STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235174	A. Building B. Wing	03/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marshall Nursing and Rehabilitation Community	575 N Madison Street Marshall, MI 49068

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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 - 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to protect the resident's right to be free from of physical abuse by a staff member. Findings include: Per the facility face sheet Resident #1 (R1) was an [AGE] year-old who was originally admitted to the facility on [DATE] with a return to the facility date of [DATE]. Diagnosis included Alzheimer's disease, bipolar disorder, dementia, and anxiety. Review of a Physician's progress note dated [DATE] revealed R1 expired and had a time of death of 3:34 PM (actual time was 2:34 PM) on [DATE]. Review of a progress note dated [DATE] revealed a phone call was made to R1's guardian at approximately 2:20 PM to discuss R1's change in condition and the assessment made by Medical Director (MD) C. The notes revealed that while the Assistant Director of Nursing (ADON) D was on the phone with R1's guardian two Certified Nurse Aids (CNA's) approached ADON D and informed her that they believed R1 had passed away and requesting a nursing assessment. The note revealed ADON D assessed R1 and found R1 to be unresponsive in bed with eyes fixed, no visible breathing, and no lung sounds present. ADON D had listened for an apical pulse (heartbeat) for full 60 seconds and no pulse was noted. The note revealed MD C assessed R1 and called official time of death at 2:34 PM. In an interview on [DATE] at 9:31 AM, R1's Guardian E stated she was made aware on [DATE] that R1 had been hostile when receiving a shower, and that she had kicked a bar on the wall in the shower room. Guardian E said it was reported to her that R1 was having a behavior and was combative during the shower. Guardian E said she received the call on the 18th of March that R1 had a bruise on her leg and then she received a call that R1 had passed away. Guardian E said it was a shock to her that R1 passed away. Guardian E said R1 was doing fine and in her normal state prior to that day and stated she had not received any phone calls about her having a change in her condition.Review of a progress note made by Director of Nursing (DON) B revealed Guardian E was notified regarding a bruise to R1's right shin. The note revealed that during the shower R1 began to be aggressive with staff and hit her leg on the shower chair which caused a bruise. An X-ray was ordered. In an interview on [DATE] at 2:08 PM, CNA F stated that she was terminated from her employment at the facility on [DATE]. CNA F said her and CNA G went into R1's room with the mechanical lift and the shower chair and said when they put the sling under R1 she became combative and was yelling that we were was not supposed to give her a shower. CNA G said R1 was digging, kicking, and hitting. CNA F said R1 was transferred to the shower chair in her room but never stopped hitting digging into her skin. CNA F said she shampooed R1's hair and CNA G washed her body all while R1 continued to dig into their skin and hit them. CNA F said she gave R1 the shower because she was told she had to by Registered Nurse (RN) H or she would get written up. Review of an Employee Memorandum dated [DATE] revealed CNA F was terminated from her employment at the facility for violation of resident rights amongst other reasons.CNA F continued to state that there were bars on the wall in the shower area, and R1 kicked the bar on the wall with her right leg. CNA F said she held R1's arms down while CNA G washed R1. CNA F stated that right from the beginning R1 said she did not want to take a shower and said R1 made the statement more than once. CNA F said she told R1 she was asked to give her a shower, and R1 said no then she got (continued on next page)

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	combative. CNA F said RN H told her that no matter what R1 was going to get a shower and told us that we had to shower her. CNA F said on [DATE] she was notified by the facility that she was suspended and then fired.CNA F further stated that it was a surprise to her that R1 died. CNA F said R1 was in her normal state up until the day she passed. CNA F said R1 was not actively declining in health prior to her death. In an interview on [DATE] at 8:20 AM, RN H stated R1 was scheduled for a shower. RN H said the CNAs reported to her that in the shower, when they transferred R1 from to the shower chair, she hit her leg on the mechanical lift bar. RN H said she was surprised R1 had passed away, and she did not make a connection between the bruising on R1's right shin and her death. RN H said R1 never complained of any pain.Review of a statement that RN H wrote post the incident dated [DATE] revealed, R1 had bruising, swelling, and an abrasion to her right shin area after hitting her leg on the mechanical lift bar. The statement revealed that the lower leg showed bruising and swelling that was not present earlier in the night. The swelling extended from the knee to the ankle. The statement revealed R1 yelled out loudly and pulled away from direct touch to the swollen area, R1 refused to allow ROM of the knee when attempted; R1 guarded the leg and yelled out. In an interview on [DATE] at 8:38 AM, CNA G stated that CNA F had approached her and asked her if she would help with showering R1. CNA G said R1 was very irate and was kicking, while in the shower room she was kicking again and she ended up kicking the shower bar, which resulted in a bruise. CNA G said R1 was being combative because she did not want to take a shower. CNA G said CNA F was told by RN H that she needed to give R1 a shower. CNA G said she visibly saw CNA F holding R1's down by her wrists so R1 did not hit her, and the whole time R1 was saying she did not want to shower. CNA G further stated that the shower should not have been given with R1 not wanting it and should have told RN H that R1 was absolutely refusing and we were going against R1's rights. CNA G said R1 was complaining about her knee hurting. CNA G stated that she did consider this to be abuse; stating that CNA F holding R1's wrists down was abuse, and she should have told CNA F to release her grip and reported the abuse to RN H. CNA G also stated that forcing R1 to take a shower was abuse.Review of a shower sheet dated [DATE], revealed documentation that R1 had bruising form kicking and did not want the shower. This was documented by CNA F and G. Review of a statement written by CNA F dated [DATE] revealed R1 was kicking and kicked the mechanical lift bar and the shower room bar. The statement revealed R1 was very combative and had fingertip bruising on her arms from keeping her form digging on and biting CNA F and G.Review of a statement written by CNA G revealed that once getting R1 into the mechanical lift R1 was so angry she was trying to kick CNA F. The statement revealed that once getting R1 to the shower she ended up kicking the shower bar that was on the wall. Review of an X-ray result dated [DATE] revealed R1 had an acute transverse fibular neck fracture (fracture of the lower leg).

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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	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** Based on interview and record review the facility failed to report to the state agency abuse against one out of three residents (R1). Per the facility face sheet Resident #1 (R1) was an [AGE] year-old who was originally admitted to the facility on [DATE] with a return to the facility date of [DATE]. Diagnosis included Alzheimer's disease, bipolar disorder, dementia, and anxiety. Review of a Physician's progress note dated [DATE] revealed R1 expired and had a time of death of 3:34 PM (actual time was 2:34 PM) on [DATE]. Review of a progress note dated [DATE] revealed a phone call was made to R1's guardian at approximately 2:20 PM to discuss R1's change in condition and the assessment made by Medical Director (MD) C. The notes revealed that while the Assistant Director of Nursing (ADON) D was on the phone with R1's guardian two Certified Nurse Aids (CNA's) approached ADON D and informed her that they believed R1 had passed away and requesting a nursing assessment. The note revealed ADON D assessed R1 and found R1 to be unresponsive in bed with eyes fixed, no visible breathing, and no lung sounds present. ADON D had listened for an apical pulse (heartbeat) for full 60 seconds and no pulse was noted. The note revealed MD C assessed R1 and called official time of death at 2:34 PM. In an interview on [DATE] at 9:31 AM, R1's Guardian E stated she was made aware on [DATE] that R1 had been hostile when receiving a shower, and that she had kicked a bar on the wall in the shower room. Guardian E said it was reported to her that R1 was having a behavior and was combative during the shower. Guardian E said she received the call on the 18th of March that R1 had a bruise on her leg and then she received a call that R1 had passed away. Guardian E said it was a shock to her that R1 passed away. Guardian E said R1 was doing fine and in her normal state prior to that day and stated she had not received any phone calls about her having a change in her condition.Review of a progress note made by Director of Nursing (DON) B revealed Guardian E was notified regarding a bruise to R1's right shin. The note revealed that during the shower R1 began to be aggressive with staff and hit her leg on the shower chair which caused a bruise. An X-ray was ordered. In an interview on [DATE] at 2:08 PM, CNA F stated that she was terminated from her employment at the facility on [DATE]. CNA F said her and CNA G went into R1's room with the mechanical lift and the shower chair and said when they put the sling under R1 she became combative and was yelling that we were was not supposed to give her a shower. CNA G said R1 was digging, kicking, and hitting. CNA F said R1 was transferred to the shower chair in her room but never stopped hitting digging into her skin. CNA F said she shampooed R1's hair and CNA G washed her body all while R1 continued to dig into their skin and hit them. CNA F said she gave R1 the shower because she was told she had to by Registered Nurse (RN) H or she would get written up. CNA F continued to state that there were bars on the wall in the shower area, and R1 kicked the bar on the wall with her right leg. CNA F said she held R1's arms down while CNA G washed R1. CNA F stated that right from the beginning R1 said she did not want to take a shower and said R1 made the statement more than once. CNA F said she told R1 she was asked to give her a shower, and R1 said no then she got combative. CNA F said RN H told her that no matter what R1 was going to get a shower and told us that we had to shower her. CNA F said on [DATE] she was notified by the facility that she was suspended and then fired.In an interview on [DATE] at 8:20 AM, RN H stated R1 was scheduled for a shower. RN H said the CNAs reported to her that in the shower, when they transferred R1 from to the shower chair, she hit her leg on the mechanical lift bar. RN H said she was surprised R1 had passed away, and she did not make a connection between the bruising on R1's right shin and her death. RN H said R1 never complained of any pain.Review of a statement that RN H wrote post the incident dated [DATE] revealed, R1 had bruising, swelling, and an abrasion to her right shin area after hitting her leg on the mechanical lift bar. The statement revealed that the lower leg showed bruising and swelling that was not present earlier in the night. The swelling extended from the knee to the ankle. The (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	statement revealed R1 yelled out loudly and pulled away from direct touch to the swollen area, R1 refused to allow ROM of the knee when attempted; R1 guarded the leg and yelled out. In an interview on [DATE] at 8:38 AM, CNA G stated that CNA F had approached her and asked her if she would help with showering R1. CNA G said R1 was very irate and was kicking, while in the shower room she was kicking again and she ended up kicking the shower bar, which resulted in a bruise. CNA G said R1 was being combative because she did not want to take a shower. CNA G said CNA F was told by RN H that she needed to give R1 a shower. CNA G said she visibly saw CNA F holding R1's down by her wrists so R1 did not hit her, and the whole time R1 was saying she did not want to shower. CNA G further stated that the shower should not have been given with R1 not wanting it and should have told RN H that R1 was absolutely refusing and we were going against R1's rights. CNA G said R1 was complaining about her knee hurting. CNA G stated that she did consider this to be abuse; stating that CNA F holding R1's wrists down was abuse, and she should have told CNA F to release her grip and reported the abuse to RN H. CNA G also stated that forcing R1 to take a shower was abuse.Review of a shower sheet dated [DATE], revealed documentation that R1 had bruising form kicking and did not want the shower. This was documented by CNA F and G. Review of a statement written by CNA F dated [DATE] revealed R1 was kicking and kicked the mechanical lift bar and the shower room wall bar. The statement revealed R1 was very combative and had fingertip bruising on her arms from keeping her form digging on and biting CNA F and G.Review of a statement written by CNA G revealed that once getting R1 into the mechanical lift R1 was so angry she was trying to kick CNA F. The statement revealed that once getting R1 to the shower she ended up kicking the shower bar that was on the wall. Review of an X-ray result dated [DATE] revealed R1 had an acute transverse fibular neck fracture (fracture of the lower leg).In an interview on [DATE] at 11:33 AM, Administrator A stated that she was not able to substantiate abuse (despite CNA F's written statement) so the incident was not reportable. The incident was not reported to the state agency.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to report to investigate abuse against one out of three residents (R1). Per the facility face sheet Resident #1 (R1) was an [AGE] year-old who was originally admitted to the facility on [DATE] with a return to the facility date of [DATE]. Diagnosis included Alzheimer's disease, bipolar disorder, dementia, and anxiety. Review of a Physician's progress note dated [DATE] revealed R1 expired and had a time of death of 3:34 PM (actual time was 2:34 PM) on [DATE]. Review of a progress note made by Director of Nursing (DON) B revealed Guardian E was notified regarding a bruise to R1's right shin. The note revealed that during the shower R1 began to be aggressive with staff and hit her leg on the shower chair which caused a bruise. An X-ray was ordered. In an interview on [DATE] at 2:08 PM, CNA F stated that she was terminated from her employment at the facility on [DATE]. CNA F said her and CNA G went into R1's room with the mechanical lift and the shower chair and said when they put the sling under R1 she became combative and was yelling that we were was not supposed to give her a shower. CNA G said R1 was digging, kicking, and hitting. CNA F said R1 was transferred to the shower chair in her room but never stopped hitting digging into her skin. CNA F said she shampooed R1's hair and CNA G washed her body all while R1 continued to dig into their skin and hit them. CNA F said she gave R1 the shower because she was told she had to by Registered Nurse (RN) H or she would get written up. CNA F continued to state that there were bars on the wall in the shower area, and R1 kicked the bar on the wall with her right leg. CNA F said she held R1's arms down while CNA G washed R1. CNA F stated that right from the beginning R1 said she did not want to take a shower and said R1 made the statement more than once. CNA F said she told R1 she was asked to give her a shower, and R1 said no then she got combative. CNA F said RN H told her that no matter what R1 was going to get a shower and told us that we had to shower her. CNA F said on [DATE] she was notified by the facility that she was suspended and then fired.Review of a statement that RN H wrote post the incident dated [DATE] revealed, R1 had bruising, swelling, and an abrasion to her right shin area after hitting her leg on the mechanical lift bar. The statement revealed that the lower leg showed bruising and swelling that was not present earlier in the night. The swelling extended from the knee to the ankle. The statement revealed R1 yelled out loudly and pulled away from direct touch to the swollen area, R1 refused to allow ROM of the knee when attempted; R1 guarded the leg and yelled out. In an interview on [DATE] at 8:38 AM, CNA G stated that CNA F had approached her and asked her if she would help with showering R1. CNA G said R1 was very irate and was kicking, while in the shower room she was kicking again and she ended up kicking the shower bar, which resulted in a bruise. CNA G said R1 was being combative because she did not want to take a shower. CNA G said CNA F was told by RN H that she needed to give R1 a shower. CNA G said she visibly saw CNA F holding R1's down by her wrists so R1 did not hit her, and the whole time R1 was saying she did not want to shower. CNA G further stated that the shower should not have been given with R1 not wanting it and should have told RN H that R1 was absolutely refusing and we were going against R1's rights. CNA G said R1 was complaining about her knee hurting. CNA G stated that she did consider this to be abuse; stating that CNA F holding R1's wrists down was abuse, and she should have told CNA F to release her grip and reported the abuse to RN H. CNA G also stated that forcing R1 to take a shower was abuse.Review of a shower sheet dated [DATE], revealed documentation that R1 had bruising form kicking and did not want the shower. This was documented by CNA F and G. Review of a statement written by CNA F dated [DATE] revealed R1 was kicking and kicked the mechanical lift bar and the shower room bar. The statement revealed R1 was very combative and had fingertip bruising on her arms from keeping her form digging on and biting CNA F and G.Review of a statement written by CNA G revealed that once getting R1 into the mechanical lift R1 was so angry she was trying to kick CNA F. The statement revealed that once getting R1 to the shower she ended up kicking the shower bar that was on the (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	wall. Review of an X-ray result dated [DATE] revealed R1 had an acute transverse fibular neck fracture (fracture of the lower leg).It was requested on [DATE] at 3:00 PM and again at 3:25 PM the facility incident report, and the facility's thorough investigation. The incident report and investigation were never received. The facility did not perform an investigation regarding the incident.