

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  235600	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/12/2025
NAME OF PROVIDER OR SUPPLIER  Medilodge of Montrose Inc		STREET ADDRESS, CITY, STATE, ZIP CODE  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 0689  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.  (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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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> This citation pertains to Intake Numbers 2688354 and 2689940. Based on observation, interview and record review the facility failed to ensure timely reporting, notification, comprehensive assessment and continued post-fall monitoring for one resident (Resident #2) following an unwitnessed fall of one resident reviewed for safety and accidents. Findings include: Resident #2 (R2): A record review for Resident 2's (R2) quarterly Minimum Data Set (MDS) assessment revealed a Brief Interview of Mental status (BIMs) score of 99 that indicated severe cognitive impairment and indicated a need for comprehensive assistance and specialized care approaches. Further record review of R2's medical record revealed medical diagnoses that included: dysphagia following cerebral infarction (stroke), aphasia following cerebral infarction, type 2 diabetes mellitus, seizures, contracture bilateral knees, Hemiplegia (one sided paralysis or weakness) and hemiparesis (one sided muscle weakness) following cerebral infarction affecting left non-dominant side, adjustment disorder with anxiety, vascular dementia, acute kidney failure, difficulty in walking, limitation of activities due to disability, need for assistance with personal care. According to a record review of complaint 2688354, it was alleged R2 had an injury of unknown origin by family member Y who found and inquired about discoloration of area on R2's buttocks and new abrasion on right knee on 12/08/2025. On 12/10/2025 at 1:40 PM, A phone call was placed to complainant family member Y for R2, a message was left to advise state agency (SA) was on site to review the complaint received and the SA call back phone number was left. On 12/10/2025 at ~ (approximately) 2:00 PM, During a brief interview NHA was asked about R2 and any known falls or incidents recently, NHA replied Yes, R2 has a history of falls. NHA further said that they have an open FRI on R2 that was filed on 12/08/2025 and they did not want to respond specifically as they were in the middle of their 5 days, and they did not want to give incomplete information yet. NHA was asked for incident reports for the falls/incident reports related to R2, for the last month. On 12/11/2025 at 10:32AM, During an interview with CNA Q it was revealed they were a first shift CNA that primarily worked on the short-term units of the facility, and they were familiar with R2. They reported that R2's shower day was changed to day shift on 12/08/2025, at the request of the nurse and family. CNA Q reported that they had made up a shower on 12/08/2025 for R2 that was not completed on the night shift 12/07/2025. When asked about the skin assessment done with showering CNA Q said, I noticed what looked like a birthmark on her tailbone but did not think it was anything but that. When CNA Q was quired about the appearance of the birthmark they reported a description of a port wine purple/red in color type birthmark. CNA Q was asked if during incontinence care for R2 they had ever noticed the birthmark and they responded they had not noticed it before and then stated, I assumed (that) I had just overlooked it before. When CNA Q was asked if she reported or documented the finding, CNA Q stated it did not look like anything new or a bruise to me. When asked about R2 right knee abrasion, CNA Q said that their attention was not called to R2's right knee abrasion until the wound care nurse asked for help with R2 when photos were taken later that day (12/08/2025) of both the right knee and tailbone. CNA Q said she was unaware of any falls for R2 prior to 12/08/2025. According to a record review of R2's point of care documentation completed by CNA's for care provided labeled TASK -skin monitoring, it was revealed that: None of the above was noted as being no: Scratched, Red Area, Discoloration, Skin Tear or Open Area none of the above was marked on each of these entries: 11/28/2025 at 10:51 11/29/2025 at 05:59 &amp; 17:59 11/30/2025 at 03:52, 17:51 &amp; 23:20 12/1/2025 at 17:23 &amp; 19:02 12/2/2025 at 10:30 12/3/2025 at 02:46 &amp; 17:43 12/4/2025 at 01:20 &amp; 09:23 12/5/2025 03:26, 17:24 &amp; 23:12 12/6/2025 at 09:26 &amp; 21:01 12/7/2025 at 07:14 12/8/2025 at 08:52 12/9/2025 at 00:26, 10:15 &amp; 19:40 12/10/2025 at 17:05 &amp; 23:27 According to a record review of R2's fall assessments in the documentation of nursing staff, it was revealed: R2 had 2 initial fall assessments completed on 11/19/2025. A record review of subsequent documents labelled follow up fall assessments, there were 2 assessments completed daily for each of the following dates 11/20 through 11/25/2025. Noted with this record review that there was no fall assessment completed for 12/01/2025 fall. According to a record review of R2's skin &amp; wound evaluation documentation of nursing staff, it was revealed: On 12/06/2025 note reported: no new abnormal skin areas, an acknowledgement that the nurse did complete an assessment and no note of existing abnormal skin areas. On 12/08/2025 note reported: Abrasion to right front knee, in house acquired, unknown age, measuring 1.2 cm, 1.8 cm length, 0.9cm width. Another note reported: Bruise on sacrum; In house acquired; unknown age; measuring 3.7 cm, 2.6 cm in length and 2.0 cm in width. According to a</p>		