

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  235197	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/02/2025
NAME OF PROVIDER OR SUPPLIER  Hillsdale County Medical Care Facility		STREET ADDRESS, CITY, STATE, ZIP CODE  140 W Mechanic Street Hillsdale, MI 49242	

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 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observations, interviews and record review, the facility failed to protect the residents' right to be free from sexual and physical abuse by other resident's. Findings include: Review of the Face Sheet and Minimum Data Set (MDS) dated [DATE], reflected R101 was an [AGE] year-old male admitted to the facility on [DATE], with diagnoses that included dementia, anxiety and depression. The MDS reflected that R101s had a BIM (assessment tool) score which indicated his ability to make daily decisions was severely impaired.</p> <p>Review of the Face Sheet and Minimum Data Set (MDS) dated [DATE], reflected R102 was an [AGE] year-old female admitted to the facility on [DATE], with diagnoses that included dementia, anxiety, falls, unsteady on feet, and depression. The MDS reflected that R102s had a BIM (assessment tool) score which indicated her ability to make daily decisions was severely impaired.</p> <p>Review of the complaint received by the State Agency on 9/24/25 alleged the facility failed to prevent and report abuse allegations to the State Agency.</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 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During a telephone interview on 9/25/25 at 11:59 a.m., Complainant &amp;ldquo;Y&amp;rdquo; verified complaint and reported often worked in basement of facility on dementia unit. Complainant &amp;ldquo;Y&amp;rdquo; reported on 8/23/25 R101 walked up to R102 and started shoving R102 and hitting R102 on the shoulder and staff separated residents and incident was reported to supervisor who was told incident needed to be reported to Director of Nursing (DON) &amp;ldquo;B&amp;rdquo; and Nursing Home Administrator (NHA) &amp;ldquo;A&amp;rdquo; because abuse allegation. Complainant &amp;ldquo;Y&amp;rdquo; believes Nurse Supervisor notified DON &amp;ldquo;B&amp;rdquo; and was told did not need to be reported because both residents had dementia and NHA &amp;ldquo;A&amp;rdquo; followed up and told Complainant Y the same. Complainant &amp;ldquo;Y&amp;rdquo; reported on 9/6/25 R101 was ramming wheelchair into R102 while she was eating and staff separated residents, assessments were completed. Complainant &amp;ldquo;Y&amp;rdquo; reported R101 behaviors increased and at one-point R101 placed hands on R102 shoulders and started shaking R102 violently making R102s entire body move. Residents were again separated and assessments completed, and same nurse supervisor was notified along with physician who ordered intramuscular Ativan. Complainant &amp;ldquo;Y&amp;rdquo; reported R101 was a strong male and R102 was frail [AGE] year-old women. Complainant &amp;ldquo;Y&amp;rdquo; reported Certified Nurse Assistant (CNA) &amp;ldquo;R&amp;rdquo; got to R102 first and separated residents and R102 was taken to her private room and event was also reported to DON &amp;ldquo;B&amp;rdquo; and NHA &amp;ldquo;A&amp;rdquo; and physician via secure conversation/text. Complainant &amp;ldquo;Y&amp;rdquo; reported was questioned after event by NHA &amp;ldquo;A&amp;rdquo; who reported not to use word, &amp;ldquo;violent&amp;rdquo; in documentation and Complainant &amp;ldquo;Y&amp;rdquo; reported there was no other word to describe the event. Complainant &amp;ldquo;Y&amp;rdquo; reported NHA &amp;ldquo;A&amp;rdquo; reported intervention would be to remove wheelchair but Complainant Y reported was unsure how that would even help because R101 was not in wheelchair when he approached R102 and started shaking her. Complainant &amp;ldquo;Y&amp;rdquo; reported was told neither resident to resident incident was reported to the State of Michigan because both residents had dementia.</p> <p>During an observation on 9/29/25 at 9:55 a.m., R101 and R102 was observed in dementia unit, located in the facility basement. R101 and R102 were in the common area sitting in recliners that were lined up around the television four chairs apart from each other. R101 had a brace on right knee and observed staff assisted R101 to the bathroom via a wheelchair. The unit had two certified nurse aids and one nurse and about 10 residents present.</p> <p>During an interview on 9/29/25 at 1:00 p.m., Nursing Home Administrator (NHA) &amp;ldquo;A&amp;rdquo; reported was the facility Abuse Coordinator. NHA &amp;ldquo;A&amp;rdquo; reported had two reported allegations of abuse in past 10 months. The two abuse allegations did not include R101 or R102.</p> <p>Requested all Incident/Accident reports with complete investigations for R101 and R102 on 9/29/25 at 2:37 p. m.</p> <p>Received all R101 and R102 Incident/Accident reports for last six months with no resident-to-resident incidents on 9/29/25 at 3:23 p.m.</p> <p>Review of R101 Nurse Progress Note, dated 6/20/25 at 9:35 p.m., reflected, &amp;ldquo;CNA [certified nurse aid] came up to writer and reports that she has seen resident put his finger in another patients face [R102] and shouldn't sit next to her because he tried to control her and calls her his wife. States she doesn't think they should sit together anymore.&amp;rdquo;</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 9/29/25 at 3:46 p.m., Licensed Practical Nurse Risk Manager (RM) &amp;ldquo;N&amp;rdquo; reported had been in that role about five months and had worked at the facility for 12 years. RM &amp;ldquo;N&amp;rdquo; reported R101 was non-complaint who had no safety awareness with diagnosis of dementia who lives in dementia unit in the basement of the facility. RM &amp;ldquo;N&amp;rdquo; reported R101 thinks R102 was his wife and often require one on one care because he becomes fixated on R102. RM &amp;ldquo;N&amp;rdquo; reported worked on R101s unit 9/25/25 second shift and reported was not aware prior to that day R101 was fixated on R102 and reported R101 had increased behaviors and had to call DON &amp;ldquo;B&amp;rdquo; for additional assistance even with one-on-one care for R101. RM &amp;ldquo;N&amp;rdquo; verified she documented the following Nurse Progress Note, dated 9/25/25 at 4:02 p.m., &amp;ldquo;Elder was sitting in personal chair in dayroom upon my arrival to the unit at 1400[2:00 p.m.]. Noticed he was picking at his arm protectors and wanted to walk. He [R101] stood up without assistance X2[times two]. First time CNA [certified nurse aid] took him to the bathroom with AX2[assist time two], gait belt and w/c[wheelchair]. 2nd time they went for a stroll in his w/c outside for a bit. He was then placed back in his personal chair with CNA sitting beside him. Writer asked CNA what usually helps him stay distracted, and she replied someone sitting with him at all times giving him attention. CNA left the unit to go to lunch. Writer sat beside Elder and conversated with him. He kept directing the topic back to who he thinks is his wife which is truly just another Resident who was sitting within his sight. The other assigned CNA was doing bed checks and toileting Elders. Family members to another Elder came in to visit which intensified his[R101] behaviors. He was so worried who was talking to his wife, I don't know those people, I need to make sure my wife is okay. AX2 [assist time two] with gait belt stood him up to reposition him to his w/c to diffuse the situation by bringing him outside. DON was paged to the unit and Social Work accompanied her. They talked with Elder and wheeled him around the facility prior to bringing him back and doing puzzles together. All was well upon my departure at 4pm.&amp;rdquo; RM &amp;ldquo;N&amp;rdquo; reported reviews and completes resident fall investigations and reported R101 has had several recent falls with recent fracture because of poor safety awareness and again reported had no prior knowledge of R101 behaviors towards R102. (Evidence that thorough investigation had not been completed for frequent falls and resident to resident events to determine root cause related to ongoing behaviors.)</p> <p>During an interview and record review on 10/1/25 at 1:34 p.m., NHA &amp;ldquo;A&amp;rdquo; reported facility had additional information that had not yet been provided related to R101 and R102 that facility felt was an issue with staff performance of Registered Nurse (RN) &amp;ldquo;P&amp;rdquo;. NHA &amp;ldquo;A&amp;rdquo; provided file for R101 and R102 resident to resident events on 8/23/25 and 9/6/25 on facility letterhead of typed events. NHA &amp;ldquo;A&amp;rdquo; reported RN &amp;ldquo;P&amp;rdquo; no longer worked at facility. Review of the file reflected handwritten statement from CNA &amp;ldquo;R&amp;rdquo;, dated 8/23/25, that reflected, &amp;ldquo;On 8/23 [named R101] became agitated at [named R102] and open hand smacked her on her shoulder/chest area. This happened approximately around 3:30 p.m.&amp;rdquo; The statement was signed by CNA &amp;ldquo;R&amp;rdquo;. Continued review of the file reflected a second timeline of events on facility letter head for R101 and R102, dated 9/6/25, reflected two, &amp;ldquo;Hey Social Work&amp;rdquo; documents, dated 9/6/25. Review of R101's first, Hey Social Work documents reflected, &amp;ldquo;Resident is being aggressive with other residents, shaking them, in their face, yelling at them accusing them.&amp;rdquo; The form included R101 had the following behavior: yelling, abusive language, grabbing, accusing, pushing, and expressing anger and unable to redirect. The document was signed by CNA &amp;ldquo;R&amp;rdquo;. Review of the second Hey Social Work document, dated 9/6/25, reflected, &amp;ldquo;resident is being aggressive towards other residents especially [named R102] he thinks she is his wife. He is running into nurse and aides with w/c[wheelchair].&amp;rdquo; The form included R101 had the same marked behaviors as the first document.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During a telephone interview on 10/1/25 at 3:11 p.m., CNA &amp;rdquo;R&amp;rdquo; reported usually worked on the dementia unit in the basement on second shift with both R101 and R102. CNA &amp;rdquo;R&amp;rdquo; reported R101 frequently gets very fixated on R102 and yells at her, grabs her and has shaken R102 in the past. CNA &amp;rdquo;R&amp;rdquo; reported staff attempt to keep R101 and R102 separated, and staff try to intervene to reduce risk of altercation. CNA &amp;rdquo;R&amp;rdquo; reported R102 was[AGE] years old with dementia and is unsure if she knows what is happening and R101 is convinced R102 is his wife. CNA &amp;rdquo;R&amp;rdquo; reported recalled incident in August 2025 when R101 was patting R102 and shoulder and shouting hay, hay. CNA &amp;rdquo;R&amp;rdquo; reported on 9/6/25 R101 approached R102 and grabbed R102 shoulders and started shaking R102 back and forth and both CNA staff separated residents. CNA &amp;rdquo;R&amp;rdquo; reported told R101 he was not allowed to put his hands on other residents, and he became upset and incident was reported to RN &amp;rdquo;P&amp;rdquo; and completed, &amp;rdquo;Hey Social Worker&amp;rdquo; document. CNA &amp;rdquo;R&amp;rdquo; reported incident was reported to nurse because potential allegation of abuse that was required to be reported immediately. CNA &amp;rdquo;R&amp;rdquo; reported after 9/6/25 incident there were no changes in interventions but to continue to attempt to keep R101 and R102 separate. CNA &amp;rdquo;R&amp;rdquo; reported R101 does get mad and R102 and had called her an old hag and reported residents do not deserve to be treated that way or called names and should be reported.</p> <p>During a telephone interview on 10/2/25 at 10:26 a.m., CNA &amp;rdquo;V&amp;rdquo; reported often worked second shift with both R101 and R102. CNA &amp;rdquo;V&amp;rdquo; reported R101 was obsessed with R102 and staff constantly have to separate them and R101starts to escalate behavior to be right next to her with attempt to even try to push her wheelchair. CNA &amp;rdquo;V&amp;rdquo; reported R101 aggressive behaviors toward R102 have increase over past four to six weeks and staff have expressed concerns to several management staff including DON &amp;rdquo;B&amp;rdquo;. CNA &amp;rdquo;V&amp;rdquo; reported R101 has also had several falls because he is so determined to get to R102 including recent fall with fracture. CNA &amp;rdquo;V&amp;rdquo; reported staff attempt to redirect but often not effective and R101 requires one on one supervision that is not always possible to properly care for other residents. CNA &amp;rdquo;V&amp;rdquo; stated R101 is often, &amp;rdquo;Locked on that thought and nothing else matters to him.&amp;rdquo; CNA &amp;rdquo;V&amp;rdquo; reported R101 has called R102 a bitch and other residents as well. CNA &amp;rdquo;V&amp;rdquo; reported R101 resident to resident altercations to second shift supervisor &amp;rdquo;AA&amp;rdquo;. CNA &amp;rdquo;V&amp;rdquo; reported R101 behaviors have been progressively getting worse and occur at least 3 times per week minimum and are reported to charge nurse because potential allegations of abuse. CNA &amp;rdquo;V&amp;rdquo; reported last week DON &amp;rdquo;B&amp;rdquo; had to take R101 off the unit because R102 had family that was visiting and R101 was agitated that he did not know who they were and did not want them with R102 and reported R102 appeared frustrated with situation.</p> <p>During an interview on 10/2/25 at 10:48 p.m., Social Worker (SW) &amp;rdquo;K&amp;rdquo; reported R101 had behaviors that included he had history of being combative with staff and thinks a female resident is his wife and gets focused and agitation often increases in afternoon. SW &amp;rdquo;K&amp;rdquo; reported the, &amp;rdquo;Hey Social Worker&amp;rdquo; was a tool that staff use to communicate behaviors residents might be having with Social Worker and reported had not received any for R101. SW &amp;rdquo;K&amp;rdquo; reported was not aware of any resident-to-resident altercations with R101 and R102 other than when R101 taps R102 on shoulder to get her attention. SW &amp;rdquo;K&amp;rdquo; reviewed, &amp;rdquo;Hey Social Worker&amp;rdquo; forms provided by NHA &amp;rdquo;A&amp;rdquo;, dated 9/6/25, and verified had never seen either one. SW &amp;rdquo;K&amp;rdquo; reported if she had received the documents would have reported to NHA &amp;rdquo;A&amp;rdquo; immediately because allegations of physical abuse that needed to be reported and investigated and need to follow up with all parties involved because facility SW.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 10/2/25 at 11:26 a.m., NHA &amp;ldquo;A&amp;rdquo; reported had been in position for five years and was also the abuse coordinator. NHA &amp;ldquo;A&amp;rdquo; reported staff are expected to report all allegations of abuse to nurse supervisor, DON &amp;ldquo;B&amp;rdquo;, or NHA &amp;ldquo;A&amp;rdquo; immediately. NHA &amp;ldquo;A&amp;rdquo; reported did not reported R101 and R102 allegations of abuse to the State of Michigan (SOM) because they delt with it as personal issue not allegation of abuse and stated, &amp;ldquo;in hindsight that was incorrect.&amp;rdquo; NHA &amp;ldquo;A&amp;rdquo; reported should have reported R101 and R102 incidents on 8/23/25 and 9/6/25 to the SOM as allegations of abuse and verified that was wrong.</p> <p>During an interview on 10/2/25 at 11:56 a.m., DON &amp;ldquo;B&amp;rdquo; reported received a call from supervisor that RN &amp;ldquo;P&amp;rdquo; had reported an incident that occurred at the beginning of the shift that CNA staff reported R101 was going after R102 related to both incidents on 8/23/25 and 9/6/25. DON &amp;ldquo;B&amp;rdquo; reported did not believe RN &amp;ldquo;P&amp;rdquo; but should have believed CNA staff that included written witness statements, should have reported to the NHA &amp;ldquo;A&amp;rdquo;, State of Michigan, and completed thorough investigation.</p> <p>Review of the medical record reflected R104 was admitted to the facility on [DATE], with diagnoses that included dementia. The Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 8/2/25, reflected R104 scored 7 out of 15 (severe impairment) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool).</p> <p>Review of the medical record reflected R105 was admitted to the facility on [DATE], with diagnoses that included dementia, need for assistance for personal care, mild cognitive impairment, and Alzheimer's disease. The Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 7/6/25, reflected R105 was unable to have a Brief Interview for Mental Status (BIMS-a cognitive screening tool) conducted due to severe cognitive impairment.</p> <p>On 9/25/25 at 2:57 PM, R104 was observed in his room seated in his wheelchair. R104 was talking out loud said &amp;ldquo;ehhhh&amp;rdquo; and &amp;ldquo;ohhh.&amp;rdquo; After entry into his room, R104 was welcoming to conversation and stated that he had a bird that he loves to talk with.</p> <p>On 9/25/25 at 3:12 PM, R105 was observed in bed resting.</p> <p>Review of R104's Care plan reflected an added intervention on 3/27/23 and revised on 3/21/25 which stated &amp;ldquo;&amp;hellip;He is also inappropriate at times. If [R104] is participating in a group setting such as eating in the dining room or an activity, wait to bring the resident down until at least one staff member is present to monitor. [R104] also sits by male residents during activities and in the dining room&amp;hellip;&amp;rdquo;.</p> <p>Review of R105's Electronic Medical Record reflected that R105 was nonverbal and used nonverbal cues and sounds/cries in an attempt to make needs known.</p> <p>Review of a Behavior Note on 2/21/25 revealed R104 had to be corrected many times during the 6-2 shift about being inappropriate with other residents and with the CNA's. He tried to grab a CNA's bottom while they were walking by. He kept whistling at another resident until it made her upset and she had to propel away. He heckled the CNA'S whenever he was in the halls and not in bed.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of a Behavior Note dated 3/7/25 revealed R104 stated to a female resident while in dining room, Hey baby, let me feel your tits. Writer did not know about this until several hours post incident but did speak to resident about it and told him how inappropriate it was.</p> <p>In an interview on 9/25/25 at 12:53 pm, Registered Nurse (RN) P stated that she received information during shift report during a shift in late March 2025 that R104 was observed groping R104's breasts in the activity room. LPN P was advised to ensure that R104 and R105 were not seated near each other to maintain R105's safety.</p> <p>In an interview on 9/29/25 at 9:59 am, Certified Nursing Assistant (CNA) J reported that she was working the day, back in March 2025, that R104 was observed fondling R105's breasts. CNA J stated that both residents were in the activity room and CNA J overheard a commotion. When CNA J responded, R104 was observed handling R105's breasts. Moving forward, staff was instructed to ensure that R104 and R105 were not placed near each other. CNA J reported this to the nurse.</p> <p>In an interview on 9/29/25 at 4:04 pm, CNA L stated that he overheard R105 yelling and immediately identified that R105 was upset about something. CNA L entered the activity room to observe R104 grabbing R105's breasts. R105 was visibly disturbed about the actions of R104. CNA L stated he separated the residents immediately and was asked to fill out an incident report.</p> <p>On 10/2/25 at 11:26 AM, Nursing Home Administrator (NHA) A verified that he was the abuse coordinator and explained the process of reporting abuse allegations. When asked if he had any awareness of this incident, NHA A denied knowing about R104 incident with R105, however, did state that the incident should have been reported to him and that he would have reported it to the State of Michigan and completed an investigation. NHA A and Director of Nursing B both reported that there were no incident reports or investigations for this incident.</p> <p>Review of the Abuse, Neglect and Exploitation Policy implemented 9/2021 and reviewed 9/2024 defined sexual abuse as non-consensual sexual contact of any type. The same policy stated, an immediate investigation is warranted when suspicion of abuse, neglect, or exploitation, or reports of abuse, neglect or exploitation occur. reporting of all alleged violations to the Administrator, state agency, immediately, but no later than 2 hours after the allegation is made.</p> <p>Applying the reasonable person standard, it can be expected that R105 would have experienced emotional distress as a result of the abuse, as such a reaction aligns with how an average person would respond under similar circumstances.</p>		

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NAME OF PROVIDER OR SUPPLIER  Hillsdale County Medical Care Facility		STREET ADDRESS, CITY, STATE, ZIP CODE  140 W Mechanic Street Hillsdale, MI 49242	
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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview and record review, the facility failed to implement facility policy and procedure for reporting allegations of abuse for 4 of 7 sampled residents (R101, R102, R104 and R105) reviewed for abuse, resulting in potential allegations of abuse not being reported, thoroughly investigated in a timely manner and continued resident abuse. Review of the Face Sheet and Minimum Data Set (MDS) dated [DATE], reflected R101 was an [AGE] year-old male admitted to the facility on [DATE], with diagnoses that included dementia, anxiety and depression. The MDS reflected that R101s had a BIM (assessment tool) score which indicated his ability to make daily decisions was severely impaired.</p> <p>Review of the Face Sheet and Minimum Data Set (MDS) dated [DATE], reflected R102 was an [AGE] year-old female admitted to the facility on [DATE], with diagnoses that included dementia, anxiety, falls, unsteady on feet, and depression. The MDS reflected that R102s had a BIM (assessment tool) score which indicated her ability to make daily decisions was severely impaired.</p> <p>Review of the complaint received by the State Agency on 9/24/25 alleged the facility failed to prevent and report abuse allegations to the State Agency.</p> <p>During a telephone interview on 9/25/25 at 11:59 a.m., Complainant &amp;Yrdquo; verified complaint and reported often worked in basement of facility on dementia unit. Complainant &amp;Yrdquo; reported on 8/23/25 R101 walked up to R102 and started shoving R102 and hitting R102 on the shoulder and staff separated residents and incident was reported to supervisor who was told incident needed to be reported to Director of Nursing (DON) &amp;Brdquo; and Nursing Home Administrator (NHA) A&amp;rdquo; because abuse allegation. Complainant &amp;Yrdquo; believes Nurse Supervisor notified DON &amp;Brdquo; and was told did not need to be reported because both residents had dementia and NHA &amp;Ardquo; followed up and told Complainant Y the same. Complainant &amp;Yrdquo; reported on 9/6/25 R101 was ramming wheelchair into R102 while she was eating and staff separated residents, assessments were completed. Complainant &amp;Yrdquo; reported R101 behaviors increased and at one-point R101 placed hands on R102 shoulders and started shaking R102 violently making R102s entire body move. Residents were again separated and assessments completed, and same nurse supervisor was notified along with physician who ordered intramuscular Ativan. Complainant &amp;Yrdquo; reported R101 was a strong male and R102 was frail [AGE] year-old women. Complainant &amp;Yrdquo; reported Certified Nurse Assistant (CNA) &amp;Rrdquo; got to R102 first and separated residents and R102 was taken to her private room and event was also reported to DON &amp;Brdquo; and NHA &amp;Ardquo; and physician via secure conversation/text. Complainant &amp;Yrdquo; reported was questioned after event by NHA &amp;Ardquo; who reported not to use word, &amp;violentrdquo; in documentation and Complainant &amp;Yrdquo; reported there was no other word to describe the event. Complainant &amp;Yrdquo; reported NHA &amp;Ardquo; reported intervention would be to remove wheelchair but Complainant Y reported was unsure how that would even help because R101 was not in wheelchair when he approached R102 and started shaking her. Complainant &amp;Yrdquo; reported was told neither resident to resident incident was reported to the State of Michigan because both residents had dementia.</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation on 9/29/25 at 9:55 a.m., R101 and R102 was observed in dementia unit, located in the facility basement. R101 and R102 were in the common area sitting in recliners that were lined up around the television four chairs apart from each other. R101 had a brace on right knee and observed staff assisted R101 to the bathroom via a wheelchair. The unit had two certified nurse aids and one nurse and about 10 residents present.</p> <p>During an interview on 9/29/25 at 1:00 p.m., Nursing Home Administrator (NHA) "A" reported was the facility Abuse Coordinator. NHA "A" reported had two reported allegations of abuse in past 10 months. The two abuse allegations did not include R101 or R102.</p> <p>Requested all Incident/Accident reports with complete investigations for R101 and R102 on 9/29/25 at 2:37 p.m.</p> <p>Received all R101 and R102 Incident/Accident reports for last six months with no resident-to-resident incidents on 9/29/25 at 3:23 p.m.</p> <p>Review of R101 Nurse Progress Note, dated 6/20/25 at 9:35 p.m., reflected, "CNA [certified nurse aid] came up to writer and reports that she has seen resident put his finger in another patients face [R102] and shouldn't sit next to her because he tried to control her and calls her his wife. States she doesn't think they should sit together anymore."</p> <p>Review of R101 Nurse Progress Note, dated 8/23/25 at 8:31 p.m., reflected, "Reported to supervisor at 2024[8:24 p.m.] that this resident was seen by CENA [Competency Evaluated Nursing Assistant] striking a female resident multiple times on shoulder and chest earlier this shift. Writer was not made aware of this until approximately 2000."</p> <p>Review of R101 Nurse Progress Note, dated 8/23/25 at 9:50 p.m., reflected, "DON notified of CN [charge nurse] report of incident."</p> <p>Review of R101 Behavior Progress Note, dated 9/6/25 at 3:00 p.m., reflected, "Resident being very aggressive to staff. Trying to run into CNAs with WC [wheelchair]. Trying to approach a female resident thinking she is his wife. Tried to go into female resident room. Phone call placed to [named Medical Director "X"] and one time order given for 1mg Ativan IM. POA [power of attorney] aware."</p> <p>Review of R101 Nursing Progress Note, dated 9/6/25 at 3:04 p.m., reflected, "At approximately 1420 [2:20 p.m.], resident ambulated to female pt. [patient] who was sitting in recliner chair in great room and placed his hands on her shoulders and began violently shaking her. Staff intervened and ended this behavior and female pt. was taken to her room to eliminate stimulus. This resident continued to try to locate female pt. whom he thought was his wife and ran his w/c into all staff members intentionally on multiple occasions. Was yelling throughout demanding to know where his wife was. Attempted to provide food, fluids and offered a walk outside all new order for Ativan 1mg IM obtained and given at approximately 1435 [2:35 p.m.]"</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of R101 Nurse Progress Note, dated 9/6/25 at 8:58 p.m., reflected, "At approx 1810 [6:10 p.m.], as most residents had eaten supper, this resident began ramming his w/c into a female resident's w/c. This resident believes this female is his wife and unable to convince him otherwise or distract him. Female resident was still eating when this occurred and residents were separated at this time. This resident went back two additional times and rammed his w/c into hers. Resident was asked why he was doing this and he stated, how else am I supposed to get her attention?"</p> <p>Review of R101 Nurse Progress Note, dated 9/7/25 at 3:43 p.m., reflected, "Per report, pt. was fine all first shift. As soon as second shift began, pt. started to ramp up again. Has been yelling about wanting to see his wife, referring to specific female pt. Female was removed from great room prior so that pt would not become fixated on her again. So far this shift he has rammed his w/c into staff X1 [times one] and tried to ram into a visitor that staff was speaking with but staff intervened. Has been yelling quite a bit this shift about specific female pt. and that staff is liars&amp;hellip;Since all this tends to happen on second shift, question if this is a circadian cycle for this pt. and if he needs a routine medication to control it. Currently gets Buspar 5mg tid[three times daily] but it is not helping. The 1mg Ativan yesterday did seem to help. Not asking for anything right now but will text you if situation worsens."</p> <p>Review of R101 Behavior Progress Note, dated 9/12/25, reflected, "At 10:05 am, [named R101] was sitting in a PC[personal chair] chair up at the TV area and began to express, Where is [named wife], I want to see my wife, [named wife]! Staff sat with him explaining that his wife lived at another facility. [named R101] expressed, No she's not, where is she, I just seen her.</p> <p>(continued on next page)</p>

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 9/29/25 at 3:46 p.m., Licensed Practical Nurse Risk Manager (RM) &amp;ldquo;N&amp;rdquo; reported had been in that role about five months and had worked at the facility for 12 years. RM &amp;ldquo;N&amp;rdquo; reported R101 was non-complaint who had no safety awareness with diagnosis of dementia who lives in dementia unit in the basement of the facility. RM &amp;ldquo;N&amp;rdquo; reported R101 thinks R102 was his wife and often require one on one care because he becomes fixated on R102. RM &amp;ldquo;N&amp;rdquo; reported worked on R101s unit 9/25/25 second shift and reported was not aware prior to that day R101 was fixated on R102 and reported R101 had increased behaviors and had to call DON &amp;ldquo;B&amp;rdquo; for additional assistance even with one-on-one care for R101. RM &amp;ldquo;N&amp;rdquo; verified she documented the following Nurse Progress Note, dated 9/25/25 at 4:02 p.m., &amp;ldquo;Elder was sitting in personal chair in dayroom upon my arrival to the unit at 1400[2:00 p.m.]. Noticed he was picking at his arm protectors and wanted to walk. He [R101] stood up without assistance X2[times two]. First time CNA [certified nurse aid] took him to the bathroom with AX2[assist time two], gait belt and w/c[wheelchair]. 2nd time they went for a stroll in his w/c outside for a bit. He was then placed back in his personal chair with CNA sitting beside him. Writer asked CNA what usually helps him stay distracted, and she replied someone sitting with him at all times giving him attention. CNA left the unit to go to lunch. Writer sat beside Elder and conversated with him. He kept directing the topic back to who he thinks is his wife which is truly just another Resident who was sitting within his sight. The other assigned CNA was doing bed checks and toileting Elders. Family members to another Elder came in to visit which intensified his[R101] behaviors. He was so worried who was talking to his wife, I don't know those people, I need to make sure my wife is okay. AX2 [assist time two] with gait belt stood him up to reposition him to his w/c to diffuse the situation by bringing him outside. DON was paged to the unit and Social Work accompanied her. They talked with Elder and wheeled him around the facility prior to bringing him back and doing puzzles together. All was well upon my departure at 4pm.&amp;rdquo; RM &amp;ldquo;N&amp;rdquo; reported reviews and completes resident fall investigations and reported R101 has had several recent falls with recent fracture because of poor safety awareness and again reported had no prior knowledge of R101 behaviors towards R102. (Evidence that thorough investigation had not been completed for frequent falls and resident to resident events to determine root cause related to ongoing behaviors.)</p> <p>During an interview and record review on 10/1/25 at 1:34 p.m., NHA &amp;ldquo;A&amp;rdquo; reported facility had additional information that had not yet been provided related to R101 and R102 that facility felt was an issue with staff performance of Registered Nurse (RN) &amp;ldquo;P&amp;rdquo;. NHA &amp;ldquo;A&amp;rdquo; provided file for R101 and R102 resident to resident events on 8/23/25 and 9/6/25 on facility letterhead of typed events. NHA &amp;ldquo;A&amp;rdquo; reported RN &amp;ldquo;P&amp;rdquo; no longer worked at facility. Review of the file reflected handwritten statement from CNA &amp;ldquo;R&amp;rdquo;, dated 8/23/25, that reflected, &amp;ldquo;On 8/23 [named R101] became agitated at [named R102] and open hand smacked her on her shoulder/chest area. This happened approximately around 3:30 p.m.&amp;rdquo; The statement was signed by CNA &amp;ldquo;R&amp;rdquo;. Continued review of the file reflected a second timeline of events on facility letter head for R101 and R102, dated 9/6/25, reflected two, &amp;ldquo;Hey Social Work&amp;rdquo; documents, dated 9/6/25. Review of R101's first, Hey Social Work documents reflected, &amp;ldquo;Resident is being aggressive with other residents, shaking them, in their face, yelling at them accusing them.&amp;rdquo; The form included R101 had the following behavior: yelling, abusive language, grabbing, accusing, pushing, and expressing anger and unable to redirect. The document was signed by CNA &amp;ldquo;R&amp;rdquo;. Review of the second Hey Social Work document, dated 9/6/25, reflected, &amp;ldquo;resident is being aggressive towards other residents especially [named R102] he thinks she is his wife. He is running into nurse and aides with w/c[wheelchair].&amp;rdquo; The form included R101 had the same marked behaviors as the first document.</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a telephone interview on 10/1/25 at 3:11 p.m., CNA &amp;rdquo;R&amp;rdquo; reported usually worked on the dementia unit in the basement on second shift with both R101 and R102. CNA &amp;rdquo;R&amp;rdquo; reported R101 frequently gets very fixated on R102 and yells at her, grabs her and has shaken R102 in the past. CNA &amp;rdquo;R&amp;rdquo; reported staff attempt to keep R101 and R102 separated, and staff try to intervene to reduce risk of altercation. CNA &amp;rdquo;R&amp;rdquo; reported R102 was[AGE] years old with dementia and is unsure if she knows what is happening and R101 is convinced R102 is his wife. CNA &amp;rdquo;R&amp;rdquo; reported recalled incident in August 2025 when R101 was patting R102 and the shoulder and shouting, hey, hey in R102 face. CNA &amp;rdquo;R&amp;rdquo; reported on 9/6/25 R101 approached R102 and grabbed R102 shoulders and started shaking R102 back and forth and both CNA staff separated residents. CNA &amp;rdquo;R&amp;rdquo; reported told R101 he was not allowed to put his hands on other residents, and R101 became upset and incident was reported to RN &amp;rdquo;P&amp;rdquo; and also completed, &amp;rdquo;Hey Social Worker&amp;rdquo; document. CNA &amp;rdquo;R&amp;rdquo; reported incident was reported to nurse because potential allegation of abuse that was required to be reported immediately. CNA &amp;rdquo;R&amp;rdquo; reported after 9/6/25 incident there were no changes in interventions but to continue to attempt to keep R101 and R102 separated. CNA &amp;rdquo;R&amp;rdquo; reported R101 does get mad at R102 and had called her an old hag and stated residents do not deserve to be treated that way or called names and should be reported.</p> <p>During a telephone interview on 10/2/25 at 10:26 a.m., CNA &amp;rdquo;V&amp;rdquo; reported often worked second shift with both R101 and R102. CNA &amp;rdquo;V&amp;rdquo; reported R101 was obsessed with R102 and staff constantly have to separate them. CNA V reported R101 behaviors escalate when not allowed to be right next to R102 with attempt to even try to push her wheelchair. CNA &amp;rdquo;V&amp;rdquo; reported R101 aggressive behaviors toward R102 have increase over past four to six weeks and staff have expressed concerns to several management staff including DON &amp;rdquo;B&amp;rdquo;. CNA &amp;rdquo;V&amp;rdquo; reported R101 has also had several falls because he is so determined to get to R102 including recent fall with fracture. CNA &amp;rdquo;V&amp;rdquo; reported staff attempt to redirect but often not effective and R101 requires one on one supervision that is not always possible to properly care for other residents. CNA &amp;rdquo;V&amp;rdquo; stated R101 is often, &amp;rdquo;Locked on that thought and nothing else matters to him. &amp;rdquo; CNA &amp;rdquo;V&amp;rdquo; reported R101 has called R102 a bitch as well as other residents. CNA &amp;rdquo;V&amp;rdquo; reported R101 resident to resident altercations to the second shift supervisor &amp;rdquo;AA&amp;rdquo;. CNA &amp;rdquo;V&amp;rdquo; reported R101 behaviors have been progressively getting worse and occur at least three times per week at a minimum and are reported to charge nurse because they are potential allegations of abuse. CNA &amp;rdquo;V&amp;rdquo; reported last week DON &amp;rdquo;B&amp;rdquo; had to take R101 off the unit because R102 had family that was visiting and R101 was agitated that he did not know who they were and did not want them with R102 and reported R102s family appeared frustrated with situation.</p> <p>During an interview on 10/2/25 at 10:48 p.m., Social Worker (SW) &amp;rdquo;K&amp;rdquo; reported R101 had behaviors that included history of being combative with staff and thinks a female resident is his wife and gets focused and agitation often increases in the afternoons. SW &amp;rdquo;K&amp;rdquo; reported the, &amp;rdquo;Hey Social Worker&amp;rdquo; was a tool that staff use to communicate behaviors residents might be having with Social Worker and reported had not received any for R101. SW &amp;rdquo;K&amp;rdquo; reported was not aware of any resident-to-resident altercations with R101 and R102 other than when R101 taps R102 on shoulder to get her attention. SW &amp;rdquo;K&amp;rdquo; reviewed, &amp;rdquo;Hey Social Worker&amp;rdquo; forms provided by NHA &amp;rdquo;A&amp;rdquo;, dated 9/6/25, and verified had never seen either one. SW &amp;rdquo;K&amp;rdquo; reported if she had received the documents would have reported to NHA &amp;rdquo;A&amp;rdquo; immediately because allegations of physical abuse that needed to be reported and investigated and need to follow up with all parties involved because she was the facility SW.</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 10/2/25 at 11:26 a.m., NHA &amp;ldquo;A&amp;rdquo; reported had been in position for five years and was also the abuse coordinator. NHA &amp;ldquo;A&amp;rdquo; reported staff are expected to report all allegations of abuse to nurse supervisor, DON &amp;ldquo;B&amp;rdquo;, or NHA &amp;ldquo;A&amp;rdquo; immediately. NHA &amp;ldquo;A&amp;rdquo; reported did not reported R101 and R102 resident to resident allegations of abuse to the State of Michigan (SOM) because they delt with it as personal issue not allegation of abuse and stated, &amp;ldquo;in hindsight that was incorrect.&amp;rdquo; NHA &amp;ldquo;A&amp;rdquo; reported should have reported R101 and R102 incidents on 8/23/25 and 9/6/25 to the SOM as allegations of abuse and verified that was wrong.</p> <p>During an interview on 10/2/25 at 11:56 a.m., DON &amp;ldquo;B&amp;rdquo; reported received a call from supervisor that RN &amp;ldquo;P&amp;rdquo; had reported an incident that occurred at the beginning of the shift that CNA staff reported R101 was going after R102 related to both incidents on 8/23/25 and 9/6/25. DON &amp;ldquo;B&amp;rdquo; reported did not believe RN &amp;ldquo;P&amp;rdquo; but should have believed CNA staff that included written witness statements, should have reported to the NHA &amp;ldquo;A&amp;rdquo;, State of Michigan, and completed thorough investigation.</p> <p>Review of the medical record reflected R104 was admitted to the facility on [DATE], with diagnoses that included dementia. The Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 8/2/25, reflected R104 scored 7 out of 15 (severe impairment) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool).</p> <p>Review of the medical record reflected R105 was admitted to the facility on [DATE], with diagnoses that included dementia, need for assistance for personal care, mild cognitive impairment, and Alzheimer's disease. The Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 7/6/25, reflected R105 was unable to have a Brief Interview for Mental Status (BIMS-a cognitive screening tool) conducted due to severe cognitive impairment.</p> <p>On 9/25/25 at 2:57 PM, R104 was observed in his room seated in his wheelchair. R104 was talking out loud said &amp;ldquo;ehhhh&amp;rdquo; and &amp;ldquo;ohhh.&amp;rdquo; After entry into his room, R104 was welcoming to conversation and stated that he had a bird that he loves to talk with.</p> <p>On 9/25/25 at 3:12 PM, R105 was observed in bed resting.</p> <p>Review of R104's Care plan reflected an added intervention on 3/27/23 and revised on 3/21/25 which stated &amp;ldquo;&amp;hellip;He is also inappropriate at times. If [R104] is participating in a group setting such as eating in the dining room or an activity, wait to bring the resident down until at least one staff member is present to monitor. [R104] also sits by male residents during activities and in the dining room&amp;hellip;&amp;rdquo;.</p> <p>Review of R105's Electronic Medical Record reflected that R105 was nonverbal and used nonverbal cues and sounds/cries in an attempt to make needs known.</p> <p>Review of a Behavior Note on 2/21/25 revealed R104 had to be corrected many times during the 6-2 shift about being inappropriate with other residents and with the CNA's. He tried to grab a CNA's bottom while they were walking by. He kept whistling at another resident until it made her upset and she had to propel away. He heckled the CNA'S whenever he was in the halls and not in bed.</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of a Behavior Note dated 3/7/25 revealed R104 stated to a female resident while in dining room, Hey baby, let me feel your tits. Writer did not know about this until several hours post incident but did speak to resident about it and told him how inappropriate it was.</p> <p>In an interview on 9/25/25 at 12:53 pm, Registered Nurse (RN) P stated that she received information during shift report during a shift in late March 2025 that R104 was observed groping R104's breasts in the activity room. LPN P was advised to ensure that R104 and R105 were not seated near each other to maintain R105's safety.</p> <p>In an interview on 9/29/25 at 9:59 am, Certified Nursing Assistant (CNA) J reported that she was working the day, back in March 2025, that R104 was observed fondling R105's breasts. CNA J stated that both residents were in the activity room and CNA J overheard a commotion. When CNA J responded, R104 was observed handling R105's breasts. Moving forward, staff was instructed to ensure that R104 and R105 were not placed near each other. CNA J reported this to the nurse.</p> <p>In an interview on 9/29/25 at 4:04 pm, CNA L stated that he overheard R105 yelling and immediately identified that R105 was upset about something. CNA L entered the activity room to observe R104 grabbing R105's breasts. R105 was visibly disturbed about the actions of R104. CNA L stated he separated the residents immediately and was asked to fill out an incident report.</p> <p>On 10/2/25 at 11:26 AM, Nursing Home Administrator (NHA) A verified that he was the abuse coordinator and explained the process of reporting abuse allegations. When asked if he had any awareness of this incident, NHA A denied knowing about R104 incident with R105, however, did stated that the incident should have been reported to him and that he would have reported it to the State of Michigan and completed an investigation. NHA A and Director of Nursing B both reported that there were no incident reports or investigations for this incident.</p> <p>Review of the Abuse, Neglect and Exploitation Policy implemented 9/2021 and reviewed 9/2024 defined sexual abuse as non-consensual sexual contact of any type. The same policy stated, an immediate investigation is warranted when suspicion of abuse, neglect, or exploitation, or reports of abuse, neglect or exploitation occur . reporting of all alleged violations to the Administrator, state agency .immediately, but no later than 2 hours after the allegation is made .</p> <p>Applying the reasonable person standard, it can be expected that R105 would have experienced emotional distress as a result of the abuse, as such a reaction aligns with how an average person would respond under similar circumstances.</p>		

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NAME OF PROVIDER OR SUPPLIER  Hillsdale County Medical Care Facility		STREET ADDRESS, CITY, STATE, ZIP CODE  140 W Mechanic Street Hillsdale, MI 49242	
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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observations, interviews, and record review, the facility failed to develop and/or implement policies and procedures for ensuring the reporting of a reasonable suspicion of a crime in accordance with section 1150B of the Act. Findings include:Review of the medical record reflected R104 was admitted to the facility on [DATE], with diagnoses that included dementia. The Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 8/2/25, reflected R104 scored 7 out of 15 (severe impairment) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool).</p> <p>Review of the medical record reflected R105 was admitted to the facility on [DATE], with diagnoses that included dementia, need for assistance for personal care, mild cognitive impairment, and Alzheimer's disease. The Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 7/6/25, reflected R105 was unable to have a Brief Interview for Mental Status (BIMS-a cognitive screening tool) conducted due to severe cognitive impairment.</p> <p>On 9/25/25 at 2:57 PM, R104 was observed in his room seated in his wheelchair. R104 was talking out loud said "ehhhh" and "ohhh." After entry into his room, R104 was welcoming to conversation and stated that he had a bird that he loves to talk with.</p> <p>On 9/25/25 at 3:12 PM, R105 was observed in bed resting.</p> <p>Review of R104's Care plan reflected an added intervention on 3/27/23 and revised on 3/21/25 which stated "He is also inappropriate at times. If [R104] is participating in a group setting such as eating in the dining room or an activity, wait to bring the resident down until at least one staff member is present to monitor. [R104] also sits by male residents during activities and in the dining room";.</p> <p>Review of R105's Electronic Medical Record reflected that R105 was nonverbal and used nonverbal cues and sounds/cries in an attempt to make needs known.</p> <p>Review of a Behavior Note on 2/21/25 revealed R104 had to be corrected many times during the 6-2 shift about being inappropriate with other residents and with the CNA's. He tried to grab a CNA's bottom while they were walking by. He kept whistling at another resident until it made her upset and she had to propel away. He heckled the CNA'S whenever he was in the halls and not in bed.</p> <p>Review of a Behavior Note dated 3/7/25 revealed R104 stated to a female resident while in dining room, Hey baby, let me feel your tits. Writer did not know about this until several hours post incident but did speak to resident about it and told him how inappropriate it was.</p> <p>In an interview on 9/25/25 at 12:53 pm, Registered Nurse (RN) P stated that she received information during shift report during a shift in late March 2025 that R104 was observed groping R104's breasts in the activity room. LPN P was advised to ensure that R104 and R105 were not seated near each other to maintain R105's safety.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 9/29/25 at 9:59 am, Certified Nursing Assistant (CNA) J reported that she was working the day, back in March 2025, that R104 was observed fondling R105's breasts. CNA J stated that both residents were in the activity room and CNA J overheard a commotion. When CNA J responded, R104 was observed handling R105's breasts. Moving forward, staff was instructed to ensure that R104 and R105 were not placed near each other. CNA J reported this to the nurse.</p> <p>In an interview on 9/29/25 at 4:04 pm, CNA L stated that he overheard R105 yelling and immediately identified that R105 was upset about something. CNA L entered the activity room to observe R104 grabbing R105's breasts. R105 was visibly disturbed about the actions of R104. CNA L stated he separated the residents immediately and was asked to fill out an incident report.</p> <p>On 10/2/25 at 11:26 AM, Nursing Home Administrator (NHA) A verified that he was the abuse coordinator and explained the process of reporting abuse allegations. When asked if he had any awareness of this incident, NHA A denied knowing about R104 incident with R105, however, did stated that the incident should have been reported to him and that he would have reported it to the State of Michigan and completed an investigation. NHA A and Director of Nursing B both reported that there were no incident reports or investigations for this incident.</p> <p>Review of the Abuse, Neglect and Exploitation Policy implemented 9/2021 and reviewed 9/2024 defined sexual abuse as non-consensual sexual contact of any type. The same policy stated, an immediate investigation is warranted when suspicion of abuse, neglect, or exploitation, or reports of abuse, neglect or exploitation occur . reporting of all alleged violations to the Administrator, state agency .immediately, but no later than 2 hours after the allegation is made .</p> <p>Applying the reasonable person standard, it can be expected that R105 would have experienced emotional distress as a result of the abuse, as such a reaction aligns with how an average person would respond under similar circumstances.</p> <p>A review of the State Operations Manual (SOM), revised 4/25/25, revealed, The facility must take the following actions in response to an alleged violation of abuse, neglect, exploitation or mistreatment: Thoroughly investigate the alleged violation . For all alleged violations of abuse, neglect, exploitation, misappropriation of resident property, exploitation, and mistreatment, including injuries of unknown source . the facility must thoroughly collect evidence to allow the Administrator to determine what actions are necessary (if any) for the protection of residents. Depending upon the type of allegation received, it is expected that the investigation would include, but is not limited to . Conducting interviews with, as appropriate, the alleged victim and representative, alleged perpetrator, witnesses .</p> <p>Review of the Face Sheet and Minimum Data Set (MDS) dated [DATE], reflected R101 was an [AGE] year-old male admitted to the facility on [DATE], with diagnoses that included dementia, anxiety and depression. The MDS reflected that R101s had a BIM (assessment tool) score which indicated his ability to make daily decisions was severely impaired.</p> <p>Review of the Face Sheet and Minimum Data Set (MDS) dated [DATE], reflected R102 was an [AGE] year-old female admitted to the facility on [DATE], with diagnoses that included dementia, anxiety, falls, unsteady on feet, and depression. The MDS reflected that R102s had a BIM (assessment tool) score which indicated her ability to make daily decisions was severely impaired.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the complaint received by the State Agency on 9/24/25 alleged the facility failed to prevent and report abuse allegations to the State Agency.</p> <p>During a telephone interview on 9/25/25 at 11:59 a.m., Complainant &amp;Yrdquo; verified complaint and reported often worked in basement of facility on dementia unit. Complainant &amp;Yrdquo; reported on 8/23/25 R101 walked up to R102 and started shoving R102 and hitting R102 on the shoulder and staff separated residents and incident was reported to supervisor who was told incident needed to be reported to Director of Nursing (DON) &amp;Brdquo; and Nursing Home Administrator (NHA) &amp;Ardquo; because abuse allegation. Complainant &amp;Yrdquo; believes Nurse Supervisor notified DON &amp;Brdquo; and was told did not need to be reported because both residents had dementia and NHA &amp;Ardquo; followed up and told Complainant Y the same. Complainant &amp;Yrdquo; reported on 9/6/25 R101 was ramming wheelchair into R102 while she was eating and staff separated residents, assessments were completed. Complainant &amp;Yrdquo; reported R101 behaviors increased and at one-point R101 placed hands on R102 shoulders and started shaking R102 violently making R102s entire body move. Residents were again separated and assessments completed, and same nurse supervisor was notified along with physician who ordered intramuscular Ativan. Complainant &amp;Yrdquo; reported R101 was a strong male and R102 was frail [AGE] year-old women. Complainant &amp;Yrdquo; reported Certified Nurse Assistant (CNA) &amp;Rrdquo; got to R102 first and separated residents and R102 was taken to her private room and event was also reported to DON &amp;Brdquo; and NHA &amp;Ardquo; and physician via secure conversation/text. Complainant &amp;Yrdquo; reported was questioned after event by NHA &amp;Ardquo; who reported not to use word, &amp;quot;violent&amp;rdquo; in documentation and Complainant &amp;Yrdquo; reported there was no other word to describe the event. Complainant &amp;Yrdquo; reported NHA &amp;Ardquo; reported intervention would be to remove wheelchair but Complainant Y reported was unsure how that would even help because R101 was not in wheelchair when he approached R102 and started shaking her. Complainant &amp;Yrdquo; reported was told neither resident to resident incident was reported to the State of Michigan because both residents had dementia.</p> <p>During an observation on 9/29/25 at 9:55 a.m., R101 and R102 was observed in dementia unit, located in the facility basement. R101 and R102 were in the common area sitting in recliners that were lined up around the television four chairs apart from each other. R101 had a brace on right knee and observed staff assisted R101 to the bathroom via a wheelchair. The unit had two certified nurse aids and one nurse and about 10 residents present.</p> <p>During an interview on 9/29/25 at 1:00 p.m., Nursing Home Administrator (NHA) &amp;Ardquo; reported was the facility Abuse Coordinator. NHA &amp;Ardquo; reported had two reported allegations of abuse in past 10 months. The two abuse allegations did not include R101 or R102.</p> <p>Requested all Incident/Accident reports with complete investigations for R101 and R102 on 9/29/25 at 2:37 p. m.</p> <p>Received all R101 and R102 Incident/Accident reports for last six months with no resident-to-resident incidents on 9/29/25 at 3:23 p.m.</p> <p>Review of R101 Nurse Progress Note, dated 6/20/25 at 9:35 p.m., reflected, &amp;quot;CNA [certified nurse aid] came up to writer and reports that she has seen resident put his finger in another patients face [R102] and shouldn't sit next to her because he tried to control her and calls her his wife. States she doesn't think they should sit together anymore.&amp;rdquo;</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of R101 Nurse Progress Note, dated 8/23/25 at 8:31 p.m., reflected, &amp;ldquo;Reported to supervisor at 2024[8:24 p.m.] that this resident was seen by CENA [Competency Evaluated Nursing Assistant] striking a female resident multiple times on shoulder and chest earlier this shift. Writer was not made aware of this until approximately 2000.&amp;rdquo;</p> <p>Review of R101 Nurse Progress Note, dated 8/23/25 at 9:50 p.m., reflected, &amp;ldquo;DON notified of CN [charge nurse] report of incident.&amp;rdquo;</p> <p>Review of R101 Behavior Progress Note, dated 9/6/25 at 3:00 p.m., reflected, &amp;ldquo;Resident being very aggressive to staff. Trying to run into CNAs with WC [wheelchair]. Trying to approach a female resident thinking she is his wife. Tried to go into female resident room. Phone call placed to [named Medical Director &amp;ldquo;X&amp;rdquo;] and one time order given for 1mg Ativan IM. POA [power of attorney] aware.&amp;rdquo;</p> <p>Review of R101 Nursing Progress Note, dated 9/6/25 at 3:04 p.m., reflected, &amp;ldquo;At approximately 1420 [2:20 p.m.], resident ambulated to female pt. [patient] who was sitting in recliner chair in great room and placed his hands on her shoulders and began violently shaking her. Staff intervened and ended this behavior and female pt. was taken to her room to eliminate stimulus. This resident continued to try to locate female pt. whom he thought was his wife and ran his w/c into all staff members intentionally on multiple occasions. Was yelling throughout demanding to know where his wife was. Attempted to provide food, fluids and offered a walk outside all new order for Ativan 1mg IM obtained and given at approximately 1435 [2:35 p.m.]&amp;rdquo;</p> <p>Review of R101 Nurse Progress Note, dated 9/6/25 at 8:58 p.m., reflected, &amp;ldquo;At approx 1810 [6:10 p.m.], as most residents had eaten supper, this resident began ramming his w/c into a female resident's w/c. This resident believes this female is his wife and unable to convince him otherwise or distract him. Female resident was still eating when this occurred and residents were separated at this time. This resident went back two additional times and rammed his w/c into hers. Resident was asked why he was doing this and he stated, how else am I supposed to get her attention?</p> <p>Review of R101 Nurse Progress Note, dated 9/7/25 at 3:43 p.m., reflected, &amp;ldquo;Per report, pt. was fine all first shift. As soon as second shift began, pt. started to ramp up again. Has been yelling about wanting to see his wife, referring to specific female pt. Female was removed from great room prior so that pt would not become fixated on her again. So far this shift he has rammed his w/c into staff X1 [times one] and tried to ram into a visitor that staff was speaking with but staff intervened. Has been yelling quite a bit this shift about specific female pt. and that staff is liars&amp;hellip;Since all this tends to happen on second shift, question if this is a circadian cycle for this pt. and if he needs a routine medication to control it. Currently gets Buspar 5mg tid[three times daily] but it is not helping. The 1mg Ativan yesterday did seem to help. Not asking for anything right now but will text you if situation worsens.&amp;rdquo;</p> <p>Review of R101 Behavior Progress Note, dated 9/12/25, reflected, &amp;ldquo;At 10:05 am, [named R101] was sitting in a PC[personal chair] chair up at the TV area and began to express, Where is [named wife], I want to see my wife, [named wife]! Staff sat with him explaining that his wife lived at another facility. [named R101] expressed, No she's not, where is she, I just seen her.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 9/29/25 at 3:46 p.m., Licensed Practical Nurse Risk Manager (RM) &amp;ldquo;N&amp;rdquo; reported had been in that role about five months and had worked at the facility for 12 years. RM &amp;ldquo;N&amp;rdquo; reported R101 was non-complaint who had no safety awareness with diagnosis of dementia who lives in dementia unit in the basement of the facility. RM &amp;ldquo;N&amp;rdquo; reported R101 thinks R102 was his wife and often require one on one care because he becomes fixated on R102. RM &amp;ldquo;N&amp;rdquo; reported worked on R101s unit 9/25/25 second shift and reported was not aware prior to that day R101 was fixated on R102 and reported R101 had increased behaviors and had to call DON &amp;ldquo;B&amp;rdquo; for additional assistance even with one-on-one care for R101. RM &amp;ldquo;N&amp;rdquo; verified she documented the following Nurse Progress Note, dated 9/25/25 at 4:02 p.m., &amp;ldquo;Elder was sitting in personal chair in dayroom upon my arrival to the unit at 1400[2:00 p.m.]. Noticed he was picking at his arm protectors and wanted to walk. He [R101] stood up without assistance X2[times two]. First time CNA [certified nurse aid] took him to the bathroom with AX2[assist time two], gait belt and w/c[wheelchair]. 2nd time they went for a stroll in his w/c outside for a bit. He was then placed back in his personal chair with CNA sitting beside him. Writer asked CNA what usually helps him stay distracted, and she replied someone sitting with him at all times giving him attention. CNA left the unit to go to lunch. Writer sat beside Elder and conversated with him. He kept directing the topic back to who he thinks is his wife which is truly just another Resident who was sitting within his sight. The other assigned CNA was doing bed checks and toileting Elders. Family members to another Elder came in to visit which intensified his[R101] behaviors. He was so worried who was talking to his wife, I don't know those people, I need to make sure my wife is okay. AX2 [assist time two] with gait belt stood him up to reposition him to his w/c to diffuse the situation by bringing him outside. DON was paged to the unit and Social Work accompanied her. They talked with Elder and wheeled him around the facility prior to bringing him back and doing puzzles together. All was well upon my departure at 4pm.&amp;rdquo; RM &amp;ldquo;N&amp;rdquo; reported reviews and completes resident fall investigations and reported R101 has had several recent falls with recent fracture because of poor safety awareness and again reported had no prior knowledge of R101 behaviors towards R102. (Evidence that thorough investigation had not been completed for frequent falls and resident to resident events to determine root cause related to ongoing behaviors.)</p> <p>During an interview and record review on 10/1/25 at 1:34 p.m., NHA &amp;ldquo;A&amp;rdquo; reported facility had additional information that had not yet been provided related to R101 and R102 that facility felt was an issue with staff performance of Registered Nurse (RN) &amp;ldquo;P&amp;rdquo;. NHA &amp;ldquo;A&amp;rdquo; provided file for R101 and R102 resident to resident events on 8/23/25 and 9/6/25 on facility letterhead of typed events. NHA &amp;ldquo;A&amp;rdquo; reported RN &amp;ldquo;P&amp;rdquo; no longer worked at facility. Review of the file reflected handwritten statement from CNA &amp;ldquo;R&amp;rdquo;, dated 8/23/25, that reflected, &amp;ldquo;On 8/23 [named R101] became agitated at [named R102] and open hand smacked her on her shoulder/chest area. This happened approximately around 3:30 p.m.&amp;rdquo; The statement was signed by CNA &amp;ldquo;R&amp;rdquo;. Continued review of the file reflected a second timeline of events on facility letter head for R101 and R102, dated 9/6/25, reflected two, &amp;ldquo;Hey Social Work&amp;rdquo; documents, dated 9/6/25. Review of R101's first, Hey Social Work documents reflected, &amp;ldquo;Resident is being aggressive with other residents, shaking them, in their face, yelling at them accusing them.&amp;rdquo; The form included R101 had the following behavior: yelling, abusive language, grabbing, accusing, pushing, and expressing anger and unable to redirect. The document was signed by CNA &amp;ldquo;R&amp;rdquo;. Review of the second Hey Social Work document, dated 9/6/25, reflected, &amp;ldquo;resident is being aggressive towards other residents especially [named R102] he thinks she is his wife. He is running into nurse and aides with w/c[wheelchair].&amp;rdquo; The form included R101 had the same marked behaviors as the first document.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a telephone interview on 10/1/25 at 3:11 p.m., CNA &amp;rdquo;R&amp;rdquo; reported usually worked on the dementia unit in the basement on second shift with both R101 and R102. CNA &amp;rdquo;R&amp;rdquo; reported R101 frequently gets very fixated on R102 and yells at her, grabs her and has shaken R102 in the past. CNA &amp;rdquo;R&amp;rdquo; reported staff attempt to keep R101 and R102 separated, and staff try to intervene to reduce risk of altercation. CNA &amp;rdquo;R&amp;rdquo; reported R102 was[AGE] years old with dementia and is unsure if she knows what is happening and R101 is convinced R102 is his wife. CNA &amp;rdquo;R&amp;rdquo; reported recalled incident in August 2025 when R101 was patting R102 and the shoulder and shouting, hey, hey in R102 face. CNA &amp;rdquo;R&amp;rdquo; reported on 9/6/25 R101 approached R102 and grabbed R102 shoulders and started shaking R102 back and forth and both CNA staff separated residents. CNA &amp;rdquo;R&amp;rdquo; reported told R101 he was not allowed to put his hands on other residents, and R101 became upset and incident was reported to RN &amp;rdquo;P&amp;rdquo; and also completed, &amp;rdquo;Hey Social Worker&amp;rdquo; document. CNA &amp;rdquo;R&amp;rdquo; reported incident was reported to nurse because potential allegation of abuse that was required to be reported immediately. CNA &amp;rdquo;R&amp;rdquo; reported after 9/6/25 incident there were no changes in interventions but to continue to attempt to keep R101 and R102 separated. CNA &amp;rdquo;R&amp;rdquo; reported R101 does get mad at R102 and had called her an old hag and stated residents do not deserve to be treated that way or called names and should be reported.</p> <p>During a telephone interview on 10/2/25 at 10:26 a.m., CNA &amp;rdquo;V&amp;rdquo; reported often worked second shift with both R101 and R102. CNA &amp;rdquo;V&amp;rdquo; reported R101 was obsessed with R102 and staff constantly have to separate them. CNA V reported R101 behaviors escalate when not allowed to be right next to R102 with attempt to even try to push her wheelchair. CNA &amp;rdquo;V&amp;rdquo; reported R101 aggressive behaviors toward R102 have increase over past four to six weeks and staff have expressed concerns to several management staff including DON &amp;rdquo;B&amp;rdquo;. CNA &amp;rdquo;V&amp;rdquo; reported R101 has also had several falls because he is so determined to get to R102 including recent fall with fracture. CNA &amp;rdquo;V&amp;rdquo; reported staff attempt to redirect but often not effective and R101 requires one on one supervision that is not always possible to properly care for other residents. CNA &amp;rdquo;V&amp;rdquo; stated R101 is often, &amp;rdquo;Locked on that thought and nothing else matters to him. &amp;rdquo; CNA &amp;rdquo;V&amp;rdquo; reported R101 has called R102 a bitch as well as other residents. CNA &amp;rdquo;V&amp;rdquo; reported R101 resident to resident altercations to the second shift supervisor &amp;rdquo;AA&amp;rdquo;. CNA &amp;rdquo;V&amp;rdquo; reported R101 behaviors have been progressively getting worse and occur at least three times per week at a minimum and are reported to charge nurse because they are potential allegations of abuse. CNA &amp;rdquo;V&amp;rdquo; reported last week DON &amp;rdquo;B&amp;rdquo; had to take R101 off the unit because R102 had family that was visiting and R101 was agitated that he did not know who they were and did not want them with R102 and reported R102s family appeared frustrated with situation.</p> <p>During an interview on 10/2/25 at 10:48 p.m., Social Worker (SW) &amp;rdquo;K&amp;rdquo; reported R101 had behaviors that included history of being combative with staff and thinks a female resident is his wife and gets focused and agitation often increases in the afternoons. SW &amp;rdquo;K&amp;rdquo; reported the, &amp;rdquo;Hey Social Worker&amp;rdquo; was a tool that staff use to communicate behaviors residents might be having with Social Worker and reported had not received any for R101. SW &amp;rdquo;K&amp;rdquo; reported was not aware of any resident-to-resident altercations with R101 and R102 other than when R101 taps R102 on shoulder to get her attention. SW &amp;rdquo;K&amp;rdquo; reviewed, &amp;rdquo;Hey Social Worker&amp;rdquo; forms provided by NHA &amp;rdquo;A&amp;rdquo;, dated 9/6/25, and verified had never seen either one. SW &amp;rdquo;K&amp;rdquo; reported if she had received the documents would have reported to NHA &amp;rdquo;A&amp;rdquo; immediately because allegations of physical abuse that needed to be reported and investigated and need to follow up with all parties involved because she was the facility SW.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Hillsdale County Medical Care Facility		STREET ADDRESS, CITY, STATE, ZIP CODE  140 W Mechanic Street Hillsdale, MI 49242	

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 10/2/25 at 11:26 a.m., NHA &amp;rdquo;A&amp;rdquo; reported had been in position for five years and was also the abuse coordinator. NHA &amp;rdquo;A&amp;rdquo; reported staff are expected to report all allegations of abuse to nurse supervisor, DON &amp;rdquo;B&amp;rdquo;, or NHA &amp;rdquo;A&amp;rdquo; immediately. NHA &amp;rdquo;A&amp;rdquo; reported did not reported R101 and R102 resident to resident allegations of abuse to the State of Michigan (SOM) because they delt with it as personal issue not allegation of abuse and stated, &amp;rdquo;in hindsight that was incorrect.&amp;rdquo; NHA &amp;rdquo;A&amp;rdquo; reported should have reported R101 and R102 incidents on 8/23/25 and 9/6/25 to the SOM as allegations of abuse and verified that was wrong.</p> <p>During an interview on 10/2/25 at 11:56 a.m., DON &amp;rdquo;B&amp;rdquo; reported received a call from supervisor that RN &amp;rdquo;P&amp;rdquo; had reported an incident that occurred at the beginning of the shift that CNA staff reported R101 was going after R102 related to both incidents on 8/23/25 and 9/6/25. DON &amp;rdquo;B&amp;rdquo; reported did not believe RN &amp;rdquo;P&amp;rdquo; but should have believed CNA staff that included written witness statements, should have reported to the NHA &amp;rdquo;A&amp;rdquo;, State of Michigan, and completed thorough investigation.</p>

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>(continued on next page)</p>

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review the facility failed to investigate an allegation of abuse in one (Resident #105) out of 7 reviewed for abuse. Findings include:Review of the medical record reflected R104 was admitted to the facility on [DATE], with diagnoses that included dementia. The Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 8/2/25, reflected R104 scored 7 out of 15 (severe impairment) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool). Review of the medical record reflected R105 was admitted to the facility on [DATE], with diagnoses that included dementia, need for assistance for personal care, mild cognitive impairment, and Alzheimer's disease. The Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 7/6/25, reflected R105 was unable to have a Brief Interview for Mental Status (BIMS-a cognitive screening tool) conducted due to severe cognitive impairment. On 9/25/25 at 2:57 PM, R104 was observed in his room seated in his wheelchair. R104 was talking out loud said ehhhh and ohhh. After entry into his room, R104 was welcoming to conversation and stated that he had a bird that he loves to talk with. On 9/25/25 at 3:12 PM, R105 was observed in bed resting. Review of R104's Care plan reflected an added intervention on 3/27/23 and revised on 3/21/25 which stated .He is also inappropriate at times. If [R104] is participating in a group setting such as eating in the dining room or an activity, wait to bring the resident down until at least one staff member is present to monitor. [R104] also sits by male residents during activities and in the dining room.Review of R105's Electronic Medical Record reflected that R105 was nonverbal and used nonverbal cues and sounds/cries in an attempt to make needs known. Review of a Behavior Note on 2/21/25 revealed R104 had to be corrected many times during the 6-2 shift about being inappropriate with other residents and with the CNA's. He tried to grab a CNA's bottom while they were walking by. He kept whistling at another resident until it made her upset and she had to propel away. He heckled the CNA'S whenever he was in the halls and not in bed.Review of a Behavior Note dated 3/7/25 revealed R104 stated to a female resident while in dining room, Hey baby, let me feel your tits. Writer did not know about this until several hours post incident but did speak to resident about it and told him how inappropriate it was.In an interview on 9/25/25 at 12:53 pm, Registered Nurse (RN) P stated that she received information during shift report during a shift in late March 2025 that R104 was observed groping R104's breasts in the activity room. LPN P was advised to ensure that R104 and R105 were not seated near each other to maintain R105's safety. In an interview on 9/29/25 at 9:59 am, Certified Nursing Assistant (CNA) J reported that she was working the day, back in March 2025, that R104 was observed fondling R105's breasts. CNA J stated that both residents were in the activity room and CNA J overheard a commotion. When CNA J responded, R104 was observed handling R105's breasts. Moving forward, staff was instructed to ensure that R104 and R105 were not placed near each other. CNA J reported this to the nurse.In an interview on 9/29/25 at 4:04 pm, CNA L stated that he overheard R105 yelling and immediately identified that R105 was upset about something. CNA L entered the activity room to observe R104 grabbing R105's breasts. R105 was visibly disturbed about the actions of R104. CNA L stated he separated the residents immediately and was asked to fill out an incident report. On 10/2/25 at 11:26 AM, Nursing Home Administrator (NHA) A verified that he was the abuse coordinator and explained the process of reporting abuse allegations. When asked if he had any awareness of this incident, NHA A denied knowing about R104 incident with R105, however, did stated that the incident should have been reported to him and that he would have reported it to the State of Michigan and completed an investigation. NHA A and Director of Nursing B both reported that there were no incident reports or investigations for this incident. Review of the Abuse, Neglect and Exploitation Policy implemented 9/2021 and reviewed 9/2024 defined sexual abuse as non-consensual sexual contact of any type. The same policy stated, an immediate investigation is warranted when suspicion of abuse, neglect, or exploitation, or reports of abuse, neglect or exploitation occur . reporting of all alleged violations to the Administrator, state agency .immediately, but no later than 2 hours after the allegation is made .Applying the reasonable person standard, it can be expected that R105 would have experienced emotional distress as a result of the abuse, as such a reaction aligns with how an average person would respond under similar circumstances.</p>		

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F 0684  Level of Harm - Actual harm  Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals.  (continued on next page)

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F 0684  Level of Harm - Actual harm  Residents Affected - Few	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review, the facility failed to provide the necessary standards of care and services for wound and skin care management in one (Resident #106) of three reviewed for quality of care. This deficient practice resulted in R106's hospitalization for septic shock, cellulitis, increased pain, and the need for intravenous antibiotic therapy, and implementation of hospice(end of life services) and death. This citation pertains to intake 2626820 Review of the Face Sheet and Minimum Data Set (MDS) dated [DATE], reflected R106 was an [AGE] year-old female admitted to the facility on [DATE], with diagnoses that included congestive heart failure (CHF), diabetes mellitus, hypertension (high blood pressure), legally blind, cellulitis, and lymphedema. The MDS reflected that R106s had a BIM (assessment tool) score of 14 which indicated her ability to make daily decisions was cognitively intact, and she required staff supervision with locomotion on unit, dressing, hygiene, bathing, and transfers. Continued review of the MDS reflected no history of refusal of care. Review of the complaint received by the State Agency alleged the facility failed to provide wound treatments as ordered resulting in sepsis and death. During a telephone interview on 9/25/25 at 11:59 a.m., Complainant Y verified complaint and reported R106 passed away after returning from hospital on hospice services. Complainant Y reported R106 was treated in the hospital for septic shock and cellulitis after a Licensed Practical Nurse (LPN) F did not follow physician orders and placed black plastic trash bags over R106's lower legs for over two days that caused infection. Complainant Y reported R106 required frequent as need dressing changes related to increase bilateral lower leg swelling and weeping around 6/20/25 and was told nurse placed trash bags on 6/21/25 and remained in place until 6/23/25 when found by the facility wound nurse who informed the Director of Nursing (DON) B. Complainant Y reported when the bags were removed from R106s legs on 6/23/25 the skin just slid off R106 legs and the wounds were significantly worse than prior week. Complainant Y reported was told R106 wanted to go to activity on 6/21/25 but legs were weeping so much the plastic bags were placed and the next shift was not informed and remained in place until found on 6/23/25 (two days later). Complainant Y reported R106 reported increased pain and was treated in the facility for cellulitis initially then transferred to the hospital after being found unresponsive on 7/10/25. Complainant Y reported had spoke with Medical Director X after R106 hospital admission and discussed black trash bags used as treatment and reported Medical Director X was shocked and unaware of situation. Complainant Y' reported facility risk manager was one of R106's nurses that weekend and stated, Common sense tells you it will cause a problem. What the h*ll were they thinking? Complainant Y reported R106 was alert and oriented who often went out with friends and had good quality of life prior to worsening of bilateral lower leg wound cellulitis on 6/23/25. Review of the Wound Evaluations, dated 6/20/25, reflected R106 had three new in-house acquired venous wounds (ruptured blisters) to bilateral lower legs with 0/10 on pain scale that included: #4 venous, Left Medial Malleolus - Middle-- measurement 3.3x3x0.1, cluster of 2, moderate serious drainage with no signs of infection. #5 venous, Right Medial Calf - Middle-- measurement: 4x2x0.1, moderate serious drainage with no signs of infection. #6 venous, Front Right Lateral Lower Leg-- measurement: 11x14x0.1, cluster of 11, moderate serious drainage with no signs of infection. Review of R106 Nurse Progress Note, dated 6/21/25 at 7:57 p.m., reflected, Wound Treatment Charting - The patient has had to have her bilateral leg dressings completed 4 times today 6 am - 8 pm. When the patient stands up the urine just runs all over her legs and the dressings are saturated with urine. The patient receives 2 Bumex 1 mg every am. The bilateral legs were washed with warm soap and water each time and new dressings applied. Supervisor notified. Review of R106's Treatment Administration Record (TAR), dated 6/21/25 through 6/23/25, reflected R106 had physician ordered treatments that included the following: Left distal medial low leg: Cleanse with normal saline, apply skin prep to periwound, cover wound with calcium alginate (2x2), cover with 4x4 bordered dressing every day shift. Left distal pretib: Cleanse with normal saline, apply skin prep to periwound, cover wound with calcium alginate (2x2), cover with 4x4 bordered dressing every day shift. Left Superior Pretib: Cleanse with normal saline, apply skin prep to periwound, cover wound with calcium alginate (2x2), cover with 4x4 bordered Dressing every day shift. Right Medial calf: Cleanse with normal saline, apply skin prep to periwound, cover wound with calcium alginate (2x2), cover with 4x4 bordered dressing every day shift. Right Pretib: Cleanse with normal saline, apply skin prep to area. Cover with ABD pads x 2, secure with kerlex and secure with tape every day shift Continued Review of R106 TAR dated 6/17/25 reflected whole (no documentation) for Bilateral lower</p>		