

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  235038	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/04/2025
NAME OF PROVIDER OR SUPPLIER  Medilodge of Grand Rapids		STREET ADDRESS, CITY, STATE, ZIP CODE 2000 Leonard NE Grand Rapids, MI 49505	

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)
<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> On 6/4/25 at 10:16 AM during a confidential group meeting, the group agreed there is not enough staffing on nights and weekend to meet resident needs. They voiced concerns there would be times at nights and on weekends there may be 1 CNA (certified nursing assistant) on each hall and 1 or 2 nurses to run clinical cares in the entire facility. According to the group, this makes longer wait times to get medications and assistance with toileting, The group voiced disheartening concerns when discussing many of the CNAs and nurses they felt were good and caring had left employment while others had put in their notices to leave because of better offers and work conditions. Another concern the group brought to attention was laundry. They stated laundry had one person currently and residents might not get their clothes back until the following week. Wash cloths are sometimes made from cut up towels, sheets have holes, towels are rough, and tattered.</p> <p>R32</p> <p>According to the MDS dated [DATE], R32 was cognitively intact with a score of 15/15 on her BIMS (Brief Interview Mental Status), with Section GG-Functional Status indicating a 2-person assist was required for transfers, dressing, and toileting.</p> <p>During an interview on 6/4/25 from 11:20 AM to 3:30 PM, R32 stated, My call light was on for a long time while I was sitting in pee. My leg was burning. I had to miss my therapy because CNAs did not get me up or change me. Therapy kept coming in to see why I wasn't up. The CNA would come to turn my light off and say she would come back to help. Then I would put the call light back on to say I was wet and needed to go to therapy and she would turn off the light and leave. That made me feel horrible because no one cared enough to have someone help me.</p> <p>(continued on next page)</p>

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 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 6/4/25 at 11:10 AM, CNA H stated, I was assigned to (R32) and other residents in her area (HC2) yesterday, 6/3/25. Around 1 pm (R32) asked to get up to therapy. She needs 2 staff to get her up. I had 5 showers assigned to me and (R25) was on 1:1 monitoring with the other CNA assigned to that task. I had to do waters, pass trays, and on top of that the CNA assigned to 1:1 had to leave, and I had to monitor (R25) on 1:1 for a while. Management came to help pass trays but that still not enough help because they didn't know the residents. I was passing trays and still checking and changing residents while answering call lights. (R32) requires a 2-person mechanical lift and I did not have time to get her up. Until 10 or 11 AM (6/3/25) I was running by myself and (R32) said she would stay in bed until lunch trays were passed but she said she had to get up for therapy. I had every intention to get her up but I just didn't have the help. The first CNA assigned with me that morning (6/3/25) was transferred over to another unit. So, it was just me and the CNA on 1:1 monitoring until 10-11 AM when the first CNA came back to HC2 but the two of just couldn't get together to get (R32) up with the assignments we had. When my shift was done at 2:30 (PM), I asked the nurse to tell the oncoming CNA I was behind with the things I needed to do with the residents, and she told me to tell the oncoming CNA to get (R32) up. The nurse will offer to help with simple things but not help with transfers. I was out of time to get my all my residents taken care of. Management needs to know that the night shift CNAs sit around the desk and do not answer call lights. Management does not come to the back unit (HC2) to make sure staff is doing their jobs and helping. The other night I was doing showers on a split for Ridgewood and Pine Units and 3 call lights were on. The CNAs behind the desk did not answer the lights because the lights were my assigned residents. If I have a bad attitude it is because the other staff do not help. Showers are not getting done. Getting residents toileted and changed is not a problem but showers are.</p> <p>During an interview on 6/4/25 at 2:50 PM, Occupational Therapist (OT) Z stated, (R32) did refuse to have therapy to get her out of bed because it would have cut her walking time during therapy. (R32) wanted the CNA to get her cleaned up, dressed, and in her wheelchair but the CNA could not. (R32) is determined to get her entire therapy time to walk and exercise. It seemed busy on the unit (HC2) that day (6/3/25) and only one CNA was available to assist (R32). (R32) rescheduled her therapy to get the whole time for walking and exercising.</p> <p>Review of CNA schedule for HC2 on 6/3/25 indicated 3 CNAs were assigned to the facility from 6:30 AM to 2:45 PM. One was assigned to the 1:1 monitoring and 2- CNAs for the resident population of 49.</p> <p>Review of an email received on 6/4/25 at 12:00 PM from Nursing Home Administrator (NHA) A revealed 6 residents on the HC2 unit required 2-person assist with transfers.</p> <p>Based on observation, interview, and record review the facility failed to have sufficient staffing to ensure resident care needs were responded to timely for 4 (Residents #13, #1, #32, and #3) of 5 residents reviewed for sufficient staffing, 4 of 4 residents from a confidential resident council group meeting, and the potential to affect all those living at the facility of the facility census of 49 resulting in feeling awful, frustration, and/or discontent with one's living situation.</p> <p>Findings include:</p> <p>Resident #13:</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 06/02/25 at 10:24 AM, Resident #13 reported the facility staff's call light response time was approximately 30-45 minutes. Resident #13 also reported waiting up to an hour and a half at least four times a month on average.</p> <p>During observations and interviews starting on 06/03/25 at 07:36 AM, Resident #13's private room (no roommate) call light was observed activated/the light on the ceiling outside the room indicated the resident had pressed his call light requesting staff assistance. The nurses' station call light monitor screen at that time indicated Resident #13's call light had been on for 50 minutes and 6 seconds. Upon returning to Resident #13's room Resident #13 confirmed his call light had been on for 50 minutes and no staff had stopped to check on him or answer his call light. Resident #13 reported when staff made him wait that long it made him feel awful. Resident #13 reported he needed to go to the bathroom, and he was visibly frustrated and uncomfortable. Approximately 3 minutes later Certified Nurse Aide (CNA) L responded to Resident #13's call light. CNA L confirmed 50 minutes was not an appropriate response time and the wait for a call light response shouldn't be that long. CNA L reported the facility didn't always have enough staff to accomplish all tasks and resident cares but sometimes they do.</p> <p>Review of Resident #13's most recent brief interview for mental status score, dated 2/24/25, was scored 14 which suggested he was cognitively intact.</p> <p>Review of Resident #13's activities of daily living (ADL) care plan, revised 12/11/2024, stated, Resident (Resident #13) has an ADL self-care performance deficit related to spondylosis (small crack between two vertebrae (bones in your spine) .paraplegia (type of paralysis that affects lower half of the body) . TOILETING: 1 person assist .Encourage resident to use call light when assistance is needed.</p> <p>Resident #1:</p> <p>During an interview on 06/02/25 at 10:50 AM, Resident #1 was in her room and reported facility staff's call light response times were often consistently longer than 15 minutes and closer to an average of 30 minutes.</p> <p>Review of Resident #1's most recent brief interview for mental status score, dated 5/16/25, was scored 14 which suggested she was cognitively intact.</p> <p>Review of Resident #1's activities of daily living (ADL) care plan, revised 5/22/2025, stated, Resident (Resident #1) has an ADL self-care performance deficit .TOILETING: .assist as needed .Encourage resident to use call light when assistance is needed.</p> <p>During an interview on 06/04/25 at 10:51 AM, Nursing Home Administrator A stated, Reasonable time for a call light should be 10-15 minutes.</p> <p>Review of the facility's Resident Council Minutes, dated 1/28/25, stated, .New Business Review/Action Plan: . Current Situation/Concern .call light .Actions Taken .concern form .Person Responsible .nursing .Outcome . Not Resolved - Action Needed .</p> <p>Review of the facility's Resident Council Minutes, dated 3/27/25, stated, .Clinical: .(Resident #24) says that he has to wait over an hour many nights to have his call light answered .</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the facility's Resident Council Minutes, dated 4/16/25, stated, Old Business Review: (List unresolved old business from last meeting's minutes .Issue .Call lights not answered timely .Status Update .ongoing .New Business Review/Action Plan: Current Situation/Concern .Call lights not being answered timely .Actions Taken .Audits going .</p> <p>Review of the facility's Resident Council Minutes, dated 5/23/25, stated, Old Business Review: (List unresolved old business from last meeting's minutes .Issue .Call lights .Status Update .still on going .Person Responsible .nursing .New Business Review/Action Plan: Current Situation/Concern .Call lights taking so long to be answered .</p> <p>Review of the facility's call light accessibility and timely response policy, revised 12/28/2023, stated, .Call lights will directly relay to a staff member or centralized location to ensure appropriate response .Any staff member who sees or hears an activated call light is responsible for responding. If the staff member cannot provide what the resident desires, the appropriate personnel should be notified.</p> <p>Resident #3</p> <p>In an interview on 6/2/25 at 1:58pm, Family Member/Durable Power of Attorney (FM/DPOA) S reported he visited Resident #3 several times per week and often waited more than 45 minutes for staff to respond after he activated the resident's call light. FM/DPOA S reported he frequently repositioned Resident #3 himself during his visits, after he waited more than 45 minutes for staff to respond. FM/DPOA S reported he always tried to find staff to assist Resident #3 with repositioning before completing the care himself but could not locate any nursing staff.</p> <p>In an interview on 6/4/25 at 11:05am, Licensed Practical Nurse (LPN) C reported nursing staff levels at the facility were horrible and she witnessed resident care needs going unmet. When further queried, LPN C reported in one instance, a resident who wanted to be assisted into a recliner immediately after meals was left sitting in a wheelchair because the staff needed to attend to the residents who were still eating. The resident fell while trying to transfer himself to a nearby recliner. LPN C stated he fell because he likes to get into a recliner right away after a meal and we couldn't assist him soon enough. LPN C reported the facility usually had 1.5 Certified Nursing Assistant's for her unit and that was not enough to meet the needs of the residents. LPN C stated The level of staffing we have is not enough based on the acuity of the residents.</p> <p>In an interview on 6/4/25 at 1:06pm, Nursing Home Administrator (NHA) A reported the facility needed to reduce the number of nursing staff absences but did not currently have a Quality Improvement Plan underway to address the issue. When further queried, NHA A reported the facility did not increase the number of nursing staff based on resident acuity and stated we make do with what we have.</p>		