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	08/01/2025

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)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 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#: 2569658Based on observation, interview and record review, the facility failed to develop and implement interventions, including monitoring and supervision, to prevent resident-to-resident abuse involving 2 residents of 4 residents reviewed for abuse, including Resident #1 who grabbed Resident #2's hand and placed it on his pants over his genitals, resulting in the potential for additional instances of abusive behavior towards other residents. A review of the Face Sheet indicated Resident #1 was admitted to the facility on [DATE] with diagnoses: History of a stroke, difficulty talking, COPD, history of falls, depression, hypertension, Dementia, arthritis, and GERD.A review of the Face Sheet indicated Resident #2 was admitted to the facility on [DATE] an readmitted on [DATE] with diagnoses: Dementia, diabetes, chronic kidney disease, depression, hypertension, and anxiety.A review of a Facility Reported Incident/FRI revealed on 7/9/2025 Resident #1 was observed by a Staff member, taking Resident #2's hand and placing it on his pants over his crotch (per the Incident summary). The report indicated the two residents were separated and Resident #2 was moved to a different room on the opposite side of the building.A review of a Statement of Witness by Certified Nursing Assistant R dated 7/9/2025 provided, I was in the main dining area, I witnessed (Resident #1) and (Resident #2) sitting close next to each other. Then (Resident #1) took his hand and placed her hand on top of his crotch. I separated the two and told the nurse.There were Psychological assessments by Psychologist O in the FRI investigation for Resident #1:Resident #1 dated March 5, 2025: . Pt (patient) is a [AGE] year-old male seen at (the facility) for capacity regarding personal sexual behavior. his cognition and memory are significantly limited. Pt. has a hx (history) of being involved in resident-to-resident conflict. his cognition and memory are severally limited. Pt. Lacks capacity to understand the limits of physical/sexual contact with a partner with infirmity, and the nuances and limits of verbal consent of a partner. Resident #1 dated February 5, 2025: . Patient was involved in a resident-to-resident conflict.Additional notes by Nurse Practitioner P for Resident #1 revealed the following:Resident #1, dated April 18, 2025, . The patient is being seen for behaviors along with irritability and depression. Staff has been having issues with him touching female residents however he denies any abilities. Staff continue to report his ongoing inappropriate social behavior towards others including but not limited to grabbing at or touching other females, combativeness, agitation and aggression towards staff and others. He is noted to continue to engage in adverse behaviors despite numerous education attempts to intervene and/or redirectResident #1, dated July 10, 2025, . Staff reports the patient had another incident where he had taken his hand and another resident's hand and put them on his lap. The residents were separated. When asking him about the recent incident with the other resident, he reports he was comforting her, they were holding hands and she had no problem with it. Nothing happened. Previously, the patient has displayed verbal aggression and inappropriate social behaviors, particularly with female residents.The following are Psychological assessments/notes for Resident #2:Resident #2 dated April 10, 2025, by Social Worker Q, Unspecified dementia, severe, with other behavioral disturbance, Patient presents with daily yelling out and incidents involving another resident invading her personal space. Resident #2 dated April 18, 2025, by Psychologist O, . The patient is being seen today to monitor for safety and recent allegation. Staff reports they were informed that a male resident may have touched this patient.Further review of the Psychological Assessments for Resident #1 and Resident #2 identified two assessments titled, Capacity for Sexual Consent dated 7/16/2025 by Psychologist O.Each document reviewed the following:1 a. Is the resident aware of who is initiating sexual contact? Yes or No? -No was checked for both residents.1 b. Does the resident believe that the other person is a spouse and, thus, acquiesces out of a delusional belief? Yes or No? -No was checked for both residents.1 b. Is he/she cognizant of the other's identity and intent? Yes or No? - No was checked for both residents.2 a. Does the resident have the capacity to say no to any uninvited sexual contact? Yes or No? - No was checked for both residents.3 a. Does the resident realize that this relationship may be time limited (placement is temporary)? Yes or No? - No was checked for both residents.3 b. Can the resident describe how (he/she) will react when the relationship ends? Yes or No? No was checked for both residents. 4a. Does the resident have the capacity for the reasoning process inherent to sexual consent and Understanding of sexual options, consequences of sexual choices, and consistency with the resident's values and preferences? Resident does not have the capacity to consent to a sexual relationship was checked for both On 7/30/2025 the Administrator was interviewed about the incident on 7/9/2025 when

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

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F 0684 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#: 2566178Based on observation, interview and record review, the facility failed to provide medications, and a right knee X-ray as ordered for one resident (#3) of three reviewed for medications and treatments, resulting in Resident #3 experiencing pain, nausea and delayed treatment. A record review of the Face sheet indicated Resident #3 was admitted to the facility on [DATE] with diagnoses: recent back surgery, neuropathy, anxiety, GERD, hypotension, history of a stroke, weakness, anemia, chronic kidney disease, and depression. On 7/31/2025 at 10: 37 AM, Resident #3 was observed lying in bed awake and alert. He said he had not received his medications for a couple of days after admission and was having pain and nausea. He said he was now receiving his medications but was upset that it took so long. The resident said his right knee had been causing him pain and he said without his pain medication, he felt nauseous. In addition, he was not receiving the medication that he normally took for his stomach upset. He said he was supposed to have an x-ray on his right knee, but it wasn't done until a few days later. A review of the physician orders for Resident #3 indicated he was supposed to receive the following medications: Start date: 5/30/2025 at 8:00 PM - Eliquis 5 mg Start date: 5/30/2025 at 8:00 PM - Atorvastatin 40 mg Start date: 5/30/2025 at 9:00 PM - Topamax 200 mg Start date: 5/30/2025 at 9:00 PM - Tamsulosin 0.4 mg Start date: 5/31/2025 at 7:00 AM - Gabapentin 600 mg Start date: 5/31/2025 at 7:00 AM - Protonix 40 mg delayed release tab Start date: 5/31/2025 at 7:00 AM - Multi-Vitamin Start date: 5/31/2025 at 7:00 AM - Ascorbic Acid oral tab Start date: 5/31/2025 at 7:00 AM - Acetaminophen (Tylenol) 500 mg, 2 tabs for pain Start date: 5/31/2025 at 7:00 AM - Aspirin 81 mg chewable Start date: 5/31/2025 at 7:00 AM - Vitamin D 50 mcg capsule A review of the Medication Administration Records/MARs for May 2025, indicated Resident #3 did not receive any of his ordered medications. On 8/1/2025 at 9:35 AM, the Director of Nursing/DON was interviewed about Resident #3's medications. The May 2025 MAR was reviewed with the DON. She confirmed there was no documentation that Resident #3 had received his ordered medications on 5/30/2025 or 5/31/2025. The DON was asked what time the resident was admitted to the facility, and she said it was approximately 4:00 PM. The DON was queried on the process for ordering the resident's medications and she said the admitting nurse would review the medications on the discharge paperwork from the hospital or other facility and send them to the provider and they would be placed into the electronic medical record/emr Physician orders tab. Reviewed Resident #3 had orders placed in the emr Physician orders tab, but they were not given. The Director of Nursing said they should have been given, and she wasn't sure why they were not. During the interview with the DON on 8/1/2025 at 9:40 AM, she was asked about medications in stock, and she looked at the list of Resident #3's medications and she said some of the medication was available all the time in the medication supply room. The DON provided a list of Inventory on Hand from the medication dispensing system. The list was reviewed and compared to Resident #3's medications that were not received on 5/30/2025 and 5/31/2025. The DON took the medication list to the medication supply room and compared which medications were on the list and available in the medication dispense system. In addition, the DON located which medications were Over the Counter medications and available in stock on the shelves in the medication supply room. All of Resident #3's medications were available to be given with stock on hand except for the Topamax 200 mg. On 8/1/2025 at 10:00 AM, the June 2025 MAR for Resident #3 was reviewed with the Director of Nursing it showed duplicate order entries for some of the resident's medications including: Ascorbic Acid, Aspirin 81 mg, Atorvastatin, Multi-Vitamin, Pantoprazole/Protonix, Tamsulosin, Topiramate/Topamax an anti-seizure medication, Vitamin D, Eliquis, and Gabapentin. Some of the medications were documented as given twice at the same time, once for each entry: Ascorbic Acid on 6/2/2025, Aspirin 81 mg on 6/2/2025, Multi-Vitamin on 6/2/2025, Pantoprazole on 6/2/2025 and 6/3/2025, Vitamin D on 6/2/2025, Gabapentin 600 mg on 6/2/2025 in the morning. The Medication Topamax/Topiramate was not given until 6/2/2025: doses were missed on 5/30/2025, 5/31/2025 and 6/1/2025. The resident had a history of a stroke and did not receive his anti-coagulant medication on 5/30/2025 and 5/31/2025. Resident #3 did not receive pain medication until 6/1/2025. The DON said she would further investigate why Resident #3's medications were not given as ordered. A review of the progress notes for Resident #3 revealed he had repeated concerns about pain in his right knee. A provider note dated 6/3/2025 at 12:37 PM, identified the following: . Patient does report feeling like his right knee will buckle when trying to walk and this is new for him. Patient states he just would like to return home as soon as

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide routine and 24-hour emergency dental care for each resident. (continued on next page)

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	This citation pertains to Intake #2577143.Based on observation, interview and record review, the facility failed to obtain timely dental services for one resident (Resident #4), who fell and injured their mouth area of one resident reviewed for dental care.A review of Resident #4 medical record revealed an admission into the facility on 6/26/25 with diagnoses that included diabetes, end stage renal disease, difficulty in walking and muscle weakness. A review of the Resident's Minimum Data Set assessment revealed a Brief Interview of Mental Status score of 15/15 that indicated the Resident was cognitively intact and the Resident needed setup or clean-up assistance with oral hygiene and substantial/maximal assistance with toileting hygiene, bathing, lower body dressing and needed partial/moderate assistance with transfers. On 7/31/25 at 1:46 PM, an observation was made of Resident #4 sitting in his room on the bed. The Resident was dressed and had a phone that he was talking on but stopped when surveyor approached. The Resident answered questions and engaged in conversation. The Resident was asked about a recent fall that he had. The Resident reported that he was using the computer up in the front lobby area and had seen a wheelchair and proceeded to transfer to the other wheelchair from his wheelchair. The Resident reported falling and stated, I fell and hit my face on the floor. The Resident reported he bit down on his tongue and had blood gushing out of my mouth. The Resident reported when staff arrived, they gave him a towel to soak up the blood and stated, I felt numbness to my mouth. The Resident reported he lost teeth in the front. An observation was made of the Resident with no teeth in the front upper area. The Resident reported he had teeth there before the fall but now they were gone. The Resident was asked if he had broken the teeth in the fall or if the whole tooth had come out, the Resident indicated he was unsure. He was asked if he had seen the teeth on the floor. The Resident reported he was in shock and did not know at the time that he had lost the teeth. The Resident stated, They got knocked out when I fell. The Resident reported that he had told the Administrator (NHA) that he had lost the teeth when he fell. The Resident was asked if he had seen the dentist or if emergency dental services were offered. The Resident reported he had not seen the dentist yet and they did not offer emergency dental services. The Resident reported he has been in pain in his mouth and foot (wound to foot) and that the mouth pain has been since the fall. The Resident reported he had asked to go to the hospital and stated, I asked to go to the hospital. They said we can handle it in-house and see the in-house dentist. I am still in pain, take Norco for pain in my foot and mouth. A review of Nursing Notes in the medical record revealed the following:-Dated 6/29/25 at 6:49 AM, patient was observed on the floor in the reception area. patient had been using the computer in the area and when he was returning to his room, he decided to try to trade his wheelchair with one of the other chairs that were in the area. patient denies hitting his head, and states he was close to a successful transfer but lost his footing and slowly fell forward. he has a small abrasion below his lower lip on the left side. vitals were obtained and wnl. (within normal limits) patient is able to move all 4 extremeties without resistance and denies pain. patient was assisted back into his wheelchiar and returned to his bed in his room.-Dated 6/29/25 at 11:42 PM, Patient had a fall and has been bleeding from his mouth since said fall, after assessment the bleeding was found to be coming from the patients tongue. Provider was notified and after ice and having him apply pressure the bleed as since stop. Staff will continue to monitor.-Dated 6/30/35, History and Physical, .Ears/Nose/Mouth/Throat Positive: difficulty swallowing. Facial Swelling Notes: Bruise/swelling to upper and lower lip due to fall. A review of the facility Quality Assistance Form, for Resident #4 revealed the date communicated/received on 7/16/2025, revealed, .Findings: This writer physically spoke with (Resident #4's name). He stated his concerns were mouth pain, issues with his vision and he states that he would like his phone replaced. He states that he needs to see a dentist and needs assistance with his vision appointment that was rescheduled. He states that his mouth hurts and I informed him that it may take some time for the dental and vision consultants to see him but we will get the order sent to (ancillary health care service group) and put him on the list to be evaluated and treated. with signatures dated 7/18/25. On 7/31/25 at 3:07 PM, an interview was conducted with the Administrator (NHA) and Director of Nursing (DON) regarding Resident #4's fall and injury to his mouth. The DON reviewed the incident report and indicated that incident was recorded as occurring on 6/29/25 at 4:00 am, the Resident was in the front area of the facility, had tried to get into a wheelchair that was in the area and fell. The NHA reported that police had shown up at the facility and were questioning the administrator. The NHA reported that the police had gotten a call and that Resident #4 was alleging he fell and knocked his teeth out. The NHA stated, From what the detective told me, he fell and knocked his teeth