

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>713010</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>4/9/2025</b>
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NAME OF PROVIDER OR SUPPLIER  <b>MEDILODGE OF ROGERS CITY</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>555 N BRADLEY HWY ROGERS CITY, MI 49779</b>
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F0000 SS=	INITIAL COMMENTS  Medilodge Of Rogers City was surveyed for an Abbreviated survey on 4/10/25.  Intakes: MI00150288, MI00150874, MI00151562.  Census=76.	F0000		
F0600 SS= E	Free from Abuse and Neglect §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by:  This citation pertains to intake: MI00150288.  Based on interview, and record review, the facility failed to provide an environment free from abuse for 3 residents (#1, #2, and #6) of 5 reviewed for abuse resulting in Residents #2 & 6 being physically abused, the potential for further resident to resident physical and verbal abuse to continue and the potential for decline in physical, mental, and psychosocial well-being for residents who may come into contact with Resident #1.  Findings include:	F0600	"Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truths or facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed in accordance with federal and state law requirements."  Element 1: Resident R1 is currently safe in facility. A psych tele-visit was completed on 4-28-25 and recommendations being reviewed. A medication review was requested on 5-2-25. Facility met with guardian on 4-25-25 related to R1 decline. Guardian declined change in Advanced Directive and hospice services at this time. R1 was sent to ED on 4-30-25 after presenting with a significant decline related to dementia diagnosis. Facility will continue to monitor R1 through documented target behaviors, 24 hour report, and staff reporting. R1 has had no reportable incidents with other residents since 2-10-25. Resident R2 is currently safe in facility. A chart review was completed and plan of care is current as written. Resident R6 is no longer in facility.  Element 2: All residents have the potential to be affected. Facility has completed a 7 day look back on resident skin assessments with a BIMS of 8 or	5/8/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

05/02/2025

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.

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	<p>Resident #1 (R1)</p> <p>Review of an "Admission Record" revealed R1, was originally admitted to the facility on 8/15/2024 with pertinent diagnoses which included: dementia-moderate with agitation.</p> <p>Review of a "Minimum Data Set" (MDS) assessment for R1, with a reference date of 1/8/25 revealed a "Brief Interview for Mental Status" (BIMS) score of 00/15, indicating Resident #1 was severely cognitively impaired. Review of "Section E - Behaviors" revealed R1 had physical behavioral symptoms directed towards others (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually), and verbal behavioral symptoms directed toward others (e.g., threatening others, screaming at others, cursing at others ...) 1-3 days, and wandering 4-6 days in the 7 day look back period.</p> <p>Review of R1's MDS dated 2/12/25 revealed: "Section E - Behaviors" had physical behavioral symptoms 1-3 days, verbal behavioral symptoms daily, and other behavioral symptoms not directed toward others (e.g., physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, disruptive sounds) daily.</p> <p>Review of a Facility Reported Incident (FRI) dated 1/8/25 revealed: "On 1-8-25 at about 9:50 am, (R1) was outside of her room in the hallway upset by another male resident in the hallway due to him clearing his throat. This upset (R1) as she thought it was too loud. Staff were able to intervene and were able to redirect (R1) who was going back towards her door. Staff members went to notify nurse of her behaviors. At this time, (R6) who shares a bathroom with (R1) came out</p>		<p>below. Residents with a BIMS of 9 or above have been interviewed to ensure they feel safe in facility and have no concerns related to other residents. IDT reviewed interviews and no concerns related to other residents were identified.</p> <p>Facility identified residents with behaviors affecting others and care plans and interventions have been reviewed and are current as written.</p> <p>Element 3: Re-education will be completed by 5-8-25 or before next shift worked with all staff related to the Abuse and Neglect Policy and behaviors affecting others. Administrator and Director of Nursing have reviewed the Abuse and Neglect Policy and deemed it appropriate.</p> <p>Element 4: Random audits of 5 interviewable residents and 5 non-interviewable residents will be completed weekly for 4 weeks. 10 staff members weekly for 4 weeks will be quizzed on how to manage behaviors and offer support to residents. Audit findings will be presented to the facility QAPI Committee and will only be discontinued with substantial compliance and with approval of the facility QAPI Committee. Any instances of noncompliance that are identified will be addressed per company policy concerning education and disciplinary action when necessary.</p> <p>The Administrator and Director of Nursing are responsible for achieving and sustaining compliance.</p>	

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	<p>of her room and approached (R1) One aide approaching the situation from another hall could see (R6) laughing and clapping her hands at (R1). This action upset (R1) and she pushed (R6) in the middle of her chest..."</p> <p>Resident #6 (R6)</p> <p>Review of an "Admission Record" revealed Resident #6, was originally admitted to the facility on 12/6/2024 with pertinent diagnoses which included: dementia.</p> <p>Review of a "Minimum Data Set" (MDS) assessment for Resident #6, with a reference date of 3/12/25 revealed a "Brief Interview for Mental Status" (BIMS) score of 04/15, indicating R6 was severely cognitively impaired. The MDS revealed no noted behaviors in Section E.</p> <p>In an interview on 4/10/25 at 8:30 a.m., CNA "G" reported R1 was much more ambulatory than she presently is. CNA "G" reported R1 was physically and verbally aggressive towards other residents and has made physical contact in the past with other residents. CNA "G" stated she did not witness R1 strike R2 or R6, but R1 was ambulatory and moved quickly before recently showing decline due to the flu and other medical issues which made her less mobile. CNA "G" reported R1 was very verbally and physically aggressive towards others and has made physical contact with other residents besides just R2 and R6.</p> <p>Review of multiple 'Progress Notes' for R1 from 12/15/24-1/8/25 revealed:</p> <p>"12/15/2024 Nurses' Notes Text: While (R1) neighbor was utilizing the bathroom, R1 opened the door and began yelling at the resident telling them "You don't belong here", "get out of my</p>			

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	<p>bathroom" and then grabbed their shirt trying to pull them off the toilet... .. 12/28/2024 the resident-to-resident altercation. (R1) has refused all her medication today (R1) has been very aggressive today .... 12/28/2024 Resident to resident verbal and physical abuse took place...12/31/2024 09:47:11 Physician Progress Note Text: (R1) is seen for follow-up of recent resident event occurring on 12/28/24. Patient is reported started yelling and swearing at another patient, then grabbed her arm and slapped her across the left side of the face. Patient then yelled back at this resident and slapped her across the face ... 1/8/2025 17:06 Nurses Notes Text: This writer contacted Inpatient Psych unit. Discussed possible need for direct admission for (R1) due to behaviors, physical aggression towards others and threats of physically harming other residents ... (R1) has had multiple physical altercations with other res in the past 3 weeks. She has voiced wanting to hurt others and is impulsive and explosive. She had PRN Ativan (anti-anxiety medication) today following incident of physical aggression towards another resident .... (R1) also has had some recent paranoia and increase in her verbal aggressiveness as well. She recently had her Depakote (antipsychotic medication) increased from ...following a previous altercation and aggressiveness towards another resident 2 weeks ago ...1/8/2025 10:48 (R1) became angry at another resident for coughing, she started yelling then pushed another resident ...1/8/2025 20:25 Physicians Orders - Administration Note Text: LOA (leave of absence) to (psychiatric hospital).. " R1 returned to the facility on 1/22/25...</p> <p>Review of R1's Progress notes revealed: "1/30/2025 Note Text: After lunch, resident (R1) approached another female resident and was verbally bashing her. Other resident left in tears ..."</p>			

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	<p>Review of R1's Progress notes revealed: "2/3/2025 03:44 Pertinent Charting-Behavior Note Text: R1 showed behaviors earlier in shift. she was very loud and verbally aggressive towards residents who share bathroom with her. She did not want them in her bathroom. She was slamming doors and yelling at them. She kept going in other resident rooms and being rude, loud and mean. Residents were scared and afraid for safety because of her behavior ..."</p> <p>Review of R1's Progress notes revealed: "2/6/2025 20:23 Pertinent Charting-Behavior Note Text: (R1) had behaviors such as assisting to push residents in wheelchairs and when RN tried to navigate/ redirect this behavior resident proceeded to yell at RN and cuss and swear that the RN "need to take better care of her children then" ..."</p> <p>Review of R1's Progress notes revealed: "2/9/2025 18:40 Nurses' Notes Text: This nurse was standing at the desk talking with a family member and heard a male resident talking loudly. This nurse turned her head toward TV area and witnessed this (R1) sprinting towards male resident in wheelchair with right fist clenched and arm drawn back behind her head in a striking position. Resident's face was tensed with furrowed brows indicating anger. This nurse yelled very loudly for resident to stop as ran towards the situation. This resident stopped when she got to resident sitting in w/c, arm still in striking position, no change in facial expression and stared at resident. This nurse was able to get in between both resident's, no contact was made. After approx. 15 seconds with nurse in between resident's this resident finally put her arm down, face relaxed and stated, " I wasn't gonna hit him." ..."</p> <p>Review of a Facility Reported Incident (FRI)</p>				

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	<p>dated 2/10/25 Revealed: "Incident Summary R1 was seen smiling and talking to R2 in dining room. Prior to walking back to her (R1) table, speech therapist stated she (R1) swatted him (R2) in the side of the head/forehead twice before leaving... Investigation Summary (R1) ...admitted to facility on 8-15-24 for long term care. Primary diagnosis are dementia, anxiety disorder, memory deficit following cerebrovascular disease, personality disorder, impulsiveness, morbid obesity, type 2 diabetes, and cognitive communication deficit. Per resident's care plan, resident is independent with ambulation, transfers and bed mobility ...Resident can be verbally aggressive towards others at times related to her dementia ...Speech therapist stated, While I was feeding a patient in the dining room, I witnessed R1 get up from her chair and walk 3 tables away and approach R2... She (R1) hit him 2 times in the side of the head/close to forehead. She then walked away. He (R2) cowered away but said nothing ...."</p> <p>Resident #2 (R2)</p> <p>Review of an "Admission Record", revealed R2 was originally admitted to the facility on 4/21/2022 with pertinent diagnoses which included: dementia-without behavioral disturbance.</p> <p>Review of a "Minimum Data Set" (MDS) assessment for R2, with a reference date of 3/22/25 revealed a "Brief Interview for Mental Status" (BIMS) score of 00/15, indicating R2 was severely cognitively impaired. R2's MDS dated 2/4/25 revealed no noted behaviors in Section E. R2's MDS dated 3/22/25 also had no noted behaviors.</p> <p>In an interview on 4/9/25 at 8:15 AM., "Certified Nurse Aide" (CNA) "E" stated they were present</p>			

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	<p>on 2/10/25 when R1 struck R2 in the head. CNA "E" reported R1 has a long history of aggressive physical and verbal behaviors towards other residents and staff. CNA "E" reported this was not the first time R1 has hit or made physical contact with another resident. CNA "E" reported R1 is combative with cares and will often say very vulgar and rude comments to both residents. CNA "E" reported a lot of residents are fearful of R1.</p> <p>Review of R1's Progress notes revealed the following:</p> <p>"3/2/2025 07:28 Pertinent Charting-Behavior Resident approached another resident at 0720 who stated "don't touch me" when this resident was reaching out for them, nursing staff intervened and this resident scratched the nurses arm, they then continued "I've been taking care of them you guys must have pissed her off, get out of my house", no contact was made between the residents ..."</p> <p>"3/3/2025 01:23 Pertinent Charting-Behavior R1 has been very confused, agitated and aggressive with redirection. She had a bowel movement and threw it all over in her room."</p> <p>"3/8/2025 19:15 Pertinent Charting-Change in Condition Note Text: Event Date: 03/06/2025 Originally identified change: Weakness, lethargy Resident has been confused and agitated through the day, (R1) sneer anytime another resident walks by or talks to another."</p> <p>"3/20/2025 19:12 Pertinent Charting-Behavior Text: Resident continues to have agitation, combativeness/anxiety towards staff and residents. Resident was seen getting into other residents faces and needed to be redirected multiple times during this shift. Resident becomes</p>			

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	<p>upset when redirected or feeling like she is "getting in trouble" .."</p> <p>On 4/10/25 at 9:40 AM., Observed/Interviewed R1 while she was sitting in her wheelchair outside the doorway to her bedroom. R1 told this surveyor I was nosey for asking her questions, when asked about what she enjoys doing R1 said "that is none of my business". This Surveyor ended any further discussion due to physical facial expressions and body language appearing to show signs of increased agitation.</p> <p>On 4/10/25 at 2:10 PM., Registered Nurse (RN) "K" reported R1's behaviors have been an ongoing concern for a long time. RN "K" reported medication changes, and a recent illness has caused her to be less mobile. RN "K" reported R1 is very verbally aggressive towards anyone near her on any given day, and it comes on quickly. RN "K" reported she has had multiple altercation with other residents, and many residents fear her, and when she comes out of her room those residents will either come closer to the nurses' station or return to their rooms. RN "K" reported she should always have eyes on her, but not a complete close contact 1:1 which would increase her behavior and agitation. RN "K" reported she would benefit from a distant 1:1, a staff member who's primary duty is to keep their eyes on her.</p> <p>Review of a facility "Policy" with a revision date of 1/10/24 revealed: "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, and misappropriation of resident property. Definitions: "Abuse" means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting</p>			

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	<p>physical harm, pain, or mental anguish, which can include staff to resident abuse and certain resident to resident altercations. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain, or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology ... "Verbal Abuse" means the use of oral, written, or gestured communication or sounds that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance regardless of their age, ability to comprehend, or disability. "Physical Abuse" includes, but is not limited to hitting, slapping, punching, biting, and kicking. It also includes controlling behavior through corporal punishment ... "Past noncompliance" occurs when noncompliance has occurred in the past, but the facility corrects the deficiency and is in substantial compliance at the time of the current survey. More specifically, a deficiency citation at past noncompliance (PNC) meets the following three criteria: 1. The facility was not in compliance with the specific regulatory requirement(s) at the time the situation occurred. 2. The noncompliance occurred after the exit date of the last standard (recertification) survey and before the survey (standard, complaint, or revisit) currently being conducted, and 3. There is sufficient evidence that the facility corrected the noncompliance and is in substantial compliance at the time of the current survey for the specific regulatory requirement(s), as referenced by the specific Ftag. "Substantial compliance" means a level of compliance with the requirements of participation such that any identified deficiencies pose no greater risk to resident health or safety than the potential for causing minimal harm ..."</p>			

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