STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235062	A. Building B. Wing	01/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grandvue Medical Care Facility	1728 South Peninsula Road East Jordan, MI 49727

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 - 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 deficient practice pertains to Intake 2711152.Based on observation, interview, and record review, the facility failed to protect a resident's right to be free from verbal abuse by a staff member for one Resident (#1) of three residents reviewed for abuse and neglect. This deficient practice resulted in psychosocial harm and mental anguish for Resident #1 based on the reasonable personal concept.Findings Include:Resident #1 (R1)Review of the Electronic Medical Record (EMR) revealed R1 was a [AGE] year-old male who admitted to the facility on [DATE] with diagnoses including dementia, aphasia (a language disorder that impairs a person's ability to communicate, affecting speaking and understanding), overactive bladder, urinary incontinence, and need for assistance for personal care. Review of Section C: Cognitive Patterns in R1's most recent Minimum Data Set (MDS) assessment, dated 12/15/25, revealed his, cognitive skills for daily decision making were severely impaired.Review of an Incident Summary to the State Agency (SA) written by the Director of Nursing (DON) on 1/7/26 at 5:33 PM read, in part: On December 31, 2025, a staff member, social worker [Social Worker (SW) A], overheard another staff member state, you're being a complete [expletive] to resident [R1]. [SW A] approached the two CNAs (certified nursing assistants) who were in the room with the resident. [CNA B] denied making the statement and indicated [CNA/Perpetrator E] had made the statement. Type of Alleged Incident: Abuse. Was the Alleged Incident Verified (Substantiated): Yes . Conclusion: [CNA/Perpetrator E] did not follow the care plan and did not employ sound dementia approach.She committed mental abuse, by making verbal, derogatory remarks to [R1].On 1/12/26 at 11:55 AM, an interview was conducted with SW A who verified she was entering her office on the morning of 12/31/25 when she heard somebody down the hall state, You're being a complete [expletive]. SW A stated she entered R1's room where she found CNA B bagging trash and witnessed CNA/Perpetrator E quickly leave the room. SW A stated she informed CNA B what was overheard. CNA B then indicated CNA/Perpetrator E had made the statement toward R1.On 1/21/26 at 11:26 AM, R1 was observed at a seating area at the end of the corridor. An interview was attempted but R1 was unable to answer questions related to the event on 12/31/25. On 1/21/26 at 5:03 PM, a telephone interview was conducted with CNA B who verified she had been assisting R1 with cares on the morning of 12/31/25. CNA B stated R1 had been known to be combative with cares at times, so it usually required the assistance of two CNAs for safety and deescalation. CNA B recalled R1 was in a good mood at that time and was amenable for assistance with a brief change with the help of one aide. CNA B stated R1 was lying in bed, and she had almost completed fastening a clean brief but could not roll R1 to get both sides of the brief attached. CNA B stated she summoned CNA/Perpetrator E for assistance but believed the loud tone of her voice and speed at which she was working may have upset R1. CNA B said they were attempting to leave the room to allow R1 to calm down, but R1 independently stood up from bed, ripped off his brief, and began walking toward the door to the hallway. CNA B stated she tried to redirect R1 by closing the curtain so he did not walk (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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(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	into the hallway unclothed during which he had nudged CNA B and laid hands on CNA/Perpetrator E. CNA B recalled R1 eventually decided to lay back down and said a rude remark under his breath which prompted CNA/Perpetrator E to state, You're being a complete [expletive].On 1/21/26 at 11:03 AM, a telephone interview was conducted with CNA/Perpetrator E who verified she assisted CNA B with R1's cares on the morning of 12/31/25. CNA/Perpetrator E stated R1 became combative after standing up from the beside while they were attempting to secure his brief. CNA/Perpetrator E alleged R1 had twisted her wrist and arm and was attempting to push CNA B. CNA/Perpetrator E stated after the situation calmed and R1 was situated back in bed, she turned around to walk out of the room when R1 kicked her in the back. CNA/Perpetrator E admitted , That's when I called him an [expletive] without even thinking about it. When CNA/Perpetrator E was asked if R1 heard her make a derogatory remark toward him she replied, He probably did, I was still in the room.On 1/21/26 at 2:02 PM, a telephone interview was conducted with R1's Durable Power of Attorney (DPOA) H regarding the incident on 12/31/25. DPOA H stated she was informed of the scenario and voiced, I just feel bad for [R1].Review of the facility policy titled, Freedom from Abuse, Neglect and Exploitation, reviewed 2/5/25, read, in part: .each resident has the right to be free from abuse, neglect, misappropriation of resident property and exploitation. Abuse means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse. Verbal Abuse means the use of oral, written or gestured language 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. The facility will: Not use verbal, mental, sexual or physical abuse. The facility will consider factors indicating possible abuse, neglect, and/or exploitation of residents, including, but not limited to, the following possible indicators: . Verbal abuse of a resident overheard.