was asked how the call light system works in the facility. LPN B stated we have a pager system, the aided have a pager and there is a central screen with call lights that are currently on. LPN B stated that the nurses carry a pager as well, LPN B stated they don't have their pager on them right now. LPN B was asked where the central screen is for the 100, 200, 300 and 400 hall call lights. LPN B stated there is a computer screen located centrally to those halls. LPN B pointed out the screen to this surveyor, it was turned off. LPN B said that is the screen we would use, but it is not functioning right now, it hasn't worked for a bit.On 7/1/25, observation revealed the main computer in the 100, 200, 300, 400 hall is not functioning. This computer screen should show all the call lights that are currently on for those halls, without this screen staff depend on the pager system to know when call lights are turned on. Two staff interviewed did not have pagers present on them. On 7/2/25 an interview was conducted with Maintenance Director C. Maintenance Director C stated they have worked in the facility since February 2025. Maintenance Director C was asked how long the monitor has not been functioning on the 100, 200, 300 and 400 hall area. Maintenance Director C stated it has not been functioning since I got here, that was in February. The staff have pagers that will tell them which lights are on. Maintenance Director C was asked, if staff do not have a pager on in that hall, will they know a call light is on. Maintenance Director C stated, no, they wouldn't have a way to know a call light was on.Review of the policy titled, Call Lights: Accessibility and Timely Response, Policy Explanation and Compliance Guidelines:6. Ensure the call system alerts staff members directly or goes to a centralized staff work area.