STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235157	A. Building B. Wing	08/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sanilac Medical Care Facility	137 North Elk Street Sandusky, MI 48471

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 - Minimal harm or potential for 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. (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 - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to prevent verbal abuse for one (Resident #40) of 19 residents reviewed for abuse, resulting in refused care, frustration with the likelihood of increased behavioral disturbances. Findings include:This citation pertains to intake 2594908 On 8/19/2025, at 12:10 PM, Resident #40 was asked if they were happy with their room and Resident #40 offered, that it was a new room. Resident #40 complained there was a girl that worked there and that they had laughed at their grandmother. Resident #40 offered, that they always say hi to them but this girl has got it in for me. Resident #40 was unable to detail the girl's appearance other than she wore pink outfits. On 8/19/2025, at 12:30 PM, the Director of Nursing (DON) offered, they called CNA H to interview them regarding Resident #40 as they left out of the facility prior to the DON arriving. The DON stated, that CNA H was alerted they would be reported for verbal abuse and that CNA H stated, no worries, I quit. On 8/19/2025, at 10:00 AM, a record review of Resident #40's electronic medical record revealed an admission on [DATE] with diagnoses that included Stroke, Dysphagia, adjustment disorder with anxiety and major depressive disorder. Resident #40 required assistance with all Activities of Daily Living and had recently been deemed incompetent to make medical decisions for themselves. A review of the care plan The resident uses psychotropic medication(s) to manage symptoms of their psychiatric disorder(s). Date Initiated: 02/28/2025 Goal My symptoms/behaviors will be reduced using a combination of psychotropic medication(s) and nonpharmacological interventions through the review date. Date Initiated: . Approaches/Tasks . Provide me with a non-confrontational environment for care. Date Initiated: 02/28/2025 . On 8/20/2025, at 9:20 AM, Resident #40 was resting in bed on back and denied any abuse complaints that day. On 8/20/2025, at 3:27 PM, a phone interview was conducted with CNA I who witnessed the verbal abuse towards Resident #40. CNA I stated, earlier that day they were in caring for Resident #40 and had asked CNA H to bring in the hoyer and assist with a transfer out of the bathroom. CNA I asked Resident #40 if CNA H could assist with the transfer and Resident #40 stated, Nope, get out. At that time, CNA I witnessed, CNA H open the bathroom door hastily and stated to Resident #40, I did nothing to you and you tried to kill me as CNA H attempted to slam the bathroom door shut but CNA H quickly stopped the door from slamming, opened back up and stated to Resident #40, You're crazy and slammed the bathroom door shut before leaving out of the room. CNA I stayed with Resident #40 who complained about CNA H stating, she hates me and that she's out to get me. CNA I completed cares for Resident #40 and propelled them down to the dining room. As CNA I pushed Resident #40 into the dining room, CNA H was overhead and observed pointing towards both Resident #40 and CNA I and loudly stated, and that dumb ass over there wants to call me crazy when she's the crazy one. She tried to kill me. She thinks my grandma's here, and she doesn't even know what she's talking about. CNA I continued to propel Resident #40 towards a dining table and CNA H further stated loudly, At least I'm an independent woman and do things for myself and get my own drinks. CNA I was asked if Resident #40 overheard the abuse and CNA I stated, yes and had to provide reassurance of everyone needs to get along to the resident. CNA I called the Director of Nursing (DON) and alerted of the verbal abuse towards Resident #40 by CNA H . On 8/20/2025, at 10:34 AM, a phone interview was conducted with CNA H regarding the verbal abuse allegation towards Resident #40. CNA H was asked if they called Resident #40 a dumb ass and CNA H stated, they were going to help with a Hoyer lift and the resident said I couldn't help her and that Resident #40 told CNA I they didn't want me to care for her because I was mean to her grandma. She's not right. A week ago, she tried to stab me with a pen. She isn't cognitive. CNA H was asked if they called the resident crazy and CNA H stated, I did not call her crazy. CNA H was asked to explain what happened next and CNA H stated, the resident was on the toilet and they left to the dining room where they were putting meal trays on the cart. CNA H admitted to venting loudly and did admit saying this is some dumb shit. CNA H was asked if there were residents in the dining room and CNA H stated, yes, but they had their back to the residents, was approximately 10 feet away and didn't use resident names. CNA H was asked why they would be accused of verbal abuse and CNA H stated, the nurse has it out for them and that they did not swear in Resident #40's room, that was crazy and further stated, they knew venting in the dining room was wrong and they did not do what they are being accused of.