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	03/05/2026

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - 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 2736807, 2736887, 2736910 and 2742953 Based on observation, interview and record review, the facility failed to ensure that one resident (Resident #2) was free from neglect when staff did not complete a skin assessment after identifying a new area of skin concern, did not ensure appropriate treatment was in place, and did not accurately monitor and document the resident's skin condition, of one resident reviewed for neglect of care, resulting in Resident #2 being admitted to the hospital for 5 days with a diagnosis of cellulitis (bacterial skin infection) and having to receive IV antibiotics.Findings include:Resident #2 (R2):A review of R2's medical record revealed an admission into the facility on [DATE] with diagnoses that included memory deficient following intracerebral hemorrhage (stroke), dysphasia (impairment of speech), hemiplegia and hemiparesis (weakness and paralysis affecting right dominant side), vascular dementia, and major depression. A review of the quarterly social services assessment on 01/02/2026 revealed a Brief Interview of Mental Status (BIMS) score of 2/15 that indicated severe problems with memory or thinking.A record review of intakes 2736807, 2736887, 2736910 and 2742953 with allegations pertaining to R2 was completed.On 03/03/2026 at 8:04AM, A phone call was made to complainant Z who said that the resident was evaluated for wavier to discharge to another facility on 02/05/2026 and was not intended to move that day but did. Complainant Z said that the facility's social workers were asked to supply appropriate discharge information including any information regarding needs of the resident and when she asked about skin issues she was told R2's chart only noted ?the use of barrier cream with no skin issues or wounds'. Complainant Z said the transfer facility requested the activities of daily living log (ADL), medication list and skin documentation for R2. Complainant Z said that no on site visual/physical skin assessment was completed by the (facility) or (evaluating agency) prior to the residents discharge that day (02/05/2026). Complainant Z (evaluating agency) asked for and reviewed R2's recent skin assessment from the resident's chart and said it did not have any documented skin issues. Complainant Z said when the resident arrived at the new facility he cried and exclaimed ?he was happy they were able to get him discharged '. Complainant Z said that shortly after his arrival at the new facility R2 was assisted to the restroom by a CNA (unknown name), that CNA alerted the family and a nurse to observe the residents' bottom and back. Complainant Z said that they reported that R2's ?lower back to his legs were bright red, his bottom had open areas and weeping bloody fluid was seen on the resident's brief'. Complainant Z said the new facility took photos and submitted them to the ombudsman. R2 was sent to the hospital within a short time of arriving at the new facility to be evaluated and treated. Complainant Z said that the hospital had reported to them and other appropriate agencies for suspicion of neglect.On 03/03/2026 at 2:33PM, During a phone call with family member N of R2 she revealed that she is also R2's guardian. Family member N said that R2 was discharged from the facility to another facility on 02/05/2026. Family member N said that she was unaware that R2 had any ongoing skin issue, she said she was aware that R2 previously had a pressure ulcer that had healed in September of 2025. Family member N said the family transported the resident to the new facility and that that once they (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 - Actual harm Residents Affected - Few	arrived at the new facility family was with R2 as he was ?getting settled in', the resident requested to go to the restroom. Family member N said that the CNA alerted the nursing staff, herself and sister that R2 had ?a red bottom with leaking sores from the top of his back throughout his bottom down to the top of his legs. The CNA requested them to observe it. Family member N said she was shocked and vomited it was so bad, she said she had no idea about his bottom and that the paperwork from the facility did not identify any skin issues. Family member N said she felt like they left R2 in his wet briefs and neglected to care for him, that was why his bottom looked like that. Family member N was asked if R2 had made complaints to her about the facility, and she said that he had only said ?he didn't like the soft food, and his old roommate was young and loud'. Family member N was queried on the roommate's name, and she identified R8. Family member N was concerned over the care he received and stated she does not want this to happen to anyone else's loved one.A record review of R2's discharge to Home/ Community /AL (assisted living) /Equal care setting dated 02/05/2026 revealed that R2 was discharged to assisted living on 02/05/2026 at 13:00 (1PM). In section (e) the Nursing summary: Skin/wounds identified No skin issues noted and was completed by Nurse I.A record review of R2's hospital records revealed that R2's registered/arrival date and time was 02/05/2026 at 16:19PM (4:19PM) with his initial exam on 02/05/2026 at 17:06 (5:06PM) with findings noted as Redness along sacral region extending to the back; Takes up much of the entire buttocks; Excoriated hyperemic (a buildup of blood) redness on the back. A record review of R2's Hospital skin exam revealed Large amount of excoriation throughout the coccygeal . region redness that extends to the lower thoracic region hyperemia tending to palpation there is no blistering however patient does have some satellite lesions compatible with possible fungal infection. Some evidence of secondary infection. And Notes from: 02/05/2026 at 17:40 (5:40PM) R2's initial lab work revealed an elevated white blood cell count of 14.8 (high) with (normal range 4.5-11.0), indicated an infection. At 17:43 (05:46PM) R2's pain scale was noted to be reported at 10 out of 10, which indicated the worst possible pain.A review of R2's Emergency room's disposition to general admission revealed in the History and Physical (H&P) . A large area of Cellulitis on his lower back. There is also a high suspicion for elderly neglect.A review of R2's of hospital discharge date d 02/10/2026 revealed that R2 was discharged from the hospital with diagnosis of Cellulitis, he had been treated with IV Vancomycin (antibiotic) and Miconazole cream (antifungal) and Morphine 2 mg (Narcotic pain medication) during his 5 day hospital course, and upon his discharge the Infectious disease doctor recommended continued antibiotics of Clindamycin 3mg to be given four times a day for an additional five days. On 03/04/2026 at 8:42 AM, during an interview with wound care (WC) nurse G was asked what the facility used as their standard barrier cream was and she said zinc oxide and every resident that had incontinence received the barrier cream with incontinence care, applied by the CNA when briefs were changed. WC nurse G further explained that, if a resident had an area of skin that was identified as reddened, there would be a specific order that identified the area of skin that was treated and how often, and that nurses applied the treatments. It was confirmed with WC nurse G that CNAs applied the ?preventative' incontinence barrier creams and nurses applied ?treatment' creams as ordered. ˆOn 03/04/26 at 8:55AM, During an Interview with R2's ex-roommate, he was asked about R2's demeanor as a roommate, and he said he was a quiet person that rarely talked. R8 was asked if he observed or heard any of R2's care while they were roommates and R8 said yes. R8 said that at night the CNAs asked R2 if he was wet and if R2 told them no, they would not check or change him. R8 further said that the CNA's did not always come back later to check and change him, and that R2 would sit in piss. On 03/04/26 at 1:15PM, During an interview with CNA H she was asked about R2's incontinence care and if there was any issues with his skin. She said his bottom was really red and had a lot of dead skin present. When CNA H was asked if R2's skin concerns were reported to the nurses she said yes, the nurses were all aware and had treatment ordered for the (coccyx) area also. CNA H was unable to give specifics of what nurses knew or when it was reported. CNA H was asked if R2 refused incontinence care, she said he did not refuse it when she worked with him. CNA H was (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	asked if she used barrier cream on R2, and she said yes with every brief change. CNA H was asked if the WC nurse evaluated the skin area, she said she was not present if she did. CNA H further explained that if the WC nurse evaluated it, she would have taken a picture and documented it. On 03/04/26 at 2:02PM, During an interview with CNA AA was asked about if he observed any skin issues when he provided activities of daily living (ADL) or incontinence care for R2, he said R2 had body eczema throughout and his bottom was red with dry skin, there were no broken areas of skin but it leaked fluid. CNA AA' said that R2 did not refuse incontinence care from him. CNA AA was asked if he applied barrier cream to R2 and he said yes. CNA AA said the nurses were aware of R2's skin issues and that R2 had creams he received treatment from the nurses for it. Record review of R2's orders revealed the following: Dated 01/01/2026 at 2200 (10 PM) Hydrocortisone Cream 2.5 % Apply to Left arm topically every day and night shift for Pruritus.Dated 01/04/2026 at 17:04 (5:04 PM) Verbal order. Zinc Oxide Ointment 10 % . Apply to coccyx topically every day and night shift for red area.AND apply to coccyx topically as needed for red area.Record review of R2's medical administration record (MAR) completed and documented by Nurses revealed: the following: January: Treatments started 01/04/2026 on night shift and ended on 01/31/2026 on night shift the ordered Zinc Oxide Ointment 10 % Apply to coccyx topically every day and night shift for red area was documented with a check and initials of the nurses, which indicated that medication was applied for all of day and night applications with one exception to that on 01/13/2026 night shift was no check mark or nurse initials indicated it not done. February: 02/01/2026 on day shift and ended on 02/05/2026 on day shift the ordered Zinc Oxide Ointment 10 % Apply to coccyx topically every day and night shift for red area was documented with a check and initials of the nurses, which indicated that medication was applied for all of day and night applications.The MAR documented a total of 63 times treatment to the coccyx was applied by nurses with no supplemental documentation, assessments, or progress notes that included description or status of the area related to the ?red area on the coccyx'.On 03/04/2026 at 3:14PM, During a phone call to Nurse K a female answered the phone and said that nurse K was not available, a message was left for a call back. On 03/04/2026 at 3:15PM, During a phone call interview Nurse J was queried about R2 and she said I vaguely remember the resident and that she was unsure about his skin issues from recollection and stated, nothing sticks out. On 03/04/2026 at 3:40PM, During a phone call interview Nurse L was queried about R2 skin and she said he scratched a lot and had eczema and dry skin on his trunk, legs and throughout his back. Nurse L was asked about R2's buttocks and backside, she said there was nothing but dry skin and that he would scratch at his butt cheeks, we used barrier cream treatment, and she denied that R2 had any red or open areas. Nurse L said she was off the day before R2 was discharged and that either Nurse K or Nurse I covered for her. Record review of R2's January point of care (POC) tasks completed and documented by CNA's revealed: Skin observation on 01/01/2026 at 17:27 (5:27PM) noted red area and indicated (Y,Y) which it was a new area and it was reported. A record review of progress notes revealed an Alert note from 01/02/2026 (that was triggered by the 01/01/2026 CNA's (Y,Y) MAR entry) in the POC charting revealed: NS - A new skin problem was observed. with WC nurse G's note - no areas of concern noted at this time.On 03/04/2026 at 4PM, During an interview with WC Nurse G said that on 09/27/2026 R2 came to the facility with a stage 2 pressure ulcer on his coccyx and that when she saw him on 09/30/2026 it was blanchable redness and she resolved it out. WC Nurse G said that R2 did not have any wounds after that she was aware of. WC Nurse G was queried about the alert note from 01/02/2026 that indicated NS = New skin area and she said that she gets those alerts off the clinical dashboard, it is triggered by CNA charting or the nurses skin assessment charting and that notified her as the WC nurse that she needs to go assess the residents skin. WC Nurse G said that because she does not know where the area of skin concern is located from the triggered note, she will ask the staff if she knows who triggered it and if not, she does a full skin assessment to capture it. WC Nurse G said after she had seen the resident, she completed the alert note. When WC Nurse was asked what no areas of concern noted at this time meant, and if there was skin assessment (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	the resident discharged if it was better, worse or the same, she replied I can't remember when she was asked how would she be able to find that out she stated if we documented on it. Nurse I said that she should have done an initial skin assessment and then it would be followed up on every 8 hours with documentation, and she admitted she did not put in a progress note nor does she recall why she placed the treatment order on 01/04/2026 now. Nurse I explained that when I treatment order is placed that the WC nurse should follow up on it to make sure it is the proper care needed, she is the certified nurse on treatment types and timing. Nurse I said that new orders also appear on the 24-hour report that is reviewed by management at morning meetings. Nurse I said the order never changed and the wound care nurse never followed up with me. Nurse I explained that she completed part of the discharge for R2 that day 02/05/2026 and that it was rushed and unexpected. Nurse I admits that no body skin assessment was done on 02/05/2026 and that she complete the discharge assessment in the nursing summary of skin/wound care needed (include location and description of any wounds): no skin issues noted, when she reviewed it. A record review of R2's Care plan revealed the following: Focus (R2) has episodes of bladder / bowel incontinence related to decreased functional mobility and physical limitations further potentiated by clinical conditions and medication adverse effects with Interventions: Observe peri/rectal-area for redness, irritation, skin excoriation/breakdown; report abnormal findings to Nurse/Physician/PA/NP; Provide peri-care after each incontinent episode; apply house barrier cream after incontinence care. Focus: (R2) s at risk for impaired skin integrity related to decreased functional mobility and physical limitations further potentiated by risk for incontinence and other clinical conditions which potentiate skin breakdown with Interventions: Administer medications as ordered; Apply protective barrier cream after incontinent episodes; Complete skin inspection weekly and as needed; Notify nurse of any new areas of skin impairment noted during bathing or daily care (e.g., redness, blisters, bruises, discoloration, impairment related to medical device/tubing); Notify Physician/NP/PA of any new areas of skin impairment. On 03/05/2026 at 11:17PM, During an Interview with Staff P she stated the facility was unaware of the resident discharge until the day it happened when he was evaluated by a community agency for wavier. Staff member P admitted the discharge was rushed by request from the family. Staff member P said that she verbally reported to the outgoing facility what was documented in R2's chart under skin assessments, and that she was not aware of anything different that what was documented about R2's skin. On 03/05/2026 at 2:35PM, During an interview with Social Worker Q said that R2's discharged was rushed due to a request by the family and evaluating agency. SW Q said that she supplied a green folder with R2's medication list, history and physical, IDT discharge summary, face sheet, advanced directives and progress note from Nurse Practitioner. SW Q said that R2 was being admitted to hospice services also. SW Q said she was unaware of any skin issues for R2 and that none are noted on the discharge summary. On 03/05/2026 at 2:35PM, During a follow up with WC Nurse G she said she was certified for wound care on 03/03/2026. WC nurse said as of today we started using an end date to trigger reassessments on skin areas that are not wounds, and that she would reassess in every 14 days or sooner until resolved. WC Nurse G said that there was now supplemental questions that the nurse will have to answer with each treatment. A review of the facilities Policy and Procedure titled Abuse, Neglect and Exploitation: revealed the following:Policy: It is the policy of this facility to provide protections for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation .Definitions: Neglect means the failure of the facility, its employees, or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distrust. Alleged Violation: is a situation or occurrence that is observed or reported by staff resident, relative. that has not been investigated and, if verified could be indication of noncompliance with the federal requirements related to mistreatment, exploitation, neglect or abuse. Serious bodily injury: means an injury involving extreme physical pain; .Requiring medical interventions such as surgery, hospitalization. Policy explanation: 1. The facility will develop and implement written policies that: a. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to Intake Number 2785490.Based on interviews and record review, the facility failed to implement policies and procedures for ensuring the reporting of a reasonable suspicion of a crime in accordance with section 1150B of the Act. Findings Include:Resident #5:On 3/3/2026 at approximately 2:30 PM, Resident #5 reported he loaned CNA S $500 (cash) and they had a verbal agreement that she would pay him back every paycheck. He explained she typically worked weekends, and he gave her $300 cash on a Friday, $100 on Saturday and $100 on Sunday. Resident #5 continued he was upset, as the aide was not abiding by their verbal agreement and had only paid back $30. He stated she eventually came into the facility on a Monday (that she was not scheduled to work) and remitted the remaining $470 that she owed. On 3/3/2025 at approximately 3:45 PM, a review was conducted of Resident #5's medical record and it indicated the resident was initially admitted to the facility on [DATE] with diagnoses that included, Diabetes, Atrial Fibrillation, Hypertension, Chronic Kidney Disease, Anxiety Disorder, and Major Depressive Disorder. Resident #5 is his own person and able to clearly articulate his needs to facility staff. There was no other documentation located in the chart regarding an allegation, or any follow up regarding misappropriation of money. On 3/4/2026 at 12:38 PM, CNA T reported CNA S was in Resident #5's room with the door closed and they were screaming at one another. CNA T stated she overheard Resident #5 yelling that (CNA S) made an agreement to give him $30 every pay period and she had not remitted payment. She had until the end of the week to pay the balance owed or he was reporting the incident to the Administrator. CNA T reported upon CNA S exiting the room she was visibly crying. On 3/4/2026 at approximately 4:08 PM, the Administrator was queried if there was a FRI (Facility Reported Incident) for the allegation of misappropriation of money between Resident #5 and CNA S. The Administrator reported there was a not a FRI related to this incident. He further explained the Social Worker informed him Resident #5 had loaned a facility staff money and he wanted it back, but would not provide the name of the facility staff. At some point he provided the name of CNA S and when she was interviewed, she was in tears, denied the allegation of misappropriation and said it was against the facility's code of conduct. The Administrator followed up with Resident #5 who said nevermind and retracked his initial account. The administrator was asked wouldn't that be considered an allegation that would be investigated by their facility and he stated No, as there was no proof provided by resident. On 3/4/2026 at 5:10 PM, Social Work Director Q stated in around December 2025 she was speaking with Resident #5 and he stated he did not know what to do about a situation. He proceeded to provide a scenario that a good employee came to him and shared she did not have enough money to pay a parking or speeding ticket. The resident loaned her the money to pay the fine and there were payments arrangements made, but he is having a difficult time getting the money repaid upon their agreed upon terms. Director Q informed him she would have to report the allegation to the Administrator/Abuse Coordinator Director Q stated the resident reported misappropriation of funds and it was assumed this was reported to the State Agency. On 3/5/2026 at 10:28 AM, Staff Development Coordinator W' was queried iif it's appropriate for staff to accept money from a resident (rather the staff asked or it was offered) she reported that is not appropriate. She explained this is company policy that is reviewed in their orientation training in depth by their corporate orientation liaison. On 3/5/2026 at approximately 12:00 PM, the administrator shared Social Work Director Q, initially informed him that Resident #5 had given money to an employee but would not provide the staff name. The Administrator stated at that time the resident was not alleging anyone stole anything from him. The next day at resident council he shared with the Activities Director and Regional Director of Operations that he loaned money to an employee with payment arrangement terms. Additionally, the Administrator received a phone call from Nurse U (on a Sunday) informing him again (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	03/05/2026

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	that Resident #5 has loaned money to CNA S, during this conversation with the nurse the Administrator did not ask the nurse to expound on how she came to receive their information. The Administrator asserted Resident #5 is his own person, there was no proof of the transaction between him and CNA S and there was no allegation made by Resident #5 of misappropriation. He was queried if it was acceptable for staff to take money/borrow money from a resident and he stated, No. The administrator stated even through the Social Work Director informed him of the incident it was not an allegation of misappropriation and there not a reportable to the state agency.It can be noted the Administrator was informed of the allegation of misappropriation three times but did not report it per regulations standards.On 3/5/2026 at 2:00 PM, Resident #5 was reinterviewed regarding the incident, he reported he informed the Social Work Director regarding the incident but did not provide her a name, the Administrator, Regional Director of Operations and Nurse U may have overhead the discussion with CNA S. He further stated the Administrator and Director of Operations assured him if CNA S paid him back they would not fire her.Review was conducted of the policy entitled, Abuse, Neglect and Exploitation, reviewed 1/10/2024. The policy stated, .Alleged Violation is a situation or occurrence that is observed or reported by staff, resident, relative or visitor or others, but has not yet been investigated and, if verified, could be indication of noncompliance with the Federal requirements.