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	11/21/2025

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This Citation Pertains to Intake Numbers 2614165, 2646780, 2646846, and 2674790.Based on observation, interview, and record review, the facility failed to protect residents' rights to be free from sexual abuse and physical abuse by other residents for three residents. Findings include: Review of Facility Reported Incident (FRI) documentation revealed a facility Certified Nursing Assistant (CNA) alleged on 8/18/25, they observed Resident #114 with their hand down Resident #105's shirt while sitting in the dining area. On 11/20/25 at 8:40 AM, Resident #105 was observed sitting at a table in the central/dining area of the unit in front of a TV. When asked questions, Resident #105 made eye contact but did not provide any verbal response. Tears were observed in Resident #105's eyes and they were making gasping noises as though crying. Two other residents, including Resident #114, and CNA H were sitting at the table. CNA H was queried regarding Resident #105 including their tearful, sad facial expression and inability to communicate and revealed they did not know the Resident. At 8:45 AM on 11/20/25, Non-Certified Staff I was asked about Resident #105 ability to communicate and stated, (The Resident) is primarily non-verbal. When asked about the Resident's tearful, sad facial expression, Staff I indicated that was normal for the Resident and stated they have allergies. When queried regarding Resident #114, Staff I revealed the Resident is a 1:1 all the time. When asked if they were aware of an incident involving Resident #105 and Resident #114, Staff I revealed they were aware but had not present when the incident occurred. Staff I was asked if Resident #114 had behaviors prior to that incident and responded that Resident #114 has dementia and gets handsy. Staff I was asked what they meant by handsy and indicated the Resident does not keep their hands to themselves. Staff I then stated, Since he has been a 1:1, it hasn't been an issue. When queried if there were other instances of Resident #114 touching other Residents inappropriately, Staff I replied, Not sure. Staff I was then asked about Resident #114's cognition and replied, (Resident #114) told me they shouldn't have done it. Resident #105 Record review revealed Resident #105 was admitted to the facility on [DATE] with diagnoses which included dementia, Multiple Sclerosis (MS), Cerebral infarction (stroke) with resulting right dominant side hemiplegia and hemiparesis (one sided paralysis) and aphasia (inability to understand or produce speech), and frontotemporal neurocognitive disorder (shrinking of the frontal and temporal brain lobes leading to difficulties with movement, language and communication). Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the Resident was severely cognitively impaired and required maximum to total assistance to complete Activities of Daily Living (ADLs). Review of Resident #105's Electronic Medical Record (EMR) revealed a care plan entitled (Resident #105) has an impaired neurological status related to MS. (Initiated: 8/30/23; Revised: 12/1/23). The care plan included the resolved intervention, Social Services to follow for wellness checks from 8/18/25 (Initiated: 8/19/25; Revised/Resolved: 10/22/25) Review of documentation in Resident #105's EMR revealed the following:- 8/18/25 at 2:34 PM: Social Services Progress Notes. Met with (Resident #105) today due to issue with a male resident. baseline is at severe cognitive impairment. is largely non-verbal. does occasional verbal spontaneous things. attempted to talk with (Resident #105) . Asked her about the encounter with the (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

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	11/21/2025

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	other resident (no response) . did not appear in distress.- 8/19/25 at 8:00 AM: Health Care Provider Progress Notes. Follow-up mood disorder- anxiety post incident from 8/17/25 (sic). Nurse denies any mood changes . Noted with severe cognitive impairment and non-verbal at baseline. does have malignant neoplasm of upper-outer quadrant of left female breast, therefore, intermittent breast pain is expected. Resident #114 Record review revealed Resident #114 was admitted to the facility on [DATE] with diagnoses which included bipolar disorder, depression, adjustment disorder with anxiety, and dementia with behavioral disturbances. Review of the Resident's EMR revealed the Resident was severely cognitively impaired per their Brief Interview for Mental Status (BIMS) score and required supervision to partial assistance to complete ADL's. Review of Resident #114's EMR revealed a care plan entitled, (Resident #114) has behavior(s) related to dementia as evidenced by: restlessness and agitation, combative on occasions. wandering and public indecency, defecating on floor in room, has attempted to urinate on staff. Urinated on doors, floors, med carts. has displayed sexual inappropriateness with staff members and other residents including groping and verbal statements/requests/ believes his 1:1 caregiver is a prostitute. has attempted to go outside without staff . (Initiated: 1/22/25; Revised: 9/15/25) Review of the care plan history revealed public indecency was added on 2/24/25, sexual inappropriateness with staff members was added on 6/10/25, and sexual inappropriateness with other residents including groping was added on 8/21/25.The care plan included the following interventions:- Interventions: offer toilet, offer rest, offer snack, report signs of pain to nurse, family visits, offer westerns on TV (Initiated: 6/10/25)- Re-direct resident with alternative conversation such as horses and farms when making sexually inappropriate statements or requests to staff (Initiated: 8/21/25)- Target behaviors: resisting cares, sexually inappropriate with staff, wandering toward doors (Initiated: 6/10/25)- Observe and document episodes of inappropriate behaviors; notify Physician/NP/PA when behaviors persist or won't de-escalate (Initiated: 1/22/25)- 1:1 supervision for resident safety (Initiated: 8/18/25; Revised: 8/21/25) Another care plan entitled, (Resident #114) prefers to be sexually active (Initiated: 8/21/25; Revised: 8/25/25) was present in Resident #114's EMR. This care plan included the interventions:- Encourage resident to discuss the topic with clinical team members as needed (Initiated: 8/28/25)- Honor resident's preference/rights to engage in sexual activity and provide privacy for resident and competent/consenting partner as needed (Initiated: 8/28/25)- Resident will communicate when they do/don't want to engage in sexual activity (Initiated: 8/28/25) On 11/20/25 at 10:15 AM, Resident #105 and Resident #114 were observed sitting at the same table in the central dining area of the unit in front of the TV. Resident #114 was at the end of the table with a staff member next to them and Resident #105 was sitting on the side at the other end of the table. An interview was conducted with Licensed Practical Nurse (LPN) R on 11/20/25 at 10:20 AM. When queried if they recalled the incident on 8/18/25 involving Resident #105 and Resident #114, LPN R verbalized they did. LPN R was asked what happened and stated, One of the CNAs came and reported it to me. LPN R revealed they reported the incident to the Administrator and/or notified management who had them implement a 1:1 for Resident #114. When queried if Resident #114 had displayed behaviors prior to this incident, LPN R stated, He has been a 1:1 before. LPN R was asked if Resident #114 had displayed sexually inappropriate behaviors prior to this incident and replied, He is a flirt. When queried if they recalled what the CNA had reported to them, LPN R replied, Saw (Resident #114's) hand under (Resident #105's) shirt. When asked if Resident #105 talks, LPN R stated, Maybe one day a week and the other 6 days she is like a mute. When asked if Resident #105 knew what happened, LPN R replied, I don't know. When asked if Resident #105 had any behavioral changes such as tearfulness following the incident, LPN R replied, She had her moments but I don't recall. When queried regarding Resident #114 and Resident #105 sitting at the same table and what they were doing, LPN R indicated staff bring residents out to sit in front of the larger TV in the common area. An interview was conducted with CNA P on 11/20/25 at 11:00 AM. When queried, CNA P verbalized they were familiar with Resident #105. With further inquiry, CNA P revealed they were aware of the incident involving Resident #105 (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	11/21/2025

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	and Resident #114 but were not working when it occurred. CNA P was asked if Resident #105 displayed any behavior changes following the incident and replied, Not sure. On 11/20/25 at 11:05 AM, an interview was completed with CNA T. When asked if they were familiar with Resident #105 and Resident #114, CNA T verbalized they were. When queried regarding the incident on 8/18/25 involving the residents, CNA T revealed they were aware but did not witness that incident. When queried if Resident #114 had displayed other inappropriate sexual behaviors prior to that incident, CNA T responded that they had. CNA T stated, I seen him (Resident #114) reaching in between (Resident #105's) legs. CNA T was asked if Resident #114's hands were above or below Resident #105's clothing and replied, Over her clothes. CNA T verbalized they immediately separated the Resident's and reported the incident to the nurse. When asked if Resident #114 said anything, CNA T stated, (Resident #105) said I not doing nothing. When queried regarding Resident #105's response to the situation, CNA T stated, (Resident #105) kind has a look like what going on. CNA T was queried regarding Resident #105's cognition and replied, I think he knew what he was doing and did it to her (Resident #105) because she nonverbal. CNA T was asked if they recalled the name of the nurse the incident was reported to and revealed they could not remember. When asked what the nurse said and/or did after they reported what they saw, CNA T revealed they were unsure. CNA T stated, I told the nurse and the other aides (CNAs) and they were like he been doing that. When asked if this incident occurred prior to or after the incident on 8/18/25, CNA T revealed it was before the 1:1 sitter was implemented for the Resident and stated, Early August. When asked if anyone else had spoke to them about what they observed, CNA T revealed they spoke to the (former) Director of Nursing (DON) the day after the incident. CNA T stated, I told the (former) DON and they said no one reported it. When asked if they wrote a witness statement regarding what they saw, CNA T stated, I don't recall. I remember the (former DON) taking notes. When queried if Resident #114 displayed sexually inappropriate behaviors towards staff, CNA T replied, He try to be touching staff. When queried regarding inappropriate verbalization by Resident #114, CNA T revealed they heard Resident #114 talking about a CNA having a nice butt. An interview was attempted to be completed with Resident #114 on 11/20/25 at 11:20 AM. When spoken to and asked questions, Resident #114 responded in an abrasive manner/tone. When queried if they had a romantic relationship or wanted to have a romantic relationship with another resident in the facility, Resident #114 stated, You're a smartass aren't you. The 1:1 staff member assigned to Resident #114 stated that was very normal for Resident #114. On 11/20/24 at 11:30 AM, Resident #105 was observed laying in their room in bed with their eyes open. When spoke to, Resident #105 made eye contact but did not provide any verbal responses. Review of facility investigation documentation related to the incident included the following documentation:- Undated interview form for Resident #105, written by the former DON which specified, Resident was questioned if someone touched her stated, ?Yes.' Asked where she was touched and was silent for a moment then lowered eyes to breast area. Questioned if she was touched there. She said yes, they hurt. Questioned if felt safe, she said yes.- 8/18/25 at 11:09 AM: Incident and Accident (I and A) Report for Resident #105. The I and A detailed, Alleged Abuse. Resident had just returned from appointment and was sitting in the dining room in wheelchair waiting for lunch when a male resident came up beside them in their wheelchair and placed hand inside shirt. Resident was returned to their room for follow skin assessment. Resident was asked if she was touched by another person and said yes, Resident was asked if she had pain/discomfort anywhere and lowered her eyes to her breast area. When asked they were tender she stated yes. - 8/18/25 at 11:09 AM: I and A Report for Resident #114. The I and A detailed, Alleged Abuse. CNA observed Resident putting his hand down female resident's shirt while sitting in dining room. - Staff X Typed and Signed Statement dated 8/18/25: I walked into the main dining at the table in front of the TV. I saw (Resident #114) leaning in towards (Resident #105). I did not see (Resident #114's) hands as I was walking up from behind the two residents. - LPN R Typed and Signed Statement dated 8/18/25: I did not see any interaction between (Resident #114) and (Resident #105). (CNA Q) had brought (Resident #105) to the nurses' station and (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	11/21/2025

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	told me what happened. We put a 1:1 on for (Resident #114). - CNA Q Typed and Signed Statement, dated 8/18/25: I saw (Resident #114) and (Resident #105) sitting at the table next to the TV . (Resident #114) had his hand down (Resident #105's shirt. I immediately separated the two residents and told (Resident #114) that is not okay to do that. I took (Resident #105) to the nurses station and told (LPN R) what happened. (Resident #105) did not seem to be in distress. - Printed face sheet, progress notes, and care plan documentation from both Resident #105 and Resident #114's EMR. - Body Audit and Resident Interview form with the questions, Do you have concerns regarding your safety? Yes/No and Has another resident touched you inappropriately? Yes/No. - Typed Summary of Incident, dated 8/18/25, which included medication information for both residents and interviews detailed above. The summary conclusion indicated both Resident #114 and Resident #105 were cognitively impaired, Resident #114 did not recall the incident, and Resident #105 did not have any adverse effects following the incident. The summary revealed the facility confirmed Resident #114 touched Resident #105's breasts but further specified, cannot substantiate that abuse has occurred as (Resident #114) does not have the capacity of understanding their actions. An interview was completed with Transportation CNA Q on 11/20/25 at 12:52 PM. When queried regarding the incident involving Resident #105 and Resident #114 on 8/18/25, CNA Q revealed they were walking through the central dining room area and saw Resident #105 and Resident #114 sitting at the table in front of the TV. CNA Q stated, (Resident #114) had his hand down (Resident #105's) shirt. When asked to explain how Resident #114 their hand down Resident #105 shirt, CNA Q explained Resident #114 had their hand down the top of Resident #105's shirt from the neckline. CNA Q was asked if Resident #114 was reaching for Resident #105's breast and replied, Oh yeah. When queried what happened next, CNA Q stated, I said (Resident #114) that is inappropriate. CNA Q was asked if Resident #114 responded to them and replied that Resident #114 said they weren't doing anything. CNA Q then stated, I had to physically move his hand. CNA Q verbalized they separated the Residents. When queried what Resident #105 was doing when Resident #114 had his hand down their shirt, CNA Q stated, I don't think she really comprehended. CNA Q was asked if Resident #105 was looking at Resident #114 and replied, No, she was staring ahead at the TV. CNA Q stated, When I pulled (Resident #105) away I asked her if she was okay and she didn't respond. When asked if they had observed any prior interactions between Resident #105 and Resident #114, CNA Q replied, (Resident #114) would sit by (Resident #105) at that table. Incident and Accident (I and A) Reports Resident #114 and Resident #105 from 1/1/25 were requested from the facility Administrator on 11/20/25 at 1:15 PM. Review of documentation in Resident #114's EMR revealed the Resident had history of verbal and physical behaviors. Documentation revealed the following: - 1/22/25 at 9:40 PM: Nursing admission Evaluation. Summary. Resident arrived via ambulance and was seen in ER. A&Ox1 (Alert and Orientated to self) . can be very rude and angry. refusing skin assessment at this time. Stating ?there is nothing wrong with me get the hell out of here, I don't even know why I'm here and I don't need some young broad looking at my dick.' . - 2/9/25: Health Care Provider Encounter. Patient with increased behaviors, urinating on floor, eating food from old trays, etc. - 2/10/25: Health Care Provider Progress Notes. On 2/8/25, the DON (Director of Nursing) reports patient with the above: urinating on floor, eating food from trays, verbally aggressive with staff. Per discussion with patient and family, states that behaviors are not new. - 2/24/25 at 4:38 AM: Pertinent Charting-Behavior. Event date: 2/23/25. Resident has been exit seeking. told no and became aggravated and aggressive with staff, walking in the hallways with . no shirt on. Resident keeps going over to ST (Short Term) and walking in other residents room on LT (Long Term). - 2/24/25 at 1:16 PM: Pertinent Charting-Behavior. Event date: 2/23/25 Resident removing clothing throughout morning. When staff approached to assist with donning clean clothing resident became agitated and verbally aggressive. Attempt to redirect unsuccessful. - 2/27/25 at 12:01 PM: Pertinent Charting-Behavior. Resident up in w/c (wheelchair) to dining room for lunch. Does become verbally agitated when staff attempted to re-direct when resident attempts to urinate on floor. - 3/1/25 at 11:16 AM: Pertinent Charting-Behavior. Resident up in w/c (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	11/21/2025

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	(wheelchair) to dining room for lunch. Does become verbally agitated when staff attempted to re-direct when resident attempts to urinate on floor. - 3/17/25 at 11:07 PM: Pertinent Charting-Behavior. Resident. becoming aggressive with staff. - 3/27/25 at 3:49 PM: Pertinent Charting-Behavior. Resident responded aggressively to CNA when toileting. - 5/4/25: Pertinent Charting Follow-up -Behavior. Resident redirected from female resident's room this AM. Became agitated upon re-direction. also making inappropriate comments to female staff and attempted to touch this writer's buttocks. - 5/5/25: Pertinent Charting Follow-up -Behavior. Resident continues to make inappropriate comments, that are in a sexual nature, to staff. Staff attempts to redirect with little to no improvement to behaviors. - 5/8/25 at 1:07 PM: Pertinent Charting-Behavior. Resident making inappropriate comments, that are in a sexual nature, to female staff. Redirection given with little to no improvement to behaviors. - 5/10/25 at 10:08 AM: Pertinent Charting-Behavior. Resident making inappropriate comments, that are in a sexual nature, to female staff. Redirection given with little to no improvement to behaviors. - 5/11/25 at 11:08 AM: Pertinent Charting-Behavior. Resident making inappropriate comments, that are in a sexual nature, to female staff. Redirection given with little to no improvement to behaviors. - 6/10/25 at 5:29 PM: Nursing Evaluation Summary. inappropriate at times with staff redirection from staff for appropriate behaviors - 6/17/25 at 10:51 PM: BH -Psychology Follow-up Visit. seen today for follow-up psychotherapy/behavior management purposes. He is seen in the common area and presents with typical mood/baseline. Staff additionally report episodes of resisting care, making sexual inappropriate comments and/or actions, becoming verbally aggressive, and voiding/defecating in inappropriate places. can be difficult to redirect and is impulsive as well as agitated at times. Staff continue to promote the safety and general wellbeing for him and fellow residents. - 6/25/25 11:03 AM: Pertinent Charting-Behavior. making sexual comments toward this nurse. - 6/26/25 3:20 AM: Pertinent Charting-Behavior. making sexual comments toward this nurse. - 7/4/25 at 4:54 PM: Pertinent Charting-Behavior. making sexual comments toward staff. Sitting in wheelchair in dining room waiting for dinner to be served. - 7/25/25 at 8:07 PM: Pertinent Charting-Behavior. going into other resident's rooms. - 7/30/25 at 1:56 PM: Pertinent Charting-Behavior.resident was in dining room for lunch, began to pull his brief down and urinate on floor. - 8/7/25 at 6:35 PM: BH -Psychology Follow-up Visit. seen today for follow-up. presents with a flat affect, easily irritated at times and does not want to engage much.gets irritated when asked questions. Staff reports the patient can be agitated and impulsive at times, voiding and defecating in inappropriate places at times, and resisting care. Recent incident on 8/5 documented patient yelling and cussing at staff. Staff had reported behaviors including refusing showers, voiding in inappropriate places, attention seeking, impulsivity, and exit seeking.Psych History. Prior outpatient psychiatric treatment. History of one suicide attempt with a gun. Social Psychiatric: Staff reports the patient refuses showers at times, has been voiding in inappropriate places, attention seeks, impulsive at times, and exit seeks. Staff reports. yelling and cussing at staff. Patient is currently his own person but has a guardianship hearing scheduled. Attention/Concentration- Good. Judgement- Impaired . Insight- Impaired. Thought Process- Organized with redirection. Flight of Ideas- Mild. Loosening of Associations- None. Thought Content- No paranoia or hallucinations. Social Psychiatric. History of noncompliance, resisting care, sexual inappropriateness, agitation, adjustment disorder with mixed mood symptoms (anxiety, depression, irritability), and insomnia. Currently, the patient is reported to be increasingly verbally aggressive and exhibit exit-seeking behaviors. - 8/18/25 at 8:00 AM: Health Care Provider Progress Notes. seen for increased behaviors. This morning, nurse reports patient with inappropriate behaviors. placed on 1:1. Nurse states that patient is currently on behavioral charting, stating (Resident #114) refuses ADL care and removes supplemental oxygen throughout the day. No recent reports of exit seeking. continues to ambulate without assistance. redirected majority of the time. - 8/18/25 at 2:32 PM: Pertinent Charting-Behavior. Resident witnessed approaching a female resident inappropriately. - 8/18/25 at 3:21 PM: Social Services Progress Notes. met with (Resident #114) due to incident with. a female resident. (Resident #114) stated his stomach is upset today (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	11/21/2025

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	because of 'everything happening'. When asked what had him upset, he just said that he is not sure why, but he has someone with him at all times and that makes him upset. cannot remember the event. - 8/19/25 at 1:29 PM: IDT-Interdisciplinary Progress Note. IDT met to discuss resident with recent behavior. Resident was in dining room in his wheelchair a female resident was near him in her wheelchair and resident was observed to be touching the female resident. - 8/19/25 at 9:41 PM: BH -Psychology Follow-up Visit. seen today per facility request for follow-up psychotherapy/behavior management purposes regarding a recent incident with another resident. currently on a one-to-one and presents with flat affect and is somewhat irritable. Staff previously reported episodes of resisting care, making sexual inappropriate comments and/or actions, becoming verbally aggressive, and voiding/defecating in inappropriate places. Evaluation. no acute distress. eye contact: poor, level of consciousness: alert. demeanor: irritable. judgment: impaired, insight: impaired, impulse control: poor, displays increased impulsiveness. - 9/13/25: Pertinent Charting-Behavior. Resident was confused on what the 1:1 duty was. When the aide tried explaining to resident, he proceeded to say he thought (staff) was there to have sex with him. - 9/15/25: Pertinent Charting-Behavior. Resident making sexually explicit comments to this writer. Re-direction given with a response of ?I thought you would like it'. Review of the Resident #114's Documentation Survey Report in the EMR revealed the task, TARGET BEHAVIOR 2: sexually inappropriate with staff (touching staff, sexual statements or requests such as ?will you suck off'). There was documentation indicating the Resident displayed these behaviors six times on 8/1/25, 8/4/25, 8/5/25, 8/15/25, 8/19/25, and 8/21/25. Review of facility provided I and A reports for both Resident #105 and #114 revealed no additional reports related to inappropriate sexual behavior and/or sexual abuse.An interview was completed with the facility Administrator on 11/20/25 at 2:15 PM. When asked if Resident #114 had attempted and/or touched Resident #105 and/or any other resident inappropriately prior to the incident on 8/18/25, the Administrator stated, This one was the only one. When asked if Resident #114 had a known history of inappropriate sexual behavior and/or verbalization with facility staff, the Administrator confirmed they did. The Administrator was then queried regarding how Resident #114's sexually inappropriate behavior was monitored/documented and stated, We have the task (documentation) to monitor. When queried regarding facility expectations if a resident displays sexually inappropriate behavior, the Administrator responded that Resident #114 was put on 1:1 staff member as soon as we noticed Resident #114 had touched Resident #105's breast. When queried regarding documentation specifying Resident #114 had started to display sexually inappropriate behaviors in May 2025 and care plan not being revised until June 2025, the Administrator indicated they would need to review the Residents EMR. When asked why there were no specific care plan interventions implemented at that time to address the Resident's sexually inappropriate behavior, the Administrator replied, I will talk to the team and get back to you. The Administrator was then queried if any other staff were interviewed as part of the abuse investigation and responded they did not have any additional documented interviews. The Administrator was then informed of staff interview where the staff member stated they spoke to the former DON regarding an observation of Resident #114 placing his hands between Resident #105's legs prior to the allegation related to touching their breast. The Administrator stated they were not aware of prior instances and would need to follow up. On 11/21/25 at 9:20 AM, an interview was completed with Social Services Director J. When queried regarding Resident #114, Director J confirmed they were aware of the Resident and the incident which occurred involving Resident #105. Director J was then asked if a resident who displays sexually inappropriate behavior with staff may also display sexually inappropriate behavior with other residents and verbalized that was reasonable. When queried if Resident #114 had a known history of sexually inappropriate behavior with staff prior to the incident on 8/18/25 where they were observed touching Resident #105's breasts, Director J verbalized they did have a history of sexually inappropriate verbalization and touching with staff. Director J was then queried regarding interventions for residents with known sexually inappropriate behaviors such as increased monitoring and stated, Yes, due to (Resident (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	11/21/2025

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	#114's) known heightened sexuality with staff with female residents especially female residents who cannot talk. Director J was then asked if interventions for potential concerns due to sexual comments/behaviors with staff should be care planned and replied, Yes. When queried what type of interventions would they anticipate and/or what would be appropriate, Director J stated, Increased supervision when out of room. Director J continued, I like to keep them (Residents) busy and indicated they would also encourage engagement in supervised activities. On 11/21/25 at 9:35 AM, Registered Nurse (RN) Y verbalized they would like to review Resident #114's behaviors and care plan and an interview was completed with RN Y and Social Services Staff AA. RN Y stated, When (Resident #114) was first admitted , he had dementia behaviors - urinating and defecating on the floor and indicated their behavior care plan was initiated at that time. When queried what occurred when the Resident stated displaying inappropriate sexual behaviors towards staff in May, RN Y stated, They updated the care plan. When asked why the care plan was not updated until June, an explanation was not provided. When queried what interventions were added to the care plan related to the inappropriate sexual behaviors, RN Y replied, It was on the care plan already and revealed the intervention they were referring to was to observe and document episodes of inappropriate behaviors; notify Health Care provider when behaviors persist or won't de-escalate and to keep engaged in positive interactions. When queried regarding the potential for sexually inappropriate behavior directed towards staff to also be directed towards other residents, SS Staff AA stated, Not an assumption that will automatically move from staff to residents. When asked if there is potential, an explanation was not provided. On 11/21/25 at 10:00 AM, Resident #114 was observed in their room sitting in a wheelchair with CNA BB present. After CNA BB stepped out of the room to allow for a private interview Resident #114 was asked if they had touched a female residents breasts. Resident #114 replied, Breast, you mean titties? Resident #113 then said, Like this and make grabbing motions towards interviewer's breasts. This interviewer backed away from Resident #114 and the Resident said, I'm not going to grab them. Resident #114 laughed and then stated while still chuckling, I didn't grab yours, and I don't remember grabbing anybody's. At 10:05 AM on 11/21/25, an interview was completed with CNA BB. When asked, CNA BB revealed they were covering for Resident #114's assigned sitter but were familiar with the Resident. CNA BB was asked if they have heard Resident #114 make any inappropriate sexual comments and/or other sexual behaviors and stated, I don't really want to repeat it. It is not appropriate things to say. After assuring CNA BB what they said would not be interpreted as their words, they verbalized Resident #114 says things like, She's got a really nice ass, Look at those titties, and I'd like that when women go by. An interview was completed with the facility Administrator on 11/21/25 at 10:15 AM. The Administrator was informed of interview completed with Resident #114 and the Resident making grabbing motions towards interviewer's breasts and stated, Well all men know what they are. When asked what willful means and if Resident #114's actions were willful when they put their hand down Resident #105's shirt and touched their breasts, the Administrator stated, I am not going to answer that. I will have to get back to you. On 11/21/25 at 11:47 AM, a follow-up interview was completed with the Administrator. The Administrator was asked what willful means in regard to sexual abuse in cognitively impaired residents and stated, I can't answer that. When asked if Resident #114 displayed repeated inappropriate sexual behaviors, with both staff and Resident #105, the Administrator did not provide a response. When asked what would be considered repeated behaviors, the Administrator did not provide a direct response and stated, It depends on the situation. The Administrator was asked again what intent means and did not provide an ex

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	11/21/2025

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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This Citation Pertains to Intake Number 2648479. Based on interview and record review, the facility failed to implement and operationalize policies and procedures to ensure comprehensive discharge planning and a safe discharge home for one resident (Resident #110) of three residents reviewed for transfer/discharge. Findings include:Review of intake documentation, dated as received 10/15/25, revealed a concern that Resident #110 was discharged from the facility without coordination of care for resumption of care with home services including transportation for dialysis, necessary Durable Medical Equipment (DME)/supplies, and training to family care givers. On 11/19/25 at 1:56 PM, an interview was completed with Agency on Aging Witness FF. When queried regarding Resident #110's discharge from the facility, Witness FF revealed the Resident had been discharged on 10/14/25 without any coordination of care and/or agreed upon notification to the local Agency on Aging, no DME equipment, no training to the Resident's family, and no transportation to dialysis. Witness F further disclosed the facility did not contact the Agency on Aging to set up an evaluation in the facility to resume services upon discharge. When queried if the facility was aware that an evaluation needed to be completed, Witness F verbalized the facility was aware as they had contacted the facility multiple times throughout Resident's stay. With further inquiry regarding the discharge, Witness FF disclosed Resident #110 was discharged from the facility, sent to dialysis and then home via ambulance services after dialysis was completed. Witness FF stated, They didn't even take (Resident #110) to the right address! When asked to explain, Witness FF revealed the ambulance originally took Resident #110 to an address they had lived at years ago. Witness FF verbalized when they got Resident #110 to the correct address, Family Member GG, who was going to be taking of Resident #110, did not have any of the necessary DME equipment to provide care and had not received any training for the Resident's drain/wound and/or how to transfer the Resident. Witness FF verbalized Resident #110 required a hospital bed and a mechanical lift which the resident did not have. Witness FF stated Family Member GG were unable to safety provide care to Resident #110 and the Resident was taken the hospital emergency room (ER). When asked, Witness FF revealed Resident #110 went back to the facility from the ER and it took almost two weeks for the facility to arrange the necessary equipment and training for the Resident to be discharged home safely. Review of Resident #110's Electronic Medical Record (EMR) revealed the resident was admitted to the facility on [DATE], discharged and readmitted on [DATE], and discharged again on 10/29/25 with diagnoses which included cerebral infarction (stroke) with resulting hemiplegia and hemiparesis (one sided paralysis), heart failure, gallbladder and bile duct obstruction with cholecystostomy tube (tube inserted through the abdomen wall to the gallbladder to drain/release bile), diabetes mellitus, and end stage renal disease with dialysis dependance. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the Resident was cognitively intact and required moderate to total assistance with toileting, dressing, and bathing. Review of Resident #110's care plans revealed a care plan entitled, (Resident #110) has an ADL self-care performance deficit related to decreased functional mobility and physical limitations. (Initiated: 8/14/25; Revised: 8/15/25). Review of the care plan interventions revealed the Resident required two-person assistance for dressing, bed mobility, bathing, toileting, and utilized a mechanical Sit to Stand lift with two person assist for transfers. A care plan entitled, (Resident #110) plans to discharge Home with family. HCC (Home Health Care) (Area Agency on Aging Services), DME Walker, WC (Wheelchair), bathchair, toilet riser. (Initiated: 8/14/25; Revised: 8/22/25). The car plan included the interventions:- Encourage resident/family/responsible party to participate in the discharge planning process (Initiated: 8/14/25)- Involve specialized home care agencies and appropriate community support services as needed for safe discharge (Initiated: 8/14/25)- Provide resident/family/responsible party with written instructions upon discharge to ensure a safe return to (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	11/21/2025

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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the community (Initiated: 8/14/25) Review of Resident #110's EMR revealed the following:- 10/14/25 at 10:15 AM: Discharge to Home/Community. Social Services Recap: (Resident #110) is returning home after dialysis with (Ambulance). (Agency on Agency) will follow up once home and homecare. and follow up with PCP for hospital bed. - 10/14/25 at 3:57 PM: Hospital Emergency Documentation. ED Note Physician/Provider. Chief Complaint. Per EMS (ambulance) pt was picked up from (facility) and supposed to go home, however they got to (Resident #110's) house and no equipment was set up at this time and family cannot take care of (Resident). presenting to the emergency department for establishment of home health . discharged from (facility) today.without hospital bed or any equipment. reportedly bedbound at baseline. admitted to hospital for social work/case management as in not currently safe for discharge home at this time. Patient has been discharged from (facility) and per EMS, they will not accept (Resident) back. - 10/14/25 at 5:56 PM: Social Services Progress Notes. Correction for prior note dc 10-14. Writer called and spoke to (Agency on Aging) and sent email resident's information and asked can you please come see at facility this week? . Spoke. NP (Nurse Practitioner) and Nurse and they said (Resident #110's) niece came in all day Monday for training and said is all good with training and that (Resident #110) has everything at home and is squared away.Note: Resident #110's nieces was not the Resident's at home care provider and was not listed on the Resident's face sheet as an emergency contact. The EMR did not identify the niece's name and/or contact information.An interview was completed with Social Services Director J on 1/19/25 at 3:07 PM. When queried if they were working when Resident #110 was discharged from the facility on 10/14/25, Director J replied, I was in the building, yes but revealed they were not involved in the discharge. When asked who coordinated the Resident's discharge, Director J responded, Social Worker (SW) Z. When asked, Director J revealed SW J was no longer employed at the facility. When queried what happened with Resident #110's discharge, Director J stated, Was attempted to be discharged home. Director J was asked what they meant when they said attempted, and verbalized Resident #110's family were unable to care for the Resident at home because they did not have the DME equipment necessary to take care of them and had not received training for transferring and wound/cholecystostomy tube care. Director J revealed the Resident was discharged on 10/14/25 abd returned the same day. When queried what family member was going to be the Resident's care provider at home, Director J responded, Their grandson (Witness GG). When asked why documentation in the EMR referred to Resident #110's niece receiving training when their niece was not taking care of them after they were discharged , Director J was unable to provide an explanation. With further inquiry, Director J revealed they did not know who the niece was and that Witness GG should have been the individual who received training as Resident #110 was going to be living with them. When queried what equipment Resident #110 needed at home to be discharged safely, Director J indicated they would need to review the EMR. The Discharge to Home/Community. assessment was reviewed with Director J when queried why the document indicated the Resident would need to follow up with their PCP (Primary Care Provider) on 10/22/25, over a week after they left the facility for a hospital bed, Director J was unable to provide an explanation. When asked if the Resident needed a hospital bed at home, Director J responded that they did. When queried how the Resident transferred, Director J replied that Resident #110 utilized a mechanical lift. When asked if the Resident had a mechanical lift at home, Director J confirmed they did not. When queried regarding transportation to and from dialysis, Director J verified the facility had not set up transportation or ensured Resident #110 had transportation to and from dialysis. When asked what equipment Resident #110 did have at home, Director J reviewed the EMR and stated, No steps, toilet riser, Walker, WC. Director J was then asked if the facility worked with the local Agency on Aging and replied, Yes. When asked if Agency on Aging staff come to the facility to complete assessments prior to admitting a resident to services, Director J stated, Yes. When asked if the local Agency on Aging was contacted prior to Resident #110's discharge on [DATE] to complete an assessment and resume services, Director J revealed that an assessment was not completed services were not resumed prior to the Resident's discharge. When (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	11/21/2025

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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	asked if the Resident was discharged with no equipment, no appropriate family training, and no plan for dialysis transportation, Director J confirmed.An interview was completed with the facility Administrator and Director J on 1/19/25 at 3:30 PM. When queried regarding Resident #110's discharge home and return to the facility from the ER on [DATE], the Administrator stated, (SW Z) told leadership that the family had everything they needed at home prior to discharge. When asked why Resident #110 was sent home without any DME including a hospital bed and mechanical lift, family training for cholecystostomy tube care, and transportation plan for dialysis. The Administrator confirmed the Resident should not have been sent home without the appropriate resources and stated that is why SW Z is no longer employed at the facility. When asked why documentation by SW Z indicated Resident #110's niece received training when Witness GG was going to be taking care of the Resident at home, the Administrator replied, I don't know. The Administrator was then queried regarding the Resident being taken to the incorrect address by EMS when they were discharged and indicated they were unaware. When asked about the potential psychosocial distress to the Resident following the incident, a response was not provided. Resident #110 was attempted to be contacted on 11/20/25 at 7:52 AM but the phone number on the Resident's face sheet was no longer in service. On 11/20/25 at 7:54 AM, Witness GG was contacted. A voicemail message with return phone number was left but a return call was not received by the conclusion of the survey. An interview was completed with Discharge Planner Staff HH. When queried regarding Resident #110's discharge from the facility on 10/14/25, Staff HH revealed they had started the Resident's discharge but then went off work. When asked what had stated, Staff HH replied, I spoke to (local Agency on Aging). With further inquiry, Staff HH stated, I did not have a date (for Resident #110's discharge) because (Witness GG) needed to come in and get trained and (local Agency on Aging) had to come in to assess. When asked about the local Agency on Aging and Resident #110, Staff HH stated, They assist with care at home and dialysis transport. Staff HH revealed they found out the facility had tried to send Resident #110 home when they returned to work. When asked why the Resident was discharged , Staff HH replied, (SW Z) who handled discharges when I was off did not realize that things were not ready for (Resident #110) to go home. Staff HH was asked how SW Z did not know what the Resident's discharge needs were and was unable to provide an explanation. Staff HH then stated, The first discharge (10/14/25) was a mistake. When (Resident #110) came back, we got everything set up before they left a second time. Review of facility policy/procedure entitled, Discharge Planning Process (Reviewed/Revised: 10/30/23) revealed, It is the policy of this facility to develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. 6. An active individualized discharge care plan will address, at a minimum: a. Discharge destination, with assurances the destination meets the resident's health/safety needs and preferences. b. Identified needs, such as medical, nursing, equipment, educational, or psychosocial needs. c. Caregiver/support person availability and the resident's or caregiver's/support person's capacity and capability to perform required care. 8. The facility will document any referrals to local contact agencies or other appropriate entities made for the purpose of the resident's interest in returning to the community. 8. The facility will document any referrals to local contact agencies or other appropriate entities made for the purpose of the resident's interest in returning to the community.

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	11/21/2025

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake Numbers 2591663, 2612086, and 2665756.Based on observation, interview and record review, the facility failed to provide urinary incontinence care per professional standards of practice for two residents (#102, #112), Findings include: Record review of R112 Minimum Data Set/MDS dated [DATE] revealed a Brief Interview of Mental Status (BIMS) score of 0 out of 15, severe cognitive impairment; It was further noted due to R112 diagnoses of aphasia (impaired verbal and/or comprehensions of verbal communication) she is unable to answer questions. Medical diagnoses included: dysphagia (impaired understanding and/or formulation of verbal communication) following cerebral infarction; aphasia; diabetes type II; seizures; acute kidney failure; chronic kidney disease (impaired renal function); contracture bilateral knees (impaired musculoskeletal status). On 11/20/2025 at 2:30PM, an observation of R112's room and bathroom was made, R112 was not present. On 11/20/2025 at 08:25AM, an observation of R112's room and bathroom was made, R112 was not present. On 11/20/2025 at 08:30 AM, during an interview with CNA B regarding R112, she reported that the resident had a limited ability to communicate verbally, but that she could speak a few words. CNA B said she worked on R112's hall and is familiar with her. CNA B said that R112 was recently hospitalized and had a UTI prior to that. When asked CNA B where R112 could be seen she said resident was at therapy. I was escorted to therapy where R112 was observed in therapy working with therapist on walking. R112 was unable to be interviewed. On 11/20/2025 at 9:12AM, during an interview with NP C she reported that she had been involved with R112's family and concerns about ongoing / reoccurring UTI. NP said that R112 had been treated for E. coli bacterial infection at hospital prior to coming to facility with 5 days of Rocephin. She reports that R112 was at the facility for several weeks and was asymptomatic for UTI symptoms, but then developed UTI and when tested it was the same E. coli bacteria, she was treated with Macrobid for 5 days and that NP C had ordered a urology consult, she reported that the family requested the resident be sent to hospital before that visit could take place. When NP C was asked about any other family concerns discussed with her, she mentioned a few others and did not report any knowledge of incontinence care issues when asked. On 11/20/2025 10:33 AM, during an interview with complainant R112's family member F, she reports that the first few weeks in the facility were tough for R112 and that every morning that they would visit her, R112 was found to be soaked in urine and sometimes feces. Family member F said that R112 has a personal caregiver, and the caregiver had cared for resident for the past 10 years at home. Family member F reports that the caregiver was at the facility most mornings throughout the week and said that caregiver reported the residents' conditions to the family on days she was present. She said the caregiver told the family that R112 was often soiled upon her arrival as well. Family member F states that on the day that she called the facility's corporate hotline that she had enough and decided to contact the corporate line to get assistance. She stated, it was on the (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	11/21/2025

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	weekend so no one in management was around. She said she had talked to the nurse on staff and the unit manager also. Family member F said that she had left a message for the NHA about this and other concerns but never heard back and she decided to call the hotline and that is when she got assistance. On 11/20/2025 at 12:27 PM, during an interview with the NHA regarding R112, he reports her BIMS as 0 and that the resident was nonverbal for the most part. He was asked about reported admission issues and complaints of R112 not being checked and changed for incontinence regularly. He stated, the standard of care for check and change is every 2 hours, he reports that by the resident's history alone she would have been every 2 hours (check and change) when she arrived. NHA was asked about complaints he had received from the family, he responded that the (family member F) did reach out on the corporate line with concerns but that was on the weekend, and that he had a orange complaint form that was also filled out on that same weekend, he reports that he did not have a chance to address concerns before the hotline was called. He was queried about hospitalization and UTI concerns and NHA requested to follow up with DON as she is clinical and he is not. On 11/20/2025 at 3:19 PM, during an interview with DON she is queried about R112 and the continence care and documentation. We reviewed R112's September, October and November's point of care (POC) 7-day bowel and bladder (B&B) intervention/ task documentation. DON was asked if this was where the q(every) 2-hour check and change documentation was recorded by the CNA's and she said, it was. She was queried about the key (symbols or numbers representing actions performed) listed and asked about what a blank space on the chart means, she replied it meant that there was just nothing charted for that time noted. When asked about why not applicable (NA) would be charted for a resident on the check and change protocol, she stated there is no reason to chart that task as not applicable. R112's records were reviewed with the DON, where she acknowledged several days on the chart that had blank or NA entries for the blocks of time listed: On 09/27/2025 at 0400. On 09/28/2025 and 09/29/2025 both at 0600,0800,1000,1200,1400,1600,1800,2000,2200 and 2200. On 10/02-03/2025 at 1800,2000,2200,0000,0200,0400. On 10/04-05/2025 at 1800,2000,2200,0000,0200,0400. On 10/05-06/2025 at 1800, 2000, 2200, 0000,0200,0400. On 10/07/2025 at 0400. On 10/12/2025 at 0400. On 10/22-23/2025 at 1800, 2000, 2200, 0000,0200,0400. On 10/23-24/2025 at 1800, 2000, 2200, 0000,0200,0400. On 10/24-25/2025 at 2000, 2200, 0000,0200,0400. On 10/27/2025 at 0400. (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	11/21/2025

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	10/28-29/2025 at 1600,1800,2000,2200,00,0200,0400. 11/01/2025 at 0100. On 11/01-02/2025 at 1800,2000,2200,0000,0200,0400. On 11/02-3/2005 at 200,2200,0200,0400. On 11/04/2025 at 0400. On 11/05/2025 at 2000,2200. On 11/05/2025 at 1800,2000,2200. On 11/07/2025 at 0000,0200,0400. On 11/08-09/2025 at 1800,2000,2200,0000,0200,0400. The DON voiced concern over the missing and NA documentation for the incontinence care for R112. The DON accounted for missing documentation for R112 from 11/10/2025 to 11/17/2025 by stating that it was due to hospitalization for metabolic encephalopathy and acute kidney injury. The DON reports that They had a care conference on 10/26/2025 with the family. A record review of R112's FRI #2660991 Investigation summary from the facility dated 10/21/2025 reveals: On the morning of 10/19/2025 at approximately 9:50 AM, it was reported that R112 was found to be in her bed by family member F, and that both the linens and resident were soaked in urine. A report to the facility was made by family member F via the corporate hotline. Per the investigation summary it was noted that a review of R112's bowel and bladder log was completed by the facility, and it concluded that bowel and bladder care was documented as being provided for R112 that day (10/19/2025); The investigation further reported a review of the bowel and bladder care log from date of admission on [DATE] to date of the investigation on 10/1/2025 was completed and concluded that there was no missed days of documented incontinence care being provided. The nurse U reported she gave medications a little before 7 am, she did not note R112 being incontinent. CNA W on R112's hallway reported that she saw the resident was asleep and did not want to wake the resident, CNA V reported that they proceeded to perform care for other residents. CNA V reportedly arrived at R112's room around 9:30 ish AM. CNA admitted to seeing resident incontinent when it was brought to her attention by the daughter and apologized. The 10/18/2025 night shift CNA W whose shift ended at 6AM on 10/19/2025, reported documented incontinence care at 1 am. Per the investigation report, CNA W verbally reported to facility that she did rounds between 4-5 am to check and change R112, per investigation admitted ly there was no documentation for that. According to the FRI investigation summary it was determined that, This investigation was completed (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	11/21/2025

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	with several findings which conclude that the facility communication processes broke down and therefore led to a delay in incontinence care and a delay in getting breakfast timely on 10/19/25. The deficient practice was confirmed by the facilities findings of delay of incontinence care being performed and a record review of R112 medical records dated 10/19/2025, in the point of care documentation survey report under ADL- toilet use intervention/task: entry at 00:53AM by CNA W with the next entry at 11:49AM by CNA V, approximately 12 hours without documented incontinence care. On 11/21/2025 at 8:14 AM, during an interview with NHA about the 5-day FRI investigation file for R112, he was referred to the statement of A review of (R112) bowel/bladder task since admission [DATE]) reveals no missed days of documented incontinence care being provided. NHA was advised that documentation was missing from the file, he was asked to supply that supporting documentation. NHA stated he will have the DON follow up with the documentation. On 11/21/2025 at 8:33 AM, during an interview with the DON, she reported that she had thought the CNA's were using the POC 7-day bowel and bladder patterning intervention/task to document the check and change protocol, because that was what they did at her last facility, further explaining it was the same corporation. She said she was just finding out that they do not document the check and change protocol on the 7-day bladder patterning, and it is used to track patterns for B&B training for residents. DON reports that at this facility they only track incontinence care on the q (each) shift toilet use task. DON further reports that at that facility the check and change protocol was being documented in the POC on the bladder and bowel toileting task. The DON was asked if that meant CNA's only document on incontinence care one time per 12-hour shift for all residents, even the residents that are required to be on the check and change program as q2-hour incontinence care. She replied, Yes it appears that way. The DON was asked if that was adequate as the standard of care and she stated, No, ideally they would add an entry every time they check and change the residents; However, they do not and they only enter documentation once per shift. The DON reported that she was pushing to change the documentation settings to flag the system and that would prompt that documentation for all residents on the check and change protocol to every two hours instead of once a shift, and she was going to re-educate the CNA's to complete the tasks to reflect when care was completed. The DON stated, The prior nursing management was not monitoring the documentation because if they were it would not be a problem now and that documentation should be done in real time and not in blocks or at end of shift. According to a record review of R112's care plan it was revealed: Focus, (R112) has an ADL self-care performance deficit related to decreased functional mobility and physical limitations status post hospitalization further complicated by recent stroke with residual deficits, diabetes mellitus type 2, seizures, hypertension, impaired musculoskeletal status 2/2 contractures, and impaired renal function. Date Initiated: 09/26/2025 Revision on: 10/15/2025. Interventions: ORAL HYGIENE: 1 person assist, WC MOBILITY: 1 person assist; AMBULATION: Therapy Only; BATHING: 1 person assist; BED MOBILITY: 1 person assist; DRESSING: 1 person assist; EATING: 1 person assist with every meal; PERSONAL HYGIENE: 1 person assist; TOILETING: 2 persons assist; TRANSFERS: 2 persons assist with walker and gait belt. (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	11/21/2025

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Focus: (R112) has an impaired neurological status related to recent CVA w/ aphasia and dysphagia deficits, seizure D/O, metabolic encephalopathy, and suspected neurocognitive disorder. Date Initiated: 09/29/2025 Revision on: 09/29/2025. Interventions: Assist with normal daily tasks as needed/tolerated. Focus: (R112) has impaired communication related to metabolic encephalopathy, concerns for dementia, recent stroke with expressive aphasia. She is able to say spontaneous responses but cannot answer questions asked. She just looks at the speaker Date Initiated: 09/26/2025 Revision on: 10/15/2025. Interventions: Pay attention to Gloria's body language and facial expressions. Date Initiated: 09/26/2025 Revision on: 09/29/2025. Focus: Gloria has episodes of bladder / bowel incontinence related to decreased functional mobility and physical limitations S/P hospitalization further potentiated by clinical conditions and medication adverse effects. Date Initiated: 09/26/2025 Revision on: 09/29/2025. Intervention: Assist resident with toileting needs; Check at regular intervals and change as needed; Offer bed pan/bedside commode as needed; Provide peri-care after each incontinent episode; Provide disposable incontinence products; apply house barrier cream after incontinence care. On 11/21/2025 at 10:12AM, during a follow up interview the DON was asked about R112's care plan date Initiated: 09/26/2025. Care plan focus: (R112) has episodes of bladder / bowel incontinence related to decreased functional mobility and physical limitations S/P hospitalization further potentiated by clinical conditions and medication adverse effects with intervention: Check at regular intervals. The DON was asked what is meant by regular intervals. The DON responded, that the care plan should be spelled out as to what that is, it is not specific to that resident and to me it is every 2 hours, regular intervals is generic. It was requested that DON search the care plan for any updates on specific continence care for R112. The DON did a search on her computer and said that she could not find any additional interventions in the care plan that was resident specific. Further, the DON was asked if she thought it should have been looked at and addressed after 09/26/2025, considering the FRI and the documented family concerns over incontinence care frequency. The [NAME] replied, Yes, it should have been updated and made resident specific. According to a record review of R112's Intradisciplinary team (IDT) functional abilities assessment dated [DATE] it was revealed: Activity: Toileting hygiene: The ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement. Assessment finding: Dependent - Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity. Activity: Toilet Transfer: The ability to get on and off a toilet or commode. Assessment finding: Dependent - Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete (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	11/21/2025

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the activity. According to the record review of R112's Intradisciplinary team (IDT) functional abilities assessment dated [DATE] it was revealed: Activity: Toileting hygiene: The ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement. Assessment finding: Substantial/maximal assistance - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort. Activity: Toilet Transfer: The ability to get on and off a toilet or commode. Assessment finding: Substantial/maximal assistance - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort. According to the facilities policy labeled Incontinence it is revealed: Policy: Based on the resident's comprehensive assessment., all residents that are incontinent will receive appropriate treatment and services. Guidelines: 4. Residents that are incontinent of bladder and bowel will receive appropriate treatment to prevent infections and restore incontinence to the extent possible. The facility's policy, labeled Quality of Care revealed: Policy: it is the policy. that each resident received the necessary care and services to attain and maintain their highest practicable physical, mental, and psychosocial well-being, in accordance with each resident's comprehensive assessment and care plan. Guidelines: each facility must ensure that the resident is provided restorative and personal care services necessary to obtain optimal improvement or does not deteriorate within the limits of a resident's right to refuse treatment. The facility's policy, labeled Activities of Daily Living, revealed: Policy: The facility takes measures to minimize the loss of residence functional abilities, including ADL's. Activities of daily living include: 1 the ability to one bathe dress and groom, 2 transfer and ambulate, 3 toilet, 4 eat and, 5 use speech language or other functional communication systems. 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. Observation and interview on 11/19/2025 at 2:35PM with Resident #102 were asked about being left wet & soiled? Resident #102 stated that yes, back in August, yes it happened I let my family know. They didn't wake me up to change me, I was wet during the night and then again in the morning I was soaked right through my bedding. It's embarrassing. They g right in here and cleaned me up and I took a shower. They are good, but back then there were some problem aides here. I haven't had a problem since that time. The head nurse supposedly took care of that problem. Resident #102 was observed to be lying in bed, and she pulled the covers back to show the surveyor that she wore a large brief and that the bedding was dry at the time of the observation. Record review of Facility report incident dated 8/3/025 of Resident #102 allegations of incident on (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	11/21/2025

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	8/3/2025 at 7:30AM the resident contacted her family member as her brief needed to be changed, and she had soaked through to her bed sheets. The family member alleged neglect because the resident had set for several hours without being changed. Record review of the facility reported incident revealed interviews with Resident #102 and staff members that were assigned to provide care. The resident #102 was noted to have had a check and change at 9:30PM (8/2/2025) and then awakened at 3:30AM to be changed. At 7:15AM the morning shift CNA came to get her for a shower and that's when she was soaked. The night shift Certified Nurse Assistant on 8/3/2025 PM through 8/3/2025 AM was noted to state that she did provide care around 3;00AM to change and reposition the resident. The day shift Certified Nurse Assistant on 8/3/2025 AM went into Resident #102's room to wake her up for her shower and found that the resident was soaked through to the sheets. In an interview and record review on 11/20/2025 at 11:13AM with the nursing home Administrator (NHA) about Resident 102's complaint of being left wet/soiled revealed that on 8/3/2025 a family member complained about the resident being left in wet briefs, the resident contacted the family member, who lives down the street and stops into visits daily. At around 2pm the family member came in to visit and she went to the front desk, because the resident was not changed and was neglected. Resident #102 is her own person, she had a check and change on 8/2/2025 at 9:30PM and then the night Certified Nurse Assistant (CNA) went in at 3:00AM and changed her, she is a heavy wetter. The family wants the resident to be up and about during the day. The nurse was interviewed about the incident and the morning shift Certified Nurse Assistant (CNA) stated that the resident was soaked through her clothing and bedding. Resident #102 received a shower at 7:15AM, and we did start to use the thicker brief, The State surveyor inquired about the Standard of care expectation? The NHA stated that the standard was to Check and change every 2 hours. The State surveyor asked if this was done? The NHA stated that They try to respect if the resident is sleeping, we had a care conference after the incident the resident agreed on thicker briefs, and to come in every 2 hours to check and change. Then on 8/12/2025 Resident #102's family complained again of the resident being left wet and soiled, the family uses Neglect as her trigger word for action from the facility. What we investigated was that the Certified Nurse Assistant (CNA) came into the resident's room around 1PM to give the roommate a shower, and Resident 102 stated that she needed to be changed, The Certified Nurse Assistant (CNA) stated that she would come back after the roommate's shower. The Certified Nurse Assistant (CNA) did not come back till 4PM. The nurse got a call from the front desk about being wet and needing to change. At 3PM the nurse administered medications, and the resident did not state that she needed changed. Special focus resident because the family comes daily. Record review of Resident #102's 8/12/2025 family allegations of neglect for the prior day (8/11/2025) from 12:00 PM through 3:00PM that no one came in to get the resident out of bed. Record review of the facility investigation noted that Resident #102 stated that she needed to be changed to the certified nurse assistant O at 1:00PM when the Certified nurse assistant O came into the resident's room to get the roommate for a shower. Resident #102 was noted to tell the certified nurse assistant O that she needed to be changed, and that the certified nurse assistant O stated that she needed to give the roommate a shower. It was noted in the investigation that the certified nurse assistant did not come back to change the resident until about 4:00 PM. The roommate was asked about the incident and was noted to state that Resident #102 told them (staff) that she needed to be changed . The facility investigation noted certified nurse assistant N was assisting her hall partner with getting Resident #102's roommate in the shower. The hall partner did talk to Resident #102 about a drink or something, but she did not say that she needed changed. The certified Nurse assistants put the roommate into the shower. Later Resident #102's call light came on and certified nurse assistant N was noted to check on Resident #102 when the resident stated that she had a 'bobo' in her brief since around lunch time. Certified nurse assistant N was noted to ask why the resident had not let (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	11/21/2025

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	anyone know. The Resident #102 was noted to state that she did say something. Record review of Resident #102's care plans from 11/6/2024 through 11/20/2025, revealed initial date 11/6/2024 Resident #102 was identified as at risk for episodes of bladder/bowel incontinence related to decreased functional mobility and physical limitations post hospitalization further potentiated by depression and medication adverse effects. Intervention: Check every 2 hours for check and change. Record review of Resident #102's care plans noted on 8/19/2025 updated intervention of: Check every 2 hours for Check and change. Record review of Resident #102's point of care 'Documentation Survey Report v2' August 2025, revealed on the evening of 8/2/2025 there was no documented bladder/bowel documentation for the evening (14:00-22:00), Nights (22:00-0600), and 8/3/2025 day (0600-1400) shifts. Further review of the 'Documentation Survey Report' revealed that there was no documented incontinence restorative, turn and reposition, oral care, skin care was all noted to be blank for those time frames. Record review of facility 'In-Service Attendance Record: Signature Sheet' dated 8/3/2025, In-service title: Wounds/ADLs/Pagers/Incontinence Care/Abuse/Dignity. All 3 pages of the signatures were reviewed and neither Certified Nursing Assistant (CNA) N and/or O were attended but still provided care on 8/12/2025 to Resident #102. Record review of Resident #102's 'Bladder Elimination' task for a 30 day look back from 10/22/2025 through 11/20/2025 revealed that the check & change pattern of documentation had one check & change documented daily for 8 days out of 30 days, and twice daily for 16 days out of 30 days, and three times daily for 5 days out of 30 days. Record review of the facility 'Incontinence' policy dated 10/26/2023 noted based on the resident's comprehensive assessment, all residents that are incontinent will receive appropriate treatment and services.