STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235175	A. Building B. Wing	05/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Frankenmuth	500 West Genesee Frankenmuth, MI 48734

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure that residents were treated in a respectful and dignified manner to ensure timely assistance with care, that call lights were in reach, privacy and a homelike environment for a Confidential Group of Residents and Residents #6, #17, #67, and #83 from a sample of 41 residents reviewed. Findings Include: Confidential Group of Residents On 5/05/2026 at 11:01 AM, during an interview with a Confidential Group of Residents they verbalized their frustration with staff entering their rooms to answer call lights and then the staff say they will be back, shut off the call lights and leave and don't come back. The Confidential residents said, Why don't they take care of our needs while they are there; sometimes they will not be back at all if you complain about it. During the interview on 5/5/2026 at 11:12 AM, the Confidential Group of Residents said, Sometimes the (meal) trays are late. The food is cold, including grilled cheese. One Confidential Resident said they received 2 hamburgers ice cold and when they told the staff about it they were laughed at. During the same interview, another Confidential Resident said they were awakened at 4:30 AM in the morning by a doctor working on their toenails. The Confidential Group of Residents said they had heard a few staff say some words that Weren't very nice. Several of the Confidential Residents said they heard what sounded like parties at the nurses desk in the evenings, at night and on the weekends when the management staff were not in the building. The Residents said, Staff go out for food and then more staff go out and bring in more at the nurses desk. The Confidential Group was frustrated because they were having issues with staff laughing about their cold food and waiting for care, while they brought in food for themselves. On 5/06/2026 at 1:13 PM, during an interview with the Director of Nursing/DON, the Confidential Group of residents' issues related to dignity, how they were spoken to and treated by some staff including staff saying not very nice words and not answering their call lights was reviewed. The DON said that was not Ok. Reviewed with the DON the residents' issues with staff congregating at the nurses desk and being very loud on 2nd and 3rd shifts and she said they would be addressing that. Reviewed the food concerns had been reviewed with the Registered Dietitian/RD, but the staff laughing at the residents was very upsetting to them. The DON said the staff should not be acting like that. A resident being awakened in the night for the Podiatry care was reviewed with the DON and she said she would check on what time the Podiatrist came in. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility policy titled Promoting/Maintaining Resident Dignity, date implemented 10/30/2020 and reviewed/revised 10/26/2023 provided, Policy: It is the practice of this facility to protect and promote resident rights and treat each resident with respect and dignity as well as care for each resident in a manner and in an environment, that maintains or enhances resident's quality of life by recognizing each resident's individuality. All staff members are involved in providing care to residents to promote and maintain resident dignity and respect resident rights. When interacting with a resident, pay attention to the resident as an individual. Respond to requests for assistance in a timely manner. Staff members do not talk to each other while performing a task for the resident as if the resident is not there. Speak respectfully to residents. Respect the residents living space. R6 A record review of the Face sheet and Minimum Data Set (MDS) assessment indicated R6 was admitted to the facility on [DATE] with diagnoses: stroke, aphasia (cognitive communication deficient with speech and understanding), tracheostomy (artificial patent airway), percutaneous endoscopic gastrostomy tubes (PEG / delivers nutrition and medications directly into the stomach), epilepsy (seizure disorder), muscle weakness, right above the knee amputation (AKA). The MDS assessment dated [DATE] indicated the resident had severely impaired cognitive abilities with a Brief Interview for Mental Status (BIMS) score of 0/15 and was dependent on assistance for care. On 05/04/2026 at 09:50AM, an observation was made of R6's call light hung over the headboard of the bed and out of reach of the resident. Hospice CNA A was present, she was asked to verify the location of the call light and Hospice CNA A verified that the resident call light was not within R6's reach. Hospice CNA A verified R6 was not verbal and relied on the call light to get help. There was a putty knife with sticky debris on the blade on R6's beside table, Hospice CNA A said she believed it was left by maintenance and said they had been scrapping the floor in the room earlier. A record review of R6's care plan revealed: Focus: (R6) is at risk for falls/injury related to other nontraumatic intracerebral hemorrhage, epilepsy, seizures, osteogenesis imperfecta with Interventions: Encourage resident to keep needed items within reach; Encourage resident to use call light. Focus: (R6) has an impaired musculoskeletal status related to osteogenesis imperfecta, acquired absence of right leg above knee with Interventions: Encourage resident to ask for assistance when needed. Focus: (R6) has an ADL self-care performance deficit related to cva (stoke), peg placement with Interventions: bed mobility: 2 person assist; toileting: 2 person assist; Encourage resident to use call light when assistance is needed. On 05/06/2026 at 09:00AM, knocked on the door and entered the room of R6, an observation of R6 privacy curtain tucked behind the tube feed pole and open to roommate / door to hall side, the window on the other side of resident had the curtain open to the outside while CNA D completed a brief change for R6. CNA D was asked if the curtains should be closed for privacy with brief changing and care and she said yes, when she was asked if there were closed, she did not answer but gave a blank look. According to a record review of the facility policy labelled promoting and maintaining resident dignity (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the Policy: it is the practice of this facility to protect and promote residents rights and treat each resident with respect and dignity. with Guidelines: 1. All staff members involved in providing care to residents (are) to promote and maintain resident dignity and respect residents rights; 12. Maintain resident privacy. R83 A record review of the Face sheet and Minimum Data Set (MDS) assessment indicated R83 was admitted to the facility on [DATE] with diagnoses: progressive multiple sclerosis (effects the central nervous system), quadriplegia (numbness / paralysis of 4 limbs), encephalopathy and depression. The MDS assessment dated [DATE] indicated the resident was cognitively intact with a Brief Interview for Mental Status (BIMS) score of 15/15 and required assistance with care. On 05/04/2026 at 09:45AM, During an interview with R83 she said she is dependent on care from staff because she was unable to walk. R83 said she had long call wait times of 30 minutes or more, explained it was especially long waits on 2nd and 3rd shifts. R83 said that last week she requested assistance from a CNA because she needed her brief changed due to having had a bowel movement and that the CNA turned off her light left her room and no one came to change her for several hours when she again requested assistance from 3rd shift. R83 expressed that she felt embarrassment from sitting in a dirty and malodourous brief that long. On 05/05/2026 at 09:20AM, during an interview with Nurse E she was asked about the call light system operations, she said that there was no centralized area that notified when a call light was triggered, that the call light are a light outside the residents room that lights up when triggered and a faint tone when from the bed side. Nurse E said that the light is red and a louder tone if it is triggered from a restroom. Nurse E acknowledged that the nurse's station was not located with clear site down each resident's hall and that if staff were not on the unit there was no central location to check for call lights. When asked about R83 complaint Nurse E said she could not account for response times on other shifts when asked. A record review of R83's care plan revealed: Focus: (R6) has an ADL self-care performance deficit related to multiple sclerosis, quadriplegia. with Interventions: ambulation: non ambulatory; bed mobility: 2 person assist with b/l (bilateral) assist bars for increased mobility; toileting: 2 person assist; transfers: (R86) will need 2 person assist and use of full mechanical lift.; Encourage resident to use call light when assistance is needed. According to a record review of the facility policy labelled promoting and maintaining resident dignity the Policy: it is the practice of this facility to protect and promote residents rights and treat each resident with respect and dignity. with Guidelines: 1. All staff members involved in providing care to residents (are) to promote and maintain resident dignity and respect residents rights; 6. Respond to request for assistance with in a timely manner. Resident #17 On 5/04/2026, at 11:17 AM, During a foot skin observation, Resident #17 was noted to pull at their chin whiskers throughout the assessment. Resident #17 was asked if they were ok with their facial (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	whiskers and the resident quickly responded, no, I have a razor somewhere. A review of the Task list for Bathing: Monday and Thursday Evening Shift Look Back . revealed the following showers were provided: 4/6/2026 4/9/2026 4/13/2026 4/20/2026 4/23/2026 4/30/2026 5/4/2026 The column Patient Refused was not checked marked for the missed showers on 4/16/2026 and 4/27/2026. A review of the progress notes revealed no explanation as to why the resident wasn't provided their showers. On 5/05/2026, at 1:30 PM, a record review of Resident #17's electronic medical record revealed an admission on [DATE] with diagnoses that included Hypertension, Heart attack and congestive heart failure. Resident #17 required assistance with activities of daily living and had intact cognition. Resident #67 On 5/06/2026, at 9:18 AM, During medication administration for Resident #67, Nurse J administered Resident #67's morphine after great encouragement to the resident. Nurse J stated to the resident, thank you (Resident #67) Jesus Christ with a smile on their face. Upon exit of Resident #67's room, Nurse J was asked if they normally say that to residents and Nurse J stated, yeah.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This Citation Pertains to Intake Number 2992230. Based on observation, interview and record review, the facility failed to provide timely assistance with activities of daily living (ADL) including grooming and shaving for 2 residents (#9 and #12), of 2 residents reviewed for ADLs. Findings Include: Resident #9: Observation and interview on 05/04/2026 at 9:42 AM of Resident #9 was observed outside in the courtyard noted with chin whiskers of gray and black in color visible. Resident #9 stated that staff only shave her on shower days and would like it more often. Observation on 05/05/2026 at 11:52 AM of Resident #9 with whiskers today. seated in dining room. Observation on 05/05/2026 at 12:59 PM of Resident #9 and a visitor to go into the courtyard to sit in the sun outside. Resident chin Whiskers were visible again. Observation on 05/06/2026 at 9:57 AM of Resident #9 was observed up in wheelchair in the hallway with chin whiskers visible. Resident #12: A review of the medical record indicated Resident #12 was admitted to the facility on [DATE] with diagnoses: Dementia, PTSD, back pain, diabetes, and depression. The Minimum Data Set/MDS assessment dated [DATE] revealed the resident had severe cognitive loss with a Brief Interview for Mental Status/BIMS score of 3/15. Section E: Behavior of the MDS assessment indicated the resident had no behaviors during the assessment look back period. Section GG of the MDS indicated the resident needed supervision or touch assistance with hygiene tasks including shaving. On 5/04/2026 at 11:09 AM, during a tour of the Dementia unit, Resident #12 was observed unshaven with whiskers approximately 1/2 to 1 inch long and sleeping at an activities table in the day room. On 5/5/26 at 10:00 AM, Resident #12 was observed in the day room in the Dementia unit, unshaven. On 5/06/2026 at 10:35 AM, Resident #12 was observed in the day room, sitting at one of the tables; his was breakfast finished. The activities staff were present, and the resident continued to be unshaven. On 5/06/2026 at 10:45 AM, the day room on the Dementia Unit was observed with Unit Manager M. Observed all male residents, approximately 6 residents but one, were unshaven: this included Resident #12. The Unit Manager/UM M was asked about this and said she did not know why they were not shaved. She said if they refused to be shaved the Nurse Aides would chart their refusal when they charted their showers. A review of the Care Plans for Resident #12 revealed: (Resident #12) has an ADL (activities of daily living) self-care performance deficit related to (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	generalized weakness and deconditioning, date initiated 12/17/2024 and revised 3/20/2025 with Interventions including: (Resident #12) showers Monday and Thursday evening, date initiated 1/25/2025 and revised 11/11/2025; Bathing: 1 person assist, date initiated 12/19/2024 and revised 3/20/2025. There was no mention of assisting the resident with shaving or that the resident refused shaving. A review of the Tasks: Behavior Symptoms charting from April 7, 2026, to May 6, 2026 revealed the resident had a few behaviors of repetitive movements and wandering. The remainder of the charting said, None of the above observed. There was no aggressive behaviors or rejection of care. A review of the Tasks: Bathing Monday and Thursday Evening shift documentation from 4/9/2026 to 5/4/2026 revealed the resident missed one bath/shower on 4/13/2026. There was no indication that the resident refused to be shaved. A review of the facility policy titled, Activities of Daily Living (ADL's), date implemented 10/30/2020 and revised 12/28/2023 provided, The facility takes measures to minimize the loss of resident's functional abilities, including activities of daily living (ADLs). Activities of Daily Living include the ability to: 1. Bathe, dress, and groom. A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to date dressings and give consistent dressing changes for 2 residents (Resident #1, Resident #17) of 3 residents reviewed for wound care, resulting in prolonged healing. Findings include: Resident #1: In an interview on 05/04/2026 at 9:28 AM with Resident #1 was lying in bed with a sheet covering him. Resident #1 was not sure if he came with the coccyx wounds or got them at facility, he believes at hospital. Observed air mattress in place. The resident stated that the treatments/dressings are not always done every day, and he does not know why, the wounds seem to be getting bigger to him. He declined to have surveyor look at his wounds. Surveyor will request wound care nurse dressing change. Record review of Resident #1's medical record revealed he is his own responsible party, Brief Interview of Mental status (BIM's) score of 13 out of 15, some cognitive impairment, will check the MAR TAR records for consistency of dressing change/treatments. Record review of treatment administration record for January through May 2026 revealed missing documentation of treats provided or performed and signed out by the nursing staff. January 2026- 3 missed treatments to the coccyx, 3 missed treatments to left gluteal. February 2026- 3 missed treatments to the coccyx, 3 missed treatments to left gluteal. March 2026- 6 missed treatments to the coccyx, 6 missed treatments to left gluteal. April 2026- 3 missed treatments to the sacrum, 3 missed treatments to left gluteal. Observation and interview on 05/06/2026 at 10:59 AM licensed Practical Nurse (LPN) wound care C of Resident #1's room and dressings. Observation on 05/06/2026 at 11:03 AM Observed pressure wearing boots when in bed, Resident stated that the boots get hot and sweaty he did not want them on, declined a pillow to elevate the feet also. LPN C stated that the resident's Coccyx wound he does not like to be off his bottom, we had a conversation that I educated again to get off his coccyx to offload, Resident #1 at present declined to offload or shift position. Residents left lateral leg abrasion, he declined soft boots and pillow he stated no. Left gluteal- facility acquired, we have an unavoidable form for him. The Resident signed on to hospice recently and has human immunodeficiency virus. LPN C stated that she did not understand the skin and wound tab, in the computer program. LPN C started in December at the facility. Resident #1 is his own person, and he is non-compliant with his care/positioning, after his last hospital admission he came back with worsening of wounds. In an interview and records review on 05/06/2026 at 1:14 PM with the Director of nursing (DON) about the skin/wound treatments on the Treatment Administration Records (TAR). Record review of Resident #1's Medication Administration Record (MAR) and Treatment Administration Records (TAR) the DON stated that she was aware there are blanks on the MARs and TARs with blank spots. The (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	DON did not know why they are blank, and there should have been a progress note if left blank. The State surveyor inquired of the chart codes/follow-up codes located at the bottom of the MAR/TARs, the DON stated that the codes chart at the bottom of the MAR/TAR forms has a documentation key for staff when resident at Hospital, refuses, Leave of Absence, the nurses are not using the key. The DON stated that the facility was trying to monitor the MAR TARs. Nurses are on 12-hour shifts, and the MAR TARs are set up for 8-hour shifts so there is a shift not accounted for. The facility is Liberal treatments and med pass but still have blank spots. Plan was to get the PCC switched to 12 shifts. But it has not happened, The DON stated that she is new to the building started March 2nd, 2026, and has a lot of work to do. On 5/04/2026, at 10:56 AM, Unit Manager (UM) , entered Resident #17's room for a skin observation of their feet. UM M removed a bandage that was covering the right great toe wound. There was no date on the bandage. The bandage appeared to be old. The inside pad of the bandage was completed saturated with dark red and black drainage that appeared old and was odorous. UM M was asked if they saw a date on the bandage and UM M stated, there's no date on it. Resident #17 stated, they had put the bandage on two days ago. On 5/05/2026, at 1:30 PM, a record review of Resident #17's electronic medical record revealed an admission on [DATE] with diagnoses that included Hypertension, Heart attack and congestive heart failure. Resident #17 required assistance with activities of daily living and had intact cognition. A review of the Treatment Administration Record 5/1/2026 – 5/31/2026 revealed a treatment order Right great toe: Cleanse with NS or wound cleanser, pat dry, apply collagen Ag and cover with foam dressing. Every day shift -Start Date- 04/29/2026 0700 – D/C Date- 05/05/2026 . On 5/06/2026, at 10:09 AM, Wound Nurse C was alerted of the observation of the undated dressing to Resident #17's right great toe wound and that the dressing appeared old.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to Intake Number 2993831.Based on observation, interview, and record review, the facility failed to ensure that nursing staff were reviewed for competency prior to caring for residents, for one of five staff reviewed for staffing education and competency.Findings include: On 05/05/2026 at 11:41Am, an e-mail request was sent requesting performance evaluations, competencies, education, license and certificates for 5 selected staff that included Nurse J. On 05/05/2026 at 10:45 AM, An observation of Nurse J was made independently working on the dementia unit and requested her assistance with resident identification in the dining/activities room. When asked Nurse J she said she had been a nurse about 1 year and was newer to the facility. On 05/05/2026 at 1:20PM, During an interview with Human Resources (HR) J she was asked to provide education, competencies, certificates and licensure requested for the 5 selected staff that included Nurse J. On 05/06/2026 a record review of Nurse J revealed that she was hired at the facility on or around on March 11th, 2026, and was assigned skilled nursing facility (SNF) competencies, in-services and trainings on March 11th, 2026, with completion due dates of March 31st and April 10th, 2026. The record revealed Nurse J had completed 2 of the 30 competencies, in-services and trainings on March 26th, 2026, and none of the others. The 2 completed competencies were PPE donning and doffing and hand hygiene. The record revealed that 4 additional competencies, in-services and trainings were assigned to Nurse J on April 10th, 2026 with completion due date of April 30th; and on May 1st, 2026, with completion due date of May 31st, 2026. None of the additional 4 assignments were marked as completed. According to a record review of the 6AM to 6PM nurse shift assignments for May 4th 2026 that Nurse J worked independently and was not indicated as orientation; 6AM to 6PM nurse shift assignments for May 5th, 2026 that Nurse J worked independently and was not indicated as orientation; 6AM to 6PM nurse shift assignments for May 6th, 2026, that Nurse J worked independently and was not indicated as orientation. On 05/06/2026 at 10:01AM, During and interview with the DON she was asked how she ensured her staff, including nurses were competent and completed the required competencies, in-services and trainings. The DON said that from what she understood that was all done upon hire and that HR tracked that. The DON said she is new to the facility and that she had not taken part in that yet, the DON said that HR I was not at work for bereavement that day. The DON was asked if staff are allowed to be on the floor independently if they have not completed the initial competencies, in-services and training, and she said, 'they are not supposed to be'. The DON said that her staff also get assignments monthly in the SNF (computerized) training program and they have a due date to complete the competencies, in-services and trainings or they will be removed from the schedule until they complete it. The DON was asked to review the competencies, in-services and trainings that were provided by HR on 05/06/2026, After review of the documentation the DON said she was surprised by this and now, I want to check everybody's competencies, in-services and training. The DON agreed that Nurse J had worked at the facility since March of 2026 and verified she was no longer on orientation and had worked independently as a nurse. On 05/06/2026 at ~(approximately) 9AM to ~3PM, Nurse ' was observed working independently on the dementia unit. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/06/2026, at 9:24 AM, the Administrator was asked to provide competency, eligibility for hire, dementia and abuse training for Nurse J . The Administrator and DON was alerted of the observation of Nurse J with Resident #67. On 5/06/2026, at 9:49 AM, the Administrator entered the conference room to clarify the request for Nurse J's dementia/abuse training needs and stated the facility had already provided the document. On 5/06/2026, at 9:50 AM, a record review along with the Administrator of Nurse J's education document revealed that Nurse J only had completed sections for Personal Protection Equipment (PPE) and Hand Hygiene. A further review revealed General Orientation-Abuse, Neglect . Behavioral health . Dementia . Resident rights . Medication Pass . Assigned [DATE] Due [DATE] . were all not completed. The Administrator was asked to provide proof Nurse J was eligible for hire and the Administrator offered that Human Resources (HR) was out of the office and would provide it as soon as they could. On 5/07/2026, at 10:00 AM, the facility provided an updated education document for Nurse J. The document was updated to revealed Nurse J had completed the above training on 5/5/2026 which was the day prior to the record review with the administrator of the incomplete education document.